THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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SC Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

Appellate Case No.: 2018-000965

Victor G. Benjamin, Employee,.....Appellant,

v.

Rexam Beverage Can Company d/b/a Rexam Beverages, Employer, and
Hartford Insurance Company of the Midwest c/o Sedgwick CMS, Carrier,..... Respondents.

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Volume I

INDEX

I. **ORDERS** **1**

Decision and Order filed September 17, 2014 1

Appellate Panel Decision and Order filed April 23, 2015 20

Decision and Order filed July 21, 2017 48

Appellant Panel Decision and Order filed April 24, 2018 74

II. **PLEADINGS** **105**

Form 50 of June 20, 2011 105

Form 50 of May 3, 2016 106

Form 51 of June 2, 2016 107

Claimant's Form 58 of August 2, 2016 109

Claimant's APA Submissions 111

McLeod Regional Medical Center 111

Florence Neurosurgery & Spine 123

Pee Dee Orthopaedic Associates 128

Grand Strand Specialty Associates 129

Grand Strand Psychological Services 228

Post Trauma Resources 406

Dynamic Physical Therapy 497

Southeastern Spine Institute 572

Columbia Neurosurgical Associates 620

Conway Hospital Community Services 652

Florence Neurosurgery & Spine 668

Coastal Orthopedic Associates 675

Vocational Assessment by Dr. Robert Brabham 678

Defendants' APA Submissions 693
McLeod Regional Medical Center 693
Pee Dee Orthopaedic Associates, PA 697
Columbia Neurosurgical at Midlands Ortho 705
Florence Neurosurgery & Spine, PC 713
Florence MRI and Imaging 717
ImageCare, LLC 721
Florence MRI and Imaging 722
Post Trauma Resources 724
Southeastern Spine Institute 745
Conway Physicians Group 765
Sedgwick Surveillance Reports 822

Form 30 of August 3, 2017 830

Claimant/Appellants' Brief to Full Commission 833

III. TRANSCRIPTS 849

Deposition of Victor G. Benjamin of March 2, 2012 849
Caption 850
Examination by Ms. Hyatt 851
Pgs. 15 – 19 851
Pgs. 21 – 22 853
Pgs. 29 – 32 854
Pgs. 45 – 48 855
Pg. 51 856

Deposition of Victor G. Benjamin of March 31, 2014 857
Caption 857
Examination by Mr. Lockhart 858
Pg. 24 858
Pgs. 27 – 29 859
Pgs. 52 – 54 861

Deposition of Karl Lozanne, M.D. of May 21, 2014 863
Caption 863
Examination by Mr. Lockhart 865
Pg. 4 865
Pgs. 13 – 21 866
Re-examination by Mr. Lockhart 875
Pgs. 49 – 50 875

Transcript of Proceedings before Commissioner Susan Barden of June 23, 2014 877
Victor G. Benjamin 880
Direct Examination by Mr. Chandler 880
Pgs. 21 – 27 880
Pg. 30 887
Pg. 34 888
Cross Examination by Mr. Lockhart 889
Pgs. 43 – 46 889

Deposition of Karl Lozanne, M.D. of July 7, 2016 893
Caption 893
Examination by Mr. Lockhart 895
Cross-examination by Mr. Chandler 910
Defendant's Exhibit No. 1 921

Transcript of Proceedings before Commissioner Aisha Taylor of August 18, 2016 947
Victor G. Benjamin 958
Direct Examination by Mr. Chandler 958
Cross Examination by Mr. Lockhart 997
Letia Anderson Benjamin 1032
Direct Examination by Mr. Chandler 1032
Cross Examination by Mr. Lockhart 1057

IV. CERTIFICATE OF COUNSEL 1078

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1106789

VICTOR G. BENJAMIN, Employee, Claimant, vs. REXAM, INC., Employer, AND SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., Carrier, Defendants.	**DECISION AND ORDER**

DATE OF HEARING:	Hearing held in Sumter, South Carolina on June 23, 2014.
APPEARANCES:	Claimant appeared and represented by Jeffrey C. Chandler, Esquire of Chandler Law Firm of Myrtle Beach, South Carolina. Defendants represented by Jason W. Lockhart, Esquire of McAngus Goudelock & Courie, L.L.C. of Columbia, South Carolina.
PURPOSE OF THE HEARING:	To determine all issues as set forth in Forms 50 and 51.
COMMISSIONER:	Commissioner Susan S. Barden
FILED:	September 17, 2014

STIPULATIONS

1. Jurisdiction is proper with the South Carolina Workers' Compensation Commission.
2. Venue is proper in Sumter County, South Carolina.
3. Claimant's average weekly wage is One Thousand Four Hundred Sixty One Dollars ($1,461.40) and 40/100 with a corresponding compensation rate of Seven Hundred Four Dollars ($704.92) and 92/100.
4. No objections to the APA submissions.
5. The issue of compensability of all other body parts/conditions, listed on the Form 50 but not admitted as compensable by the Defendants, is held in abeyance.

APA SUBMISSIONS

Claimant submitted the following:

1. Dr. William B. Naso, McLeod Regional Medical Center, 06/15/11-06/17/11, pages 1-11;
2. Dr. William B. Naso, Florence Neurosurgery & Spine, 06/24/11-08/03/11, pages 12-17;
3. Dr. Matthew Welch, Pee Dee Orthopaedic Associates, 06/22/11-10/14/13, pages 18-29;
4. Brian Feagin, PT, Pee Dee Orthopaedic Associates, 06/27/11-10/04/11, pages 30-88;
5. Dr. George Sandoz, Grand Strand Specialty Associates, 09/16/11-01/14/14, pages 89-161;
6. Dr. Leonard Goldschmidt, Grand Strand Psychological Services, 10/18/11-06/07/12, pages 162-340;
7. Dr. Lawrence Bergmann, Post Trauma Resources, 06/06/12-03/04/14, pages 341-408;
8. Dr. Roger Deal, Post Trauma Resources, 06/21/12-02/05/14, pages 409-432;
9. Dr. Karl Lozanne, Columbia Neurosurgical Associates, 01/22/13-03/11/14, pages 433-460;

10. Dr. Steven Poletti, Southeastern Spine Institute, 11/05/12-04/04/14, pages 461-476;

A. Dr. Steven Poletti, Southeastern Spine Institute, 04/20/14, page 477;

B. Dr. Karl Lozanne, Columbia Neurosurgical Associates, 11/21/13, page 478.

Defendants submitted the following:

11. Columbia Neurosurgical Associates, 01/22/13-08/20/13, pages 478-480;

12. The Southeastern Spine Institute, 01/20/14-01/21/14, pages 481-484;

13. ImageCare LLC, 08/02/13, pages 485-486;

14. Florence MRI & Imaging, 10/10/11-10/15/12, pages 487-490;

15. Pee Dee Orthopaedic Associates, PA, 10/14/13, pages 491-492;

16. Deposition of Karl Lozanne, 05/21/14, pages 493-519.

STATEMENT OF THE CASE

A hearing was scheduled pursuant to a Form 50, filed by the Claimant's attorney, who was seeking an Order from the undersigned Commissioner Barden Dr. Poletti at the Southeastern Spine Institute as the Claimant's authorized treating physician. The Claimant's attorney maintained that the Claimant's authorized treating physician, Dr. Lozanne of Columbia Neurosurgical Associates, did not provide the Claimant with necessary medical treatment, and that the Claimant, due to an emergency medical need, sought medical treatment with Dr. Poletti, who performed surgery upon the Claimant in February 2014. In response, the Defendants maintained that, in light of the fact that the Claimant sustained an admitted injury to the neck, the Defendants are entitled to direct medical treatment, pursuant to S.C. Code Ann. §42-15-60 of the Act, and that §42-15-60 does not provide the Claimant with the unilateral right to select his treating physician. More specifically, the Defendants maintained that the deposition testimony of Dr. Lozanne and the medical records of the Claimant's treating physicians did not substantiate

the Claimant's attorney's contention that the Claimant's need for medical treatment, which resulted in the Claimant undergoing surgery in February 2014, was the result of an emergency medical need.

EVIDENCE OF THE CASE

Testimony

The Claimant was the only witness to testify on his behalf. The Claimant testified that he is currently 53 years of age, and resides in Sumter, South Carolina with his wife and children (Hr'g Tr. 16:16-25; 17:1-19). The Claimant stated he began working with the Defendants in February 1982 as an operator, and was employed as an operator on the date of his June 2011 work-related accident. (Hr'g Tr. 19:20-25; 20:1-13). The Claimant indicated that he sustained multiple injuries while in the course and scope of his employment with the Defendants on June 15, 2011 when he was struck by a piece of equipment that fell from a height of approximately 20 to 30 feet. (Hr'g Tr. 21:15-25; 22:1-25; 23:1-25; 24:1-25).

The Claimant testified that he has sought and received medical treatment with a variety of physicians due to the injury sustained to his neck as a result of his June of 2011 work-related accident. The Claimant stated he was initially examined by Dr. Giddens, who is a neurosurgeon in Myrtle Beach, South Carolina, and that Dr. Giddens recommended that the Claimant undergo a cervical fusion at C3-4. (Hr'g Tr. 26:22-24). However, the Claimant indicated that he did not have confidence in Dr. Giddens, and chose not to undergo the surgery, which was recommended by Dr. Giddens. (Hr'g Tr. 27:4-23). The Claimant testified that he eventually began receiving authorized causally-related medical treatment with Dr. Lozanne, who is a neurosurgeon in Columbia, South Carolina. The Claimant stated that he possessed a good patient/physician relationship with Dr. Lozanne, and that Dr. Lozanne, following his initial examination of the

Claimant in January 2013, recommended that the Claimant undergo a cervical fusion at C4-C7. The Claimant testified that he underwent surgery, pursuant to the recommendations of Dr. Lozanne, but that he experienced significant pain and problems, following surgery, and that the surgery, which was performed by Dr. Lozanne, did not result in the improvement of the pain and problems that existed prior to the above-referenced surgery. (Hr'g Tr. 34:10-25; 35:1-22).

The Claimant testified that he eventually underwent an Independent Medical Examination with Dr. Poletti, pursuant to the recommendation of the Claimant's attorney, and that Dr. Poletti recommended that the Claimant undergo an additional cervical surgery at C3-4. The Claimant stated that he returned to Dr. Poletti, on a second occasion, in January 2014, and that his second examination with Dr. Poletti was also scheduled by the Claimant's attorney. The Claimant indicated that, during his second examination with Dr. Poletti, he provided complaints of ongoing pain and problems in the neck and right upper extremity, and that Dr. Poletti recommended that the Claimant undergo surgery. (Hr'g Tr. 40:1-7). The Claimant testified that he underwent cervical surgery, which was performed by Dr. Poletti in February of 2014, and that he has experienced some improvement of his neck and right upper extremity problems as a result of surgery. (Hr'g Tr. 42:1-13).

On cross-examination, the Claimant testified that his firs two visits with Dr. Poletti were scheduled by the Claimant's attorney. (Hr'g Tr. 45:11-18; 46:8-9). The Claimant testified that the medical bills, associated with the treatment provided by Dr. Poletti, had been paid by the Claimant's group health insurance through his employment with the Defendants. (Hr'g Tr. 44:4-9). The Claimant stated that he was seeking reimbursement for out-of-pocket medical expenses, but that he presented no documentary evidence supporting his request for reimbursement for out-of-pocket medical expenses at the hearing before the undersigned Commissioner. (Hr'g Tr.

44:10-15). The Claimant indicated that he has received causally-related medical treatment from a variety of medical providers, including Dr. Lozanne, Post Trauma Resources, and Dr. Welsch, and the medical bills, associated with authorized causally-related medical treatment, have been paid by the carrier. (Hr'g Tr. 47:19-25; 48:1-22).

Medical Evidence

The deposition of Dr. Lozanne was conducted on May 21, 2014. Dr. Lozanne testified that he initially examined the Claimant in January 2013, and diagnosed the Claimant with multi-level degenerative disc disease with disc/osteophyte complexes at C4 thru C7, and recommended that the Claimant undergo an anterior cervical discectomy and fusion. (Depo. of Dr. Lozanne, pgs. 4-6). Dr. Lozanne stated that he performed an anterior cervical discectomy and fusion at C4 to C7 in February 2014, and that the Claimant did experience short term improvement of his neck and upper extremity problems following surgery. (Depo. of Dr. Lozanne, pgs. 8-9). Most notably, Dr. Lozanne indicated that, following his initial examination of the Claimant in January 2013, he was of the opinion that the Claimant, while possessing pathology at C3-4, did not require surgical intervention at C3-4 because the C3-4 pathology was a pathology that could not be repaired surgically. (Depo. of Dr. Lozanne, pgs. 6-8). Dr. Lozanne testified that he provided the Claimant with postoperative care, including injections, physical therapy and prescription medications, but that the Claimant did not significantly improve with the above-referenced medical treatment. (Depo. of Dr. Lozanne, pgs. 9-10). Dr. Lozanne indicated that he examined the Claimant in November 2013, and had provided the Claimant with a treatment plan, which was designed to continue to address the Claimant's ongoing physical pain and problems, and that the treatment plan did include a possible referral to a pain management physician for additional medical treatment. (Depo. of Dr. Lozanne, pgs. 28-29).

Dr. Lozanne testified that he next examined the Claimant in March 2014, and was informed by the Claimant that the Claimant had undergone cervical surgery, which was performed by Dr. Poletti in February 2014. (Depo. of Dr. Lozanne, pg. 20). Dr. Lozanne stated that the Claimant's decision to undergo surgery with Dr. Poletti did affect Dr. Lozanne's ability to provide the Claimant with causally related medical treatment. (Depo. of Dr. Lozanne, pgs. 20-21). Most notably, Dr. Lozanne indicated that he was of the opinion that the Claimant should continue his treatment with Dr. Poletti, but that Dr. Lozanne would be willing to re-examine the Claimant once Dr. Poletti had released the Claimant from his care for the recent surgery, which was performed by Dr. Poletti. (Depo. of Dr. Lozanne, pgs. 36 and 37). Dr. Lozanne testified that the Claimant had not reached maximum medical improvement, but that he would be willing to make a determination, regarding maximum medical improvement, once the Claimant is released from the care of Dr. Poletti. (Depo. of Dr. Lozanne, pgs. 21-22). Dr. Lozanne did state that the Claimant would not need future surgery, with regards to the cervical spine, but that the Claimant would likely be in need of pain management, including, but not limited to, prescription medications. (Depo. of Dr. Lozanne, p. 23).

With regards to the issue of whether the Claimant's February 2014 surgery was the result of an emergency medical need, Dr. Lozanne adamantly testified that, based on his physical examinations of the Claimant and a review of diagnostic testing, the Claimant did not possess pathology at C3-4 that would warrant emergency medical treatment. Dr. Lozanne was also provided with an opportunity to review the multiple diagnostic reports of Dr. Poletti from January 2014, and Dr. Lozanne stated that, based on his review of the medical records of Dr. Poletti, he was of the opinion that the Claimant's C3-4 pathology was not a medical problem necessitating an emergency medical procedure. (Depo. of Dr. Lozanne, pgs. 17-20). The

Claimant's attorney questioned Dr. Lozanne as to the medical necessity of the procedure, which was performed by Dr. Poletti. Dr. Lozanne testified that he could not provide an opinion regarding the medical necessity of the C3-4 surgery, which was performed by Dr. Poletti, but that he was of the opinion that the Claimant's C3-4 pathology was not a pathology that would need to be addressed with an emergency cervical procedure. Most notably, Dr. Lozanne stated that, in his expert opinion, the Claimant was not in need of emergency cervical surgery in either January 2014 or February 2014.

FINDINGS OF FACT

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

1. The South Carolina Workers' Compensation Commission has jurisdiction over the subject matter and parties of this claim.
2. Claimant's average weekly wage is One Thousand Four Hundred Sixty One Dollars and 40/100 ($1,461.40) with a corresponding compensation rate of Seven Hundred Four Dollars and 92/100 ($704.92).
3. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, Claimant injured his neck in an admitted accident on June 15, 2011. (Hr'g Tr. 21:15-25; 22:1-25; 23:1-25; 24:1-25).
4. The issue of compensability of all other body parts/conditions listed on the Form 50 but not admitted as compensable by the Defendants, is held in abeyance.
5. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony,

Claimant is 52 years of age. (Hr'g Tr. 16:16-25; medical evidence establishing Claimant's date of birth as 4/19/62).

6. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, Claimant is a high school graduate. After high school, Claimant received a certificate in welding (Hr'g Tr. 18:7-25; 19:1-3).

7. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, Claimant filed a Form 50 on February 19, 2014 in order to request that the Commission transfer Claimant's treatment to unauthorized physician Dr. Poletti. Five days earlier, Claimant had undergone unauthorized C3-4 fusion surgery with Dr. Poletti.

8. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, as of the date of the February 2014 Form 50, Claimant was still actively treating with authorized treating physician Dr. Lozanne; Claimant had not been released from care by Dr. Lozanne. In fact, Claimant was to return to Dr. Lozanne the very same month in which Claimant underwent the unauthorized surgery with Dr. Poletti (Claimant's APA, pg. 478).

9. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, Defendants have provided Claimant with treatment for his neck, including but not limited to the cervical fusion surgery (C4-C7) performed by Dr. Lozanne in February

2013. (Hr'g Tr. 47:19-25; 48:1-22)

10. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, the undersigned finds Dr. Lozanne to be a reputable physician, a finding I base in part upon the stipulation by the parties that Dr. Lozanne is an expert in neurosurgery (medical evidence as a whole; Depo. of Dr. Lozanne, pg. 4; Claimant's APA, pgs. 440-443).

11. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, prior to Claimant's reaching maximum medical improvement (*i.e.*, he was still treating with Dr. Lozanne), Claimant underwent the unauthorized cervical fusion surgery at C3-4 with Dr. Poletti (Claimant's APA, pgs. 471-472).

12. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, this is not the situation where a claimant has already been released with no further medical care being provided or authorized (Claimant's APA, pgs. 471-472).

13. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Dr. Poletti's treatment notes do not state that the surgery was an emergency. In fact, at the second of the two visits, Dr. Poletti stated that Claimant should "consider" the surgery. (Claimant's APA, pg. 468). Dr. Poletti did not hospitalize Claimant that day; nor did Dr. Poletti perform the surgery in the next few days. Instead, Claimant did not undergo the unauthorized C3-4 surgery with Dr. Poletti until 3 weeks afterwards, and not until

months after the C3-4 surgery was first discussed. (Claimant's APA, pgs. 471-472).

14. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Dr. Poletti's operative notes do not state that the C3-4 surgery was provided on an emergency basis (Claimant's APA, pgs. 471-472).

15. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I disagree that Dr. Lozanne was dismissive of Claimant's ongoing complaints, as such a theory is not borne out by the medical evidence (Claimant's APA, pgs. 437-460; Defendants' APA, pgs. 478-480).

16. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, after Dr. Lozanne performed surgery, he was concerned (based upon Claimant's ongoing complaints) about shoulder pathology, and therefore ordered a shoulder MRI and evaluation/treatment with a shoulder specialist. (Claimant's APA, pgs. 450, 453, 456-458).

17. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Dr. Lozanne's November 2013 record states that Claimant was not at maximum medical improvement, and that he wanted to see Claimant in February 2014—the very same month in which Claimant underwent the unauthorized surgery with Dr. Poletti (Defendants' APA, pg. 480; Depo. of Dr. Lozanne, pgs. 9-11; Claimant's APA, pgs. 453-455, 457, and 478).

18. Based on the entirety of the evidence including the medical records submitted, the

testimony of Dr. Lozanne, and the Claimant's testimony, I give the greatest weight to the opinion of Dr. Lozanne, who testified unequivocally--and no fewer than six or seven times--that there was nothing emergent about Claimant's C3-4 condition/surgery. (Depo. of Dr. Lozanne, pgs. 34, 40, 49-50).

19. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, the testimony of Dr. Lozanne is supported by the fact that Dr. Poletti did not perform the C3-4 surgery until 3 weeks after Dr. Poletti last told Claimant to consider surgery (Depo. of Dr. Lozanne, *e.g.*, pgs. 13, 15-20, 34, 40, and 49-50).

20. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, according to Dr. Lozanne, an emergency situation means that "we got to get this patient to the hospital and get this procedure done here within the next couple of days." Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, this is not the situation at hand. As Dr. Lozanne points out, for the situation to have been an emergency, Dr. Poletti "would have admitted [Claimant] that day" (Depo. of Dr. Lozanne, pgs. 18-19 and 40).

21. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, by contrast, Dr. Poletti told Claimant in late January 2014 that he should "consider" the C3-4 surgery; the surgery was performed 3 weeks later in February 2014 (Claimant's APA, pg. 468, 471-472).

22. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, there is no statement in Dr.

Poletti's records to the effect that Claimant needed the surgery on an emergency basis or even on an imminent need basis (Claimant's APA, pgs. 462 and 468).

23. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, in February 2014 (several days after his surgery with Dr. Poletti), Claimant filed a Form 50 to transfer care to Dr. Poletti although Dr. Poletti had previously recommended C3-4 surgery at the first Poletti visit in November 2012 (Claimant's APA, pg. 461).

24. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, in addition to the fact that Claimant had not even reached maximum medical improvement (but nonetheless underwent the C3-4 surgery with Dr. Poletti), Dr. Lozanne had explicitly (according to his treatment note) planned to re-evaluate Claimant after one year after the surgery to make a "determination if there was any need for any additional either studies or further evaluation *or any further treatment*" (Depo. of Dr. Lozanne, pgs. 21-22; Claimant's APA, pg. 478).

25. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, no physician other than Dr. Lozanne defines the word "emergency" (medical evidence in its entirety; Depo. of Dr. Lozanne, pgs. 18-19 and 40).

26. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find that Dr. Poletti's questionnaire statement—that the unauthorized C3-4 surgery was performed on an "emergency" basis--is not supported by the medical evidence, including Dr. Poletti's

own treatment notes and operative notes: Dr. Poletti's January 2014 treatment note states that Claimant should "consider" C3-4 surgery; the C3-4 surgery was not performed until 3 weeks later. (Claimant's APA, pgs. 468, 471-472). These records refute the accuracy and legitimacy of the questionnaire's responses. Therefore, based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I accord the questionnaire of Dr. Poletti only *de minimis* weight.

27. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, claimant did not provide the undersigned with any evidence of e-mail or letter communications (regarding the need for additional surgery) between Claimant's counsel and Defendants' counsel dated prior to—or after—the filing of the Form 50 request to transfer treatment. Nor did Claimant provide any documentation of telephone communications regarding the issue. It is incumbent upon Claimant to meet his burden of proof.

28. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Claimant does not meet the "emergency" standard set forth in Section 42-15-60.

29. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Dr. Lozanne testified (after the date of the Poletti surgery) that he does not disagree that it would be "reasonable" to have surgery on an adjacent level (the C3-C4 level) if there is increasing stenosis; however, (a) the unauthorized care was not rendered on an emergency basis; (b) Claimant sought unauthorized treatment the very month he was to see Dr. Lozanne;

and (c) Claimant had not reached maximum medical improvement; Defendants were still providing treatment (Depo. of Dr. Lozanne, pgs. 36-37 and 49).

30. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I also considered the opinion of Dr. Giddens who recommended C3-C6 surgery (Claimant's APA, pg. 146-147).

31. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, none of the physicians involved agreed completely on the levels to be surgically addressed (Depo. of Dr. Lozanne, pgs. 30-31).

32. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I additionally note that Dr. Poletti told Claimant that Claimant was "most likely not to improve" with the C3-4 surgery, but that the surgery "*could*" (not even "would") prevent Claimant from worsening (Defendants' APA, pg. 483).

33. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Claimant's request for transfer of treatment to Dr. Poletti is denied.

34. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Claimant's request for reimbursement for the surgery and other care/treatment provided by Dr. Poletti is denied.

CONCLUSIONS OF LAW

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

1. Pursuant to S.C. Code Ann. § 42-15-10 and § 42-17-20, jurisdiction and venue are proper.
2. Pursuant to South Carolina Workers' Compensation Commission Rules and Regulations, Rule 67-210(B) and Rule 67-213(C), the parties were properly served with Notice of the Hearing.
3. Workers' Compensation awards may not be based upon surmise, conjecture, or speculation, but must be founded on evidence of sufficient substance to afford a reasonable basis for it. Tiller v. Nat'l Health Care Ctr. of Sumter, 334 S.C. 333, 339, 513 S.E.2d 843, 845 (1999) ; Sharpe v. Case Produce Co., 329 S.C. 534, 543, 495 S.E.2d 790, 794 (Ct.App.1997) rev'd on other grounds.
4. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, the Claimant sustained a compensable injury to the neck, pursuant to Section 42-1-160 of the Act, as a result of an admitted accident that occurred on June 15, 2011.
5. Section 42-15-60 of the Act states: "The employer shall provide medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be required, for a period not exceeding ten weeks from the date of an injury, to effect a cure or give relief and for an additional time as in the judgment of the commission will tend to lessen the period of disability as evidenced by expert medical evidence stated to a reasonable degree of medical certainty." See S.C. Code Ann. §42-15-60.

6. Section 42-15-60 of the Act states: "If in an emergency, on account of the employer's failure to provide the medical care as specified in this section, a physician other than provided by the employer is called to treat the employee, the reasonable cost of the service must be paid by the employer, if ordered by the commission." See S.C. Code Ann. §42-15-60 (emphasis added).

7. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find Claimant does not meet the "emergency" standard set forth in Section 42-15-60.

8. In order for the Commission to order reimbursement, Section 42-15-60 requires that the Claimant satisfy his burden of proving that the care, for which he is seeking reimbursement, be provided (a) on an emergency basis, and (b) on account of Defendants' failure to provide medical treatment.

9. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find I find that neither prong of Section 42-15-60 is satisfied in this case. More specifically, the Claimant did not satisfy his burden of proving that the care, for which he is seeking reimbursement, was provided (a) on an emergency basis, and (b) on account of Defendants' failure to provide medical treatment.

10. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find that Claimant's reliance on Martin v.

Rapid Plumbing, 369 S.C. 278, 631 S.E.2d 547 (Ct. App. 2006) is misplaced. In that case, (1) the claimant had been released by Dr. Felmly to return to work, and (2) Doctors Care refused to see the claimant because the visit to Doctors' Care was not authorized by the carrier. By contrast, in the case *sub judice*, Claimant sought unauthorized care when he (a) had not been released by the authorized treating physician, (b) had not been told to return to work, and (c) had not been denied treatment.

11. In Turner v. South Carolina Dept. of Health and Environmental Control, the Court of Appeals stated that Section 42-15-60 establishes "the rights of the employer and the employee with regard to payment for treatments." The Court explicitly stated that Section 42-15-60 "does not give a unilateral right to claimants to select their treating physician, and such an unencumbered right undermines the authority of the commission, as prescribed by the legislature." See Turner, 377.S.C. 540, 661 S.E.2d 118 reh'g denied, cert. denied (S.C.App. 2008).

12. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find that, unless Claimant meets the requirements of Section 42-15-60, he is not entitled to unilaterally seek treatment with physicians of his choosing.

13. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find Claimant's request for transfer of treatment to Dr. Poletti is denied.

14. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find Claimant's request for reimbursement for the surgery and other care/treatment provided by Dr. Poletti is denied.

ORDER

IT IS HEREBY ORDERED that Claimant has failed to satisfy his burden of proof pursuant to Section 42-15-50 of the Act that the care, for which he is seeking reimbursement, was provided on an emergency basis, and on account of Defendants' failure to provide medical treatment.

IT IS FURTHER ORDERED that Claimant's request for transfer of treatment to Dr. Poletti is denied.

IT IS FURTHER ORDERED that Claimant's request for reimbursement for the surgery and other care/treatment provided by Dr. Poletti is denied

AND IT IS SO ORDERED.

Susan S. Barden

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid, in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).
September 17, 2014

By: Kristi Love, Administrative Assistant to Commissioner Barden

APPELLATE PANEL DECISION AND ORDER

OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1106789

Victor G. Benjamin — EMPLOYEE, CLAIMANT/APPELLANT

VS.

Rexam, Inc. — EMPLOYER,

AND

Hartford Insurance Company of the Midwest
c/o Sedgwick CMS Inc. — CARRIER, DEFENDANTS/RESPONDENTS,

Appellate Panel Review held in Columbia, South Carolina, on February 24, 2015 per notices timely and properly served upon all parties of interest.

Appellate Panel Decision and Order Filed:

April 23, 2015

APPEARANCES: Claimant/Appellant represented by Jeffrey C. Chandler, Esquire

Defendants/Respondents represented by Jason W. Lockhart, Esquire

STATEMENT OF THE CASE

Claimant filed a Form 50 seeking an Order from the Single Commissioner designating Dr. Poletti of the Southeastern Spine Institute as the Claimant's authorized treating physician. The Claimant's attorney maintained that the Claimant's authorized treating physician, Dr. Lozanne of Columbia Neurosurgical Associates, did not provide the Claimant with necessary medical treatment, and that the Claimant, due to an emergency medical need, sought medical treatment with Dr. Poletti, who performed surgery upon the Claimant in February 2014. In response, the Defendants maintained that, in light of the fact that the Claimant sustained an admitted injury to the neck, the Defendants were entitled to direct medical treatment, pursuant to S.C. Code Ann. §42-15-60 of the Act, and that §42-15-60 does not provide the Claimant with the unilateral right to select his treating physician. More specifically, the Defendants maintained that the deposition testimony of Dr. Lozanne and the medical records of the Claimant's treating physicians did not substantiate the Claimant's attorney's contention that the Claimant's need for medical treatment, which resulted in the Claimant undergoing surgery in February 2014, was the result of an emergency medical need.

A hearing in this matter was held before Commissioner Barden on June 23, 2014. At the conclusion of the hearing, Commissioner Barden issued a Decision and Order making the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. The South Carolina Workers' Compensation Commission has jurisdiction over the subject matter and parties of this claim.

2. Claimant's average weekly wage is One Thousand Four Hundred Sixty One Dollars ($1,461.40) and 40/100 with a corresponding compensation rate of Seven Hundred Four Dollars ($704.92) and 92/100.

3. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, Claimant injured his neck in an admitted accident on June 15, 2011. (Hr'g Tr. 21:15-25; 22:1-25; 23:1-25; 24:1-25).

4. The issue of compensability of all other body parts/conditions listed on the Form 50 but not admitted as compensable by the Defendants, is held in abeyance.

5. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, Claimant is 52 years of age. (Hr'g Tr. 16:16-25; medical evidence establishing Claimant's date of birth as 4/19/62).

6. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, Claimant is a high school graduate. After high school, Claimant received a certificate in welding (Hr'g Tr. 18:7-25; 19:1-3).

7. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, Claimant filed a Form 50 on February 19, 2014 in order to request that the Commission transfer Claimant's treatment to unauthorized physician Dr. Poletti. Five days earlier, Claimant had undergone unauthorized C3-4 fusion surgery with Dr. Poletti.

8. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, as of the date of the February 2014 Form 50, Claimant was still actively treating with authorized treating physician Dr. Lozanne; Claimant had not been released from care by Dr. Lozanne. In fact, Claimant was to return to Dr. Lozanne the very same month in which Claimant underwent the unauthorized surgery with Dr. Poletti (Claimant's APA, pg. 478).

9. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, Defendants have provided Claimant with treatment for his neck, including but not limited to the cervical fusion surgery (C4-C7) performed by Dr. Lozanne in February 2013. (Hr'g Tr. 47:19-25; 48:1-22).

10. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, the undersigned finds Dr. Lozanne to be a reputable physician, a finding I base in part upon the stipulation by the parties that Dr. Lozanne is an expert in neurosurgery (medical evidence as a whole; Depo. of Dr. Lozanne, pg. 4; Claimant's APA, pgs. 440-443).\

11. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, prior to Claimant's reaching maximum medical improvement (*i.e.*, he was still treating with Dr. Lozanne), Claimant underwent the unauthorized cervical fusion surgery at C3-4 with Dr. Poletti (Claimant's APA, pgs. 471-472).

12. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, this is not the situation where a claimant has already been released with no further medical care being provided or authorized (Claimant's APA, pgs. 471-472).

13. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Dr. Poletti's treatment notes do not state that the surgery was an emergency. In fact, at the second of the two visits, Dr. Poletti stated that Claimant should "consider" the surgery. (Claimant's APA, pg. 468). Dr. Poletti did not hospitalize Claimant that day; nor did Dr. Poletti perform the surgery in the next few days. Instead, Claimant did not undergo the unauthorized C3-4 surgery with Dr. Poletti until 3 weeks afterwards, and not until months after the C3-4 surgery was first discussed. (Claimant's APA, pgs. 471-472).

14. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Dr. Poletti's operative notes do not state that the C3-4 surgery was provided on an emergency basis (Claimant's APA, pgs. 471-472).

15. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I disagree that Dr. Lozanne was dismissive of Claimant's ongoing complaints; as such a theory is not borne out by the medical evidence (Claimant's APA, pgs. 437-460; Defendants' APA, pgs. 478-480).

16. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, after Dr. Lozanne performed surgery, he was concerned (based upon Claimant's ongoing complaints) about shoulder pathology, and therefore ordered a shoulder MRI and evaluation/treatment with a shoulder specialist. (Claimant's APA, pgs. 450, 453, 456-458).

17. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Dr. Lozanne's November 2013 record states that Claimant was not at maximum medical improvement, and that he wanted to see Claimant in February 2014—the very same month in which Claimant underwent the unauthorized surgery with Dr. Poletti (Defendants' APA, pg. 480; Depo. of Dr. Lozanne, pgs. 9-11; Claimant's APA, pgs. 453-455, 457, and 478).

18. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I give the greatest weight to the opinion of Dr. Lozanne, who testified unequivocally--and no fewer than six or seven times--that there was nothing emergent about Claimant's C3-4 condition/surgery. (Depo. of Dr. Lozanne, pgs. 34, 40, 49-50).

19. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, the testimony of Dr. Lozanne is supported by the fact that Dr. Poletti did not perform the C3-4 surgery until 3 weeks after Dr. Poletti last told Claimant to consider surgery (Depo. of Dr. Lozanne, *e.g.*, pgs. 13, 15-20, 34, 40, and 49-50).

20. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, according to Dr. Lozanne, an emergency situation means that "we got to get this patient to the hospital and get this procedure done here within the next couple of days." Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, this is not the situation at hand. As Dr. Lozanne points out, for the situation to have been an emergency, Dr. Poletti "would have admitted [Claimant] that day" (Depo. of Dr. Lozanne, pgs. 18-19 and 40).

21. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, by contrast, Dr. Poletti told Claimant in late January

2014 that he should "consider" the C3-4 surgery; the surgery was performed 3 weeks later in February 2014 (Claimant's APA, pg. 468, 471-472).

22. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, there is no statement in Dr. Poletti's records to the effect that Claimant needed the surgery on an emergency basis or even on an imminent need basis (Claimant's APA, pgs. 462 and 468).

23. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, in February 2014 (several days after his surgery with Dr. Poletti), Claimant filed a Form 50 to transfer care to Dr. Poletti although Dr. Poletti had previously recommended C3-4 surgery at the first Poletti visit in November 2012 (Claimant's APA, pg. 461).

24. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, in addition to the fact that Claimant had not even reached maximum medical improvement (but nonetheless underwent the C3-4 surgery with Dr. Poletti), Dr. Lozanne had explicitly (according to his treatment note) planned to re-evaluate Claimant after one year after the surgery to make a "determination if there was any need for any additional either studies or further evaluation *or any further treatment*" (Depo. of Dr. Lozanne, pgs. 21-22; Claimant's APA, pg. 478).

25. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, no physician other than Dr. Lozanne defines the word "emergency" (medical evidence in its entirety; Depo. of Dr. Lozanne, pgs. 18-19 and 40).

26. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find that Dr. Poletti's questionnaire statement—that the unauthorized C3-4 surgery was performed on an "emergency" basis--is not supported by the medical evidence, including Dr. Poletti's own treatment notes and operative notes; Dr. Poletti's January 2014 treatment note states that Claimant should "consider" C3-4 surgery; the C3-4 surgery was not performed until 3 weeks later. (Claimant's APA, pgs. 468, 471-472). These records refute the accuracy and legitimacy of the questionnaire's responses. Therefore, based on the entirety of the evidence including the

medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I accord the questionnaire of Dr. Poletti only *de minimis* weight.

27. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, claimant did not provide the undersigned with any evidence of e-mail or letter communications (regarding the need for additional surgery) between Claimant's counsel and Defendants' counsel dated prior to—or after—the filing of the Form 50 request to transfer treatment. Nor did Claimant provide any documentation of telephone communications regarding the issue. It is incumbent upon Claimant to meet his burden of proof.

28. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Claimant does not meet the "emergency" standard set forth in Section 42-15-60.

29. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Dr. Lozanne testified (after the date of the Poletti surgery) that he does not disagree that it would be "reasonable" to have surgery on an adjacent level (the C3-C4 level) if there is increasing stenosis; however, (a) the unauthorized care was not rendered on an emergency basis; (b) Claimant sought unauthorized treatment the very month he was to see Dr. Lozanne; and (c) Claimant had not reached maximum medical improvement; Defendants were still providing treatment (Depo. of Dr. Lozanne, pgs. 36-37 and 49).

30. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I also considered the opinion of Dr. Giddens who recommended C3-C6 surgery (Claimant's APA, pg. 146-147).
31. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, none of the physicians involved agreed completely on the levels to be surgically addressed (Depo. of Dr. Lozanne, pgs. 30-31).

32. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I additionally note that Dr. Poletti told Claimant that Claimant was "most like not to improve" with the C3-4 surgery,

but that the surgery "*could*" (not even "would") prevent Claimant from worsening (Defendants' APA, pg. 483).

33. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Claimant's request for transfer of treatment to Dr. Poletti is denied.

34. Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, Claimant's request for reimbursement for the surgery and other care/treatment provided by Dr. Poletti is denied.

CONCLUSIONS OF LAW

1. Pursuant to S.C. Code Ann. § 42-15-10 and § 42-17-20, jurisdiction and venue are proper.

2. Pursuant to South Carolina Workers' Compensation Commission Rules and Regulations, Rule 67-210(B) and Rule 67-213(C), the parties were properly served with Notice of the Hearing.

3. Workers' Compensation awards may not be based upon surmise, conjecture, or speculation, but must be founded on evidence of sufficient substance to afford a reasonable basis for it. Tiller v. Nat'l Health Care Ctr. of Sumter, 334 S.C. 333, 339, 513 S.E.2d 843, 845 (1999) ; Sharpe v. Case Produce Co., 329 S.C. 534, 543, 495 S.E.2d 790, 794 (Ct.App.1997) rev'd on other grounds.

4. Based on the entirety of the evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, the Claimant sustained a compensable injury to the neck, pursuant to Section 42-1-160 of the Act, as a result of an admitted accident that occurred on June 15, 2011.

5. Section 42-15-60 of the Act states: "The employer shall provide medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be required, for a period not exceeding ten weeks from the date of an injury, to effect a cure or give relief and for an additional time as in the judgment of the commission will tend to lessen the period of disability as evidenced by expert medical evidence stated to a reasonable degree of medical certainty." See S.C. Code Ann. §42-15-60.

6. Section 42-15-60 of the Act states: "If in an emergency, on account of the employer's failure to provide the medical care as specified in this section, a physician other than provided by the employer is called to treat the employee, the reasonable cost of the service must be paid by the employer, if ordered by the commission." See S.C. Code Ann. §42-15-60 (emphasis added).

7. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find Claimant does not meet the "emergency" standard set forth in Section 42-15-60.

8. In order for the Commission to order reimbursement, Section 42-15-60 requires that the Claimant satisfy his burden of proving that the care, for which he is seeking reimbursement, be provided (a) on an emergency basis, and (b) on account of Defendants' failure to provide medical treatment.

9. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find I find that neither prong of Section 42-15-60 is satisfied in this case. More specifically, the Claimant did not satisfy his burden of proving that the care, for which he is seeking reimbursement, was provided (a) on an emergency basis, and (b) on account of Defendants' failure to provide medical treatment.

10. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find that Claimant's reliance on Martin v. Rapid Plumbing, 369 S.C. 278, 631 S.E.2d 547 (Ct. App. 2006) is misplaced. In that case, (1) the claimant had been released by Dr. Felmly to return to work, and (2) Doctors Care refused to see the claimant because the visit to Doctors' Care was not authorized by the carrier. By contrast, in the case *sub judice*, Claimant sought unauthorized care when he (a) had not been released by the authorized treating physician, (b) had not been told to return to work, and (c) had not been denied treatment.

11. In Turner v. South Carolina Dept. of Health and Environmental Control, the Court of Appeals stated that Section 42-15-60 establishes "the rights of the employer and the employee with regard to payment for treatments." The Court explicitly stated that

Section 42-15-60 "does not give a unilateral right to claimants to select their treating physician, and such an unencumbered right undermines the authority of the commission, as prescribed by the legislature." See Turner, 377.S.C. 540, 661 S.E.2d 118 reh'g denied, cert. denied (S.C.App. 2008).

12. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find that, unless Claimant meets the requirements of Section 42-15-60, he is not entitled to unilaterally seek treatment with physicians of his choosing.

13. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find Claimant's request for transfer of treatment to Dr. Poletti is denied.

14. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, I find Claimant's request for reimbursement for the surgery and other care/treatment provided by Dr. Poletti is denied.

Following the Decision and Order, Claimant filed a Form 30 and asserted several exceptions to the Decision and Order. According to the Claimant's Appellant's Brief, these exceptions were consolidated as follows:

I. Was it factual and legal error for the Commissioner to find that the Claimant failed to prove that the surgery performed by Dr. Poletti was done on an emergency basis and thus failing to meet the "emergency" standard set forth in §42-15-60?

II. Was it factual and legal error to not find that Dr. Lozanne had been dismissive of Claimant's ongoing complaints and refused to provide additional treatment for the Claimant?

III. Was it factual and legal error for the Commissioner to misapply the language of §42-15-60 and require the Claimant to prove he required a medical emergency to compel the Defendant to provide medical care that was

otherwise medically necessary care that would tend to lessen his disability?

EVIDENCE OF THE CASE

Testimony

The Claimant was the only witness to testify on his behalf. The Claimant testified that he is currently 53 years of age, and resides in Sumter, South Carolina with his wife and children (Hr'g Tr. 16:16-25; 17:1-19). The Claimant stated he began working with the Defendants in February 1982 as an operator, and was employed as an operator on the date of his June 2011 work-related accident. (Hr'g Tr. 19:20-25; 20:1-13). The Claimant indicated that he sustained multiple injuries while in the course and scope of his employment with the Defendants on June 15, 2011 when he was struck by a piece of equipment that fell from a height of approximately 20 to 30 feet. (Hr'g Tr. 21:15-25; 22:1-25; 23:1-25; 24:1-25).

The Claimant testified that he has sought and received medical treatment with a variety of physicians due to the injury sustained to his neck as a result of his June of 2011 work-related accident. The Claimant stated he was initially examined by Dr. Giddens, who is a neurosurgeon in Myrtle Beach, South Carolina, and that Dr. Giddens recommended that the Claimant undergo a cervical fusion at C3-4. (Hr'g Tr. 26:22-24). However, the Claimant indicated that he did not have confidence in Dr. Giddens, and chose not to undergo the surgery, which was recommended by Dr. Giddens. (Hr'g Tr. 27:4-23). The Claimant testified that he eventually began receiving authorized causally-related medical treatment with Dr. Lozanne, who is a neurosurgeon in Columbia, South Carolina. The Claimant stated that he possessed a good patient/physician relationship with Dr. Lozanne, and that Dr. Lozanne, following his initial examination of the Claimant in January 2013, recommended that the Claimant undergo a cervical fusion at C4-C7. The Claimant testified that he underwent surgery, pursuant to the recommendations of Dr.

Lozanne, but that he experienced significant pain and problems, following surgery, and that the surgery, which was performed by Dr. Lozanne, did not result in the improvement of the pain and problems that existed prior to the above-referenced surgery. (Hr'g Tr. 34:10-25; 35:1-22).

The Claimant testified that he eventually underwent an Independent Medical Examination with Dr. Poletti, pursuant to the recommendation of the Claimant's attorney, and that Dr. Poletti recommended that the Claimant undergo an additional cervical surgery at C3-4. The Claimant stated that he returned to Dr. Poletti, on a second occasion, in January 2014, and that his second examination with Dr. Poletti was also scheduled by the Claimant's attorney. The Claimant indicated that, during his second examination with Dr. Poletti, he provided complaints of ongoing pain and problems in the neck and right upper extremity, and that Dr. Poletti recommended that the Claimant undergo surgery. (Hr'g Tr. 40:1-7). The Claimant testified that he underwent cervical surgery, which was performed by Dr. Poletti in February of 2014, and that he has experienced some improvement of his neck and right upper extremity problems as a result of surgery. (Hr'g Tr. 42:1-13).

On cross-examination, the Claimant testified that his first two visits with Dr. Poletti were scheduled by the Claimant's attorney. (Hr'g Tr. 45:11-18; 46:8-9). The Claimant testified that the medical bills, associated with the treatment provided by Dr. Poletti, had been paid by the Claimant's group health insurance through his employment with the Defendants. (Hr'g Tr. 44:4-9). The Claimant stated that he was seeking reimbursement for out-of-pocket medical expenses, but that he presented no documentary evidence supporting his request for reimbursement for out-of-pocket medical expenses at the hearing before the undersigned Commissioner. (Hr'g Tr. 44:10-15). The Claimant indicated that he has received causally-related medical treatment from a variety of medical providers, including Dr. Lozanne, Post Trauma Resources, and Dr. Welsch,

and the medical bills, associated with authorized causally-related medical treatment, have been paid by the carrier. (Hr'g Tr. 47:19-25; 48:1-22).

Medical Evidence

The deposition of Dr. Lozanne was conducted on May 21, 2014. Dr. Lozanne testified that he initially examined the Claimant in January 2013, and diagnosed the Claimant with multi-level degenerative disc disease with disc/osteophyte complexes at C4 thru C7, and recommended that the Claimant undergo an anterior cervical discectomy and fusion. (Depo. of Dr. Lozanne, pgs. 4-6). Dr. Lozanne stated that he performed an anterior cervical discectomy and fusion at C4 to C7 in February 2014, and that the Claimant did experience short term improvement of his neck and upper extremity problems following surgery. (Depo. of Dr. Lozanne, pgs. 8-9). Most notably, Dr. Lozanne indicated that, following his initial examination of the Claimant in January 2013, he was of the opinion that the Claimant, while possessing pathology at C3-4, did not require surgical intervention at C3-4 because the C3-4 pathology was a pathology that could not be repaired surgically. (Depo. of Dr. Lozanne, pgs. 6-8). Dr. Lozanne testified that he provided the Claimant with postoperative care, including injections, physical therapy and prescription medications, but that the Claimant did not significantly improve with the above-referenced medical treatment. (Depo. of Dr. Lozanne, pgs. 9-10). Dr. Lozanne indicated that he examined the Claimant in November 2013, and had provided the Claimant with a treatment plan, which was designed to continue to address the Claimant's ongoing physical pain and problems, and that the treatment plan did include a possible referral to a pain management physician for additional medical treatment. (Depo. of Dr. Lozanne, pgs. 28-29).

Dr. Lozanne testified that he next examined the Claimant in March 2014, and was informed by the Claimant that the Claimant had undergone cervical surgery, which was

performed by Dr. Poletti in February 2014. (Depo. of Dr. Lozanne, pg. 20). Dr. Lozanne stated that the Claimant's decision to undergo surgery with Dr. Poletti did affect Dr. Lozanne's ability to provide the Claimant with causally related medical treatment. (Depo. of Dr. Lozanne, pgs. 20-21). Most notably, Dr. Lozanne indicated that he was of the opinion that the Claimant should continue his treatment with Dr. Poletti, but that Dr. Lozanne would be willing to re-examine the Claimant once Dr. Poletti had released the Claimant from his care for the recent surgery, which was performed by Dr. Poletti. (Depo. of Dr. Lozanne, pgs. 36 and 37). Dr. Lozanne testified that the Claimant had not reached maximum medical improvement, but that he would be willing to make a determination, regarding maximum medical improvement, once the Claimant is released from the care of Dr. Poletti. (Depo. of Dr. Lozanne, pgs. 21-22). Dr. Lozanne did state that the Claimant would not need future surgery, with regards to the cervical spine, but that the Claimant would likely be in need of pain management, including, but not limited to, prescription medications. (Depo. of Dr. Lozanne, p. 23).

With regards to the issue of whether the Claimant's February 2014 surgery was the result of an emergency medical need, Dr. Lozanne adamantly testified that, based on his physical examinations of the Claimant and a review of diagnostic testing, the Claimant did not possess pathology at C3-4 that would warrant emergency medical treatment. Dr. Lozanne was also provided with an opportunity to review the multiple diagnostic reports of Dr. Poletti from January 2014, and Dr. Lozanne stated that, based on his review of the medical records of Dr. Poletti, he was of the opinion that the Claimant's C3-4 pathology was not a medical problem necessitating an emergency medical procedure. (Depo. of Dr. Lozanne, pgs. 17-20). The Claimant's attorney questioned Dr. Lozanne as to the medical necessity of the procedure, which was performed by Dr. Poletti. Dr. Lozanne testified that he could not provide an opinion

regarding the medical necessity of the C3-4 surgery, which was performed by Dr. Polettl, but that he was of the opinion that the Claimant's C3-4 pathology was not a pathology that would need to be addressed with an emergency cervical procedure. Most notably, Dr. Lozanne stated that, in his expert opinion, the Claimant was not in need of emergency cervical surgery in either January 2014 or February 2014.

FULL COMMISSION FINDINGS OF FACT AND CONCLUSIONS OF LAW

FINDINGS OF FACTS

1. The parties are subject to and bound by the South Carolina Workers' Compensation Act.
2. Claimant's average weekly wage is One Thousand Four Hundred Sixty One Dollars ($1,461.40) and 40/100 with a corresponding compensation rate of Seven Hundred Four Dollars ($704.92) and 92/100.
3. Based on the substantial evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, we find Claimant injured his neck in an admitted accident on June 15, 2011. (Hr'g Tr. 21:15-25; 22:1-25; 23:1-25; 24:1-25).
4. Pursuant to the stipulation of the parties, the issue of compensability of all other body parts/conditions listed on the Form 50, but not admitted as compensable by the Defendants, was held in abeyance.
5. Based on the substantial evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, we find Claimant is 52 years of age. (Hr'g Tr. 16:16-25; medical evidence establishing Claimant's date of birth as 4/19/62).

6. Based on the substantial evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, we find Claimant is a high school graduate. After high school, Claimant received a certificate in welding (Hr'g Tr. 18:7-25; 19:1-3).

7. Based on the substantial evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, we find Claimant filed a Form 50 on February 19, 2014 in order to request that the Commission transfer Claimant's treatment to unauthorized physician Dr. Poletti. Five days earlier, Claimant had undergone unauthorized C3-4 fusion surgery with Dr. Poletti.

8. Based on the substantial evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, as of the date of the February 2014 Form 50, we find Claimant was still actively treating with authorized treating physician Dr. Lozanne: Claimant had not been released from care by Dr. Lozanne. In fact, Claimant was to return to Dr. Lozanne the very same month in which Claimant underwent the unauthorized surgery with Dr. Poletti (Claimant's APA, pg. 478).

9. Based on the substantial evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, we find Defendants have provided Claimant with treatment for his neck, including but not limited to the cervical fusion surgery (C4-C7) performed by Dr. Lozanne in February 2013. (Hr'g Tr. 47:19-25; 48:1-22)

10. Based on the substantial evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, we find Dr. Lozanne to be a reputable physician, a finding we base in part upon the stipulation by the parties that Dr. Lozanne is an expert in neurosurgery (medical evidence as a whole; Depo. of Dr. Lozanne, pg. 4; Claimant's APA, pgs. 440-443).

11. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that prior to Claimant's reaching maximum medical improvement (*i.e.*, he was still treating with Dr. Lozanne), Claimant underwent the unauthorized cervical fusion surgery at C3-4 with Dr. Poletti (Claimant's APA, pgs. 471-472).

12. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that this is not the situation where a claimant has already been released with no further medical care being provided or authorized (Claimant's APA, pgs. 471-472).

13. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that Dr. Poletti's treatment notes do not state that the surgery was an emergency. In fact, at the second of the two visits, Dr. Poletti stated that Claimant should "consider" the surgery. (Claimant's APA, pg. 468). Dr. Poletti did not hospitalize Claimant that day; nor did Dr. Poletti perform the surgery in the next few days. Instead, Claimant did not undergo the unauthorized C3-4 surgery with Dr. Poletti until 3 weeks afterwards, and not until months after the C3-4 surgery was first discussed. (Claimant's APA, pgs. 471-472).

14. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that Dr. Poletti's operative notes do not state that the C3-4 surgery was provided on an emergency basis (Claimant's APA, pgs. 471-472).

15. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we disagree that Dr. Lozanne was dismissive of Claimant's ongoing complaints; as such a theory is not borne out by the medical evidence (Claimant's APA, pgs. 437-460; Defendants' APA, pgs. 478-480).

16. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that after Dr. Lozanne performed surgery, he was concerned (based upon Claimant's ongoing complaints) about shoulder pathology, and therefore ordered a shoulder MRI and evaluation/treatment with a shoulder specialist. (Claimant's APA, pgs. 450, 453, 456-458).

17. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that Dr. Lozanne's November 2013 record states that Claimant was not at maximum medical improvement, and that he wanted to see Claimant in February 2014—the very same month in which Claimant underwent the unauthorized surgery with Dr. Poletti (Defendants' APA, pg. 480; Depo. of Dr. Lozanne, pgs. 9-11; Claimant's APA, pgs. 453-455, 457, and 478).

18. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we give the greatest weight to the opinion of Dr. Lozanne, who testified unequivocally--and no fewer than six or seven times--that there was nothing emergent about Claimant's C3-4 condition/surgery. (Depo. of Dr. Lozanne, pgs. 34, 40, 49-50).

19. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find the testimony of Dr. Lozanne is supported by the fact that Dr. Poletti did not perform the C3-4 surgery until 3 weeks after Dr. Poletti last told Claimant to consider surgery (Depo. of Dr. Lozanne, *e.g.*, pgs. 13, 15-20, 34, 40, and 49-50).

20. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, according to Dr. Lozanne, we find an emergency situation means that "we got to get this patient to the hospital and get this procedure done here within the next couple of days." Based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find this is not the situation at hand. As Dr. Lozanne points out, for the situation to have been an emergency, Dr. Poletti "would have admitted [Claimant] that day" (Depo. of Dr. Lozanne, pgs. 18-19 and 40).

21. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find, by contrast, Dr. Poletti told Claimant in late January 2014 that he should "consider" the C3-4 surgery;

the surgery was performed 3 weeks later in February 2014 (Claimant's APA, pg. 468, 471-472).

22. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find there is no statement in Dr. Poletti's records to the effect that Claimant needed the surgery on an emergency basis or even on an imminent need basis (Claimant's APA, pgs. 462 and 468).

23. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, in February 2014 (several days after his surgery with Dr. Poletti), we find Claimant filed a Form 50 to transfer care to Dr. Poletti although Dr. Poletti had previously recommended C3-4 surgery at the first Poletti visit in November 2012 (Claimant's APA, pg. 461).

24. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that, in addition to the fact that Claimant had not even reached maximum medical improvement (but nonetheless underwent the C3-4 surgery with Dr. Poletti), Dr. Lozanne had explicitly (according to his treatment note) planned to re-evaluate Claimant after one year after the surgery to make a "determination if there was any need for any additional either studies or further evaluation *or any further treatment*" (Depo. of Dr. Lozanne, pgs. 21-22; Claimant's APA, pg. 478).

25. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that no physician

other than Dr. Lozanne defines the word "emergency" (medical evidence in its entirety; Depo. of Dr. Lozanne, pgs. 18-19 and 40).

26. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that Dr. Poletti's questionnaire statement—that the unauthorized C3-4 surgery was performed on an "emergency" basis--is not supported by the medical evidence, including Dr. Poletti's own treatment notes and operative notes: Dr. Poletti's January 2014 treatment note states that Claimant should "consider" C3-4 surgery; the C3-4 surgery was not performed until 3 weeks later. (Claimant's APA, pgs. 468, 471-472). These records refute the accuracy and legitimacy of the questionnaire's responses. Therefore, based on the entirety of the evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we accord the questionnaire of Dr. Poletti only *de minimis* weight.

27. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find Claimant did not provide the undersigned with any evidence of e-mail or letter communications (regarding the need for additional surgery) between Claimant's counsel and Defendants' counsel dated prior to—or after—the filing of the Form 50 request to transfer treatment, nor did Claimant provide any documentation of telephone communications regarding the issue. We find that it is incumbent upon Claimant to meet his burden of proof.

28. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find Claimant does not meet the "emergency" standard set forth in Section 42-15-60.

29. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find Dr. Lozanne testified (after the date of the Poletti surgery) that he does not disagree that it would be "reasonable" to have surgery on an adjacent level (the C3-C4 level) if there is increasing stenosis; however, (a) the unauthorized care was not rendered on an emergency basis; (b) Claimant sought unauthorized treatment the very month he was to see Dr. Lozanne; and (c) Claimant had not reached maximum medical improvement; Defendants were still providing treatment (Depo. of Dr. Lozanne, pgs. 36-37 and 49).

30. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we also considered the opinion of Dr. Giddens who recommended C3-C6 surgery (Claimant's APA, pg. 146-147).

31. Based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find none of the physicians involved agreed completely on the levels to be surgically addressed (Depo. of Dr. Lozanne, pgs. 30-31).

32. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we additionally note that Dr. Poletti told Claimant that Claimant was "most like not to improve" with the C3-4

surgery, but that the surgery "*could*" (not even "would") prevent Claimant from worsening (Defendants' APA, pg. 483).

33. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find Claimant's request for transfer of treatment to Dr. Poletti is denied.

34. Based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find Claimant's request for reimbursement for the surgery and other care/treatment provided by Dr. Poletti is denied.

35. Based on the substantial evidence, including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, we find that the Decision and Order of the Single Commissioner is affirmed in its entirety.

CONCLUSIONS OF LAW

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

1. Pursuant to S.C. Code Ann. § 42-15-10 and § 42-17-20, jurisdiction and venue are proper.
2. Pursuant to South Carolina Workers' Compensation Commission Rules and Regulations, Rule 67-210(B) and Rule 67-213(C), the parties were properly served with Notice of the Hearing.
3. The scope of review of the Full Commission is not limited. The Commission can, like the Single Commissioner, consider all of the evidence and reach its own findings

of fact and conclusions of law. Lowe v. Am-Can Transport Services, Inc., 283 S.C. 534, 324 S.E.2d 87 (S.C. Ct. App. 1984).

4. The Full Commission is not necessarily bound by the Single Commissioner's findings of fact, and is empowered to make its own findings of fact and to reach its own conclusions of law consistent or inconsistent with those of the Single Commission. Green v. Raybestos-Manhattan, Inc., 250 S.C. 58, 64, 156 S.E.2d 318, 321 (S.C. 1967). See also Muir v. C.R. Bard, Inc.

5. Workers' Compensation awards may not be based upon surmise, conjecture, or speculation, but must be founded on evidence of sufficient substance to afford a reasonable basis for it. Tiller v. Nat'l Health Care Ctr. of Sumter, 334 S.C. 333, 339, 513 S.E.2d 843, 845 (1999) ; Sharpe v. Case Produce Co., 329 S.C. 534, 543, 495 S.E.2d 790, 794 (Ct.App.1997) rev'd on other grounds.

6. Based on the substantial evidence, including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, we find that the Claimant sustained a compensable injury to the neck, pursuant to Section 42-1-160 of the Act, as a result of an admitted accident that occurred on June 15, 2011.

7. Section 42-15-60 of the Act states: "The employer shall provide medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be required, for a period not exceeding ten weeks from the date of an injury, to effect a cure or give relief and for an additional time as in the judgment of the commission will tend to lessen the period of disability as evidenced by expert medical

evidence stated to a reasonable degree of medical certainty." See S.C. Code Ann. §42-15-60.

8. Section 42-15-60 of the Act states: "If in an emergency, on account of the employer's failure to provide the medical care as specified in this section, a physician other than provided by the employer is called to treat the employee, the reasonable cost of the service must be paid by the employer, if ordered by the commission." See S.C. Code Ann. §42-15-60 (emphasis added).

9. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that Claimant does not meet the "emergency" standard set forth in Section 42-15-60.

10. In order for the Commission to order reimbursement, Section 42-15-60 requires that the Claimant satisfy his burden of proving that the care, for which he is seeking reimbursement, be provided (a) on an emergency basis, and (b) on account of Defendants' failure to provide medical treatment.

11. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that neither prong of Section 42-15-60 is satisfied in this case. More specifically, we find that the Claimant did not satisfy his burden of proving that the care, for which he is seeking reimbursement, was provided (a) on an emergency basis, and (b) on account of Defendants' failure to provide medical treatment.

12. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the substantial evidence including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that Claimant's reliance on Martin v. Rapid Plumbing, 369 S.C. 278, 631 S.E.2d 547 (Ct. App. 2006) is misplaced. In that case, (1) the claimant had been released by Dr. Felmly to return to work, and (2) Doctors Care refused to see the claimant because the visit to Doctors' Care was not authorized by the carrier. By contrast, in the case *sub judice*, Claimant sought unauthorized care when he (a) had not been released by the authorized treating physician, (b) had not been told to return to work, and (c) had not been denied treatment.

13. In Turner v. South Carolina Dept. of Health and Environmental Control, the Court of Appeals stated that Section 42-15-60 establishes "the rights of the employer and the employee with regard to payment for treatments." The Court explicitly stated that Section 42-15-60 "does not give a unilateral right to claimants to select their treating physician, and such an unencumbered right undermines the authority of the commission, as prescribed by the legislature." See Turner, 377.S.C. 540, 661 S.E.2d 118 reh'g denied, cert. denied (S.C.App. 2008).

14. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that, unless Claimant meets the requirements of Section 42-15-60, he is not entitled to unilaterally seek treatment with physicians of his choosing.

15. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that Claimant's request for transfer of treatment to Dr. Poletti is denied.

16. Pursuant to an application of South Carolina Code Ann. §42-15-60, and based on the substantial evidence, including the medical records submitted, the testimony of Dr. Lozanne, and the Claimant's testimony, we find that Claimant's request for reimbursement for the surgery and other care/treatment provided by Dr. Poletti is denied.

17. Based on the substantial evidence including the medical records submitted, the testimony of the representatives of the Defendants, and the Claimant's testimony, we find that the Decision and Order of the Single Commissioner is affirmed in its entirety.

ORDER

IT IS HEREBY ORDERED, that the substantial evidence supports a finding that the Decision and Order of the Single Commissioner is **AFFIRMED** in its entirety.

IT IS HEREBY ORDERED that Claimant has failed to satisfy his burden of proof pursuant to §42-15-60 of the Act that the care, for which he is seeking reimbursement, was provided on an emergency basis, and on account of Defendants' failure to provide medical treatment.

IT IS FURTHER ORDERED that Claimant's request for transfer of treatment to Dr. Poletti is denied.

IT IS FURTHER ORDERED that Claimant's request for reimbursement for the surgery and other care/treatment provided by Dr. Poletti is denied.

IT IS SO ORDERED.

Commissioner Gene McCaskill
For the Appellate Panel

WE CONCUR:

Commissioner Melody L. James

Commissioner Aisha Taylor

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Eugenia Hollmon on April 23, 2015

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1106789

VICTOR G. BENJAMIN, Employee, Claimant, vs. REXAM, INC., Employer, AND HARTFORD INSURANCE COMPANY OF THE MIDWEST c/o SEDGWICK CMS, Carrier, Defendants.	**DECISION AND ORDER**

DATE OF HEARING:	Hearing held in St. Matthews, South Carolina on August 18, 2016.
APPEARANCES:	Claimant appeared and represented by Jeffrey C. Chandler, Esquire of Chandler Law Firm, P.A. of Myrtle Beach, South Carolina. Defendants represented by Jason W. Lockhart, Esquire of McAngus Goudelock & Courie, L.L.C. of Columbia, South Carolina.
PURPOSE OF THE HEARING:	To determine all issues as set forth in Forms 50 and 51.
COMMISSIONER:	Commissioner Aisha Taylor
FILED:	July 21, 2017

STIPULATIONS

1. Jurisdiction is proper with the South Carolina Workers' Compensation Commission.
2. Venue is proper in Calhoun County, South Carolina.
3. Claimant's average weekly wage is One Thousand Four Hundred Sixty One Dollars ($1,461.40) and 40/100 with a corresponding compensation rate of Seven Hundred Four Dollars ($704.92) and 92/100.
4. No objections to the APA submissions.

APA SUBMISSIONS

STATEMENT OF THE CASE

Claimant sustained a compensable injury to the neck, psyche and right upper extremity by accident arising out of and in the course and scope of his employment on June 15, 2011. Claimant also alleges compensable injuries to the back, brain, left shoulder, right shoulder, left lower extremity and/or right lower extremity.

A Hearing was conducted on May 5, 2014 pursuant to a Form 50, filed by Claimant's attorney, who sought an order from Commissioner Barden designating Dr. Poletti of the Southeastern Spine Institute as the Claimant's authorized treating physician. Claimant's attorney maintained that Claimant's authorized treating physician, Dr. Lozanne of Columbia Neurosurgical Associates, who already performed surgery on the Claimant, did not provide the Claimant with necessary medical treatment, and that Claimant, due to an emergency medical need, sought medical treatment with Dr. Poletti, who performed surgery upon Claimant in February 2014. In response, Defendants maintained, in light of the fact that the Claimant sustained an admitted injury to the neck, they were entitled to direct medical treatment pursuant to Section 42-15-60 of the Act. More specifically, Defendants maintained that the medical

records of Claimant's physicians did not substantiate the Claimant's attorney's contention that the Claimant's need for medical treatment, which resulted in the Claimant undergoing surgery in February 2014, was the result of an emergency medical need.

During the pre-hearing conference, Commissioner Barden stated that she would like to receive an opinion from Dr. Lozanne with regards to the issue of whether the Claimant's need for surgery in February 2014 was the result of an emergency medical need. Subsequently, Commissioner Barden requested that Defendants conduct the deposition of Dr. Lozanne. As a result, Defendants conducted Dr. Lozanne's deposition on May 21, 2014. Most notably, with regards to the issue of whether the Claimant's February 2014 surgery was the result of an emergency medical need, Dr. Lozanne testified that, based on his physical examinations of Claimant and a review of diagnostic testing, Claimant did not possess pathology at C3-4 that would warrant emergency medical treatment.

Following Dr. Lozanne's deposition, a Hearing was re-scheduled before Commissioner Barden for June 23, 2014. Commissioner Barden issued a Decision and Order on September 17, 2014 denying Claimant's request that Dr. Poletti be designated as Claimant's authorized treating physician. More specifically, Commissioner Barden concluded that Section 42-15-60 of the Act requires that a claimant prove that, if in an emergency, on account of the Employer's failure to provide medical care as specified in Section 42-15-60, the Defendants would be responsible for the payment of reasonable costs associated with treatment sought by Claimant. Commissioner Barden indicated that the substantial evidence, including the medical records of Claimant's treating physicians and the deposition testimony of Dr. Lozanne, did not support Claimant's contention that Claimant needed surgery on an emergency basis or even on an imminent need basis. Commissioner Barden also indicated that the substantial evidence indicated that the

Employer/Carrier was providing Claimant with authorized causally-related medical treatment on a timely basis, and, therefore, Claimant did not satisfy his burden of proving, pursuant to Section 42-15-60, that the Employer/Carrier had failed to provide Claimant with authorized causally-related medical treatment.

Claimant appealed the Decision and Order of Commissioner Barden. The Full Commission affirmed the Decision and Order of Commissioner Barden in its entirety on April 23, 2015.

The hearing before the undersigned Commissioner was scheduled pursuant to a Form 50 filed by the Claimant's attorney on May 3, 2016. The Claimant's attorney alleged that the Claimant sustained multiple injuries while in the course and scope of the Claimant's employment with the Defendants on June 15, 2011. More specifically, the Claimant's attorney alleged that the Claimant sustained physical brain damage and/or incomplete quadriplegia as a result of the Claimant's work related accident and that, therefore, the Claimant was entitled to an award of lifetime compensation. In response, the Defendants admitted that the Claimant sustained a compensable injury to the neck, psyche and/or right upper extremity, but denied that the Claimant sustained physical brain damage and/or incomplete quadriplegia. Defendants also maintained that, if the undersigned Commissioner were to determine that the Claimant sustained a compensable injury to the lower back, the Claimant had not reached maximum medical improvement for the lower back and, therefore, any award of permanent disability benefits would be premature. The Claimant's attorney was also requesting a partial lump sum payment of any award of permanent disability benefits, and Defendants informed the undersigned Commissioner that Defendants opposed any partial lump sum payment based on the lack of evidence to support the Claimant's request for a partial lump sum payment.

EVIDENCE OF THE CASE

The Claimant testified on his behalf. The Claimant stated that he is currently 54-years of age, and resides in Sumter, South Carolina with his wife and son. The Claimant indicated that he worked with the Defendants for approximately 29 years, and sustained multiple injuries while in the course and scope of his employment with the Defendants on June 15, 2011 when the Claimant was struck by a protective guard which fell from above the Claimant, striking the Claimant on the head and right shoulder. The Claimant, who was wearing a neck brace and utilizing a cane at the hearing, indicated that he had sought and received medical treatment for his work related injuries with a variety of physicians including Dr. Lozanne, Dr. Naso, Dr. Poletti, and Dr. Sandoz. The Claimant testified that he continues to receive treatment from Dr. Sandoz in the form of prescription medications due to a variety of ongoing problems, including dizziness and migraine headaches. The Claimant stated that he is also utilizing anti-seizure medication which was prescribed by Dr. Sandoz, but that he has not experienced a seizure in the last few years. The Claimant testified that he is also currently receiving psychological treatment with Dr. Bergmann of Post Trauma Resources and receives treatment from Dr. Bergmann in the form of counseling. Based on review of the medical records, Dr. Lozanne, who provided the Claimant with authorized causally related medical treatment with regards to the neck, determined that the Claimant reached maximum medical improvement on July 22, 2016. The Claimant sought and received unauthorized medical treatment for the neck with Dr. Poletti.

The Claimant testified that he currently experiences a variety of physical and psychological problems as a result of his work related accident. The Claimant stated that his work related injuries have rendered the Claimant incapable of performing personal hygiene, including bathing, and that the Claimant's wife both bathes the Claimant on a daily basis as well

as assists the Claimant with dressing. The medical records of the Claimant's authorized treating physicians do not indicate that the Claimant is in need of daily assistance with regards to bathing and/or dressing. The Claimant indicated he also currently experiences weakness in both hands, which prevent the Claimant from utilizing utensils without problem. The Claimant testified that he also experiences weakness in both his left lower extremity and right lower extremity that requires the Claimant to utilize a cane, which was prescribed by Dr. Sandoz. The Claimant indicated that Dr. Sandoz has also prescribed a motorized scooter for the Claimant due to Claimant's lack of mobility. The Claimant stated that he spends the majority of his day at home watching TV or sleeping, and that the Claimant incapable of preparing meals on his behalf requiring his wife to prepare meals each day prior to her leaving to go to work.

On cross-examination, the Claimant testified that he does engage in driving on an infrequent basis, and has driven to a medical appointment within the last 30 days. The Claimant stated that he was physically capable of driving an automobile and also mentally capable of driving an automobile, but did experience some problems performing the above-referenced activity. Most notably, the Claimant indicated that he was a member of a labor union while employed with the Defendants, and that he actually served as the treasurer of the local chapter of his labor union from 2011 to 2013, which would have been following the date of his work related accident. Most notably, the Claimant testified that, while serving as treasurer from 2011 to 2013, he signed checks on behalf of the local chapter of his labor union. The Claimant stated that, on the date of his work related accident, he also operated a towing business known as Benjamin & Sons, but that Benjamin & Sons has not generated income since the date of the Claimant's work related accident. The Claimant stated that he also sustained an injury to the lower back as a result of his June 2011 work related accident, but was presented with medical records, which

were contemporaneous with the date of the accident, that made no mention of the Claimant providing his treating physicians with complaints of lower back pain and problems. Claimant testified he had no explanation as to why the above-referenced medical records made no mention of his alleged lower back injury.

Leta Benjamin testified on behalf of the Claimant. Ms. Benjamin testified that she is the Claimant's wife, and currently resides with the Claimant in Sumter, South Carolina. Ms. Benjamin indicated that she is currently employed with Wells Fargo, and has taken FMLA leave since March 2016 in order to provide the Claimant with care in light of the Claimant work related injuries. Ms. Benjamin indicated that the Claimant's work related injuries have placed significant physical and psychological limitations upon the Claimant. More specifically, Ms. Benjamin testified that she is required to provide the Claimant with both personal hygiene on a daily basis as well as dressing the Claimant and preparing the Claimant's food. Ms. Benjamin stated that she attends most, if not all of the Claimant's medical examination. Ms. Benjamin indicated that she had observed the Claimant's psychological problems, including anger and depression, as well as the Claimant's physical limitations, such as instability and loss of strength of the right upper extremity.

Medical Evidence

The parties conducted the deposition of Dr. Lozanne on July 7, 2016. Dr. Lozanne testified that the primary criteria used to establish a diagnosis of paraplegia is physical examination. (Depo. of Dr. Lozanne p. 6). Dr. Lozanne also testified that diagnostic testing, including MRIs and/or EMG/NCS are also helpful in reaching a determination of whether a patient is a paraplegic. (Depo. of Dr. Lozanne pp. 6-8). Furthermore, Dr. Lozanne testified that,

generally, a plegic condition will manifest itself rather quickly following an acute injury. (Depo. of Dr. Lozanne p. 17).

On the date of the June 15, 2011 work accident, Claimant presented to McLeod Regional Medical Center with a head injury. (APA p. 658). On physical examination, Claimant was well-developed and fit-appearing, was awake/alert/conversant/fluent speech, had normal affect, had intact extraocular movement, had 5/5 strength in both upper extremities and lower extremities with normal bulk and tone. (APA p. 658). Claimant later underwent right hand extensor tendon repair with Dr. Welsch. Following surgery, Claimant treated with Dr. Welsch from September 23, 2011 through October 14, 2013. (APA pp. 669-676). The records of Dr. Welsch indicate that Claimant presented with no acute distress and was alert and oriented. (APA pp. 669-676).

Defendants initially conducted Claimant's deposition on March 2, 2012. Regarding his right arm, Claimant testified that he experiences pain and stiffness in all four fingers and right wrist pain. (Claimant's March 2, 2012 Depo. Tr. pp. 26-28). Regarding his neck, Claimant testified that he suffered from neck pain radiating into his right arm that comes and goes on a daily basis. (Claimant's March 2, 2012 Depo. Tr. p. 28). Claimant testified that he also experiences dizziness and headaches. (Claimant's March 2, 2012 Depo. Tr. pp. 29-30). Claimant complained of sharp pains in different parts of his body which occur from time to time. (Claimant's March 2, 2012 Depo. Tr. p. 44). Claimant also stated that he gets "lost in thought" and "lost in conversation" resulting in his inability to participate in a conversation because he can no longer remember what he was talking about. (Claimant's March 2, 2012 Depo. Tr. pp. 45-48). When asked if he felt capable of returning to work, Claimant testified that he did not believe he could return to work. (Claimant's March 2, 2012 Depo. Tr. p. 51). Claimant did not feel that he could lift because he doesn't have the strength that he used to have, and that he

would not feel comfortable returning to work because he would not want to be around the machine for fear of suffering a panic attack. (Claimant's March 2, 2012 Depo. Tr. p. 51). Claimant did not mention his cognitive difficulties, dizziness, headaches, etc., as an impediment to returning to work, nor did Claimant describe any physical symptoms consistent with plegia (i.e. complete loss of sensory or motor function).

Claimant sought unauthorized treatment with Dr. Poletti at Southeastern Spine Institute on November 5, 2012. (APA pp. 718-719). A review of Claimant's symptoms was positive for eye pain with headaches, ringing in both ears, joint pain in his arms or his hands, headaches, seizures, anxiety and depression. (APA p. 718). However, Claimant denied any fevers, chills, night sweats, changes in weight, changes in appetite, chest pain, palpitations, shortness of breath, dysmea, wheezing, kidney/bowel/bladder dysfunction, paralysis, diabetes and hypothyroidism. (APA p. 718). A physical examination indicated that Claimant is a well-developed, well-nourished male alert and oriented and in no acute distress. (APA p. 719). Claimant also presented in an ambulatory fashion with a non-antalgic gait. (APA p. 719). Claimant had 5/5 strength and symmetry in the lower extremities. (APA p. 719).

Claimant underwent an initial evaluation with Dr. Lozanne on January 22, 2013. Claimant reported continued headaches, neck pain, right-sided intrascapular and shoulder pain radiating down the right arm, and also indicated that he had developed difficulties of balance and has had numbness and tingling worse on the right than the left. (APA p. 677). Claimant denied any urinary or bowel symptoms. (APA p. 677). His motor strength in the right deltoid, bicep, tricep and hand intrinsics were 4/5. (APA p. 677). However, all other muscle groups were 5/5 strength and his gait was normal. (APA p. 677). Dr. Lozanne diagnosed Claimant with cervical myelopathy and radiculopathy. (APA p. 677). Dr. Lozanne recommended, and later performed,

an anterior cervical discectomy and plated fusion at the C4-5, C5-6 and C6-7 levels. (APA p. 679).

Claimant began treating with Dr. Sandoz on September 16, 2011. The initial report indicates that Claimant had no sensory loss, no motor weakness, intact coordination, intact balance and gait, and normal motor skills. (APA p. 742). Additional reports of Dr. Sandoz confirm these physical findings throughout Claimant's treatment. (APA pp. 745, 748, 749-750, 752, 754, 756, 769, 792).

Claimant followed up with Dr. Poletti on January 20, 2014. (APA p. 721). Claimant reported complaints of neck, shoulder and right arm pain, along with continued issues with difficulty walking and imbalance; however, he denied any bowel or bladder issues. (APA p. 721). Claimant continued to treat with Dr. Poletti's office from August 14, 2014 through December 17, 2015. (APA pp. 722-736). Most notably, there is no indication in the reports of Southeastern Spine Institute of a complete loss of sensory or motor function or any paralysis. Each of the reports of "Dr. Poletti" is signed off on by his physician's assistants. (APA pp. 722-736). As a result, it is unclear when, or if, Dr. Poletti actually examined Claimant. The only mention of an "incomplete quadriparesis" or "incomplete quadriplegia" was contained in a written letter of Dr. Poletti addressed to the Claimant's attorney on May 27, 2015. (APA pp. 729-730). Dr. Poletti indicated that Claimant has a form of spinal cord injury or "incomplete quadriplegia." (APA p. 730).

Significantly, following the written letter of Dr. Poletti, on October 2, 2015, Claimant presented to Dr. Poletti's office and denied any focal muscle deficits, paralysis or changes in bowel and bladder function. (APA p. 731). A physical examination classified Claimant as "well-developed, well-nourished. . . alert and oriented x3 and in no acute distress." (APA p.

731). Furthermore, the physical examination indicated that Claimant was ambulatory with a slightly antalgic gait using the assistance of a cane primarily for fall prevention. (APA p. 731). Claimant had strength of the lower extremity between 4/5 and 5/5 and strength of the upper extremities was intact. (APA p. 731). Again, this visit was signed off on by a physician's assistant. (APA pp. 731-732). On December 17, 2015, Claimant again denied loss of bowel and bladder function, any focal muscle deficits or paralysis. Again, this visit was signed off on by a physician's assistant. (APA pp. 735-736). Finally, Claimant returned to Dr. Poletti's office on April 21, 2016. (APA p. 577). Claimant was evaluated for 15 minutes by a physician's assistant and denied any significant progression of his symptoms. (APA p. 577).

Defendants conducted the updated deposition of Claimant on March 31, 2014. Most notably, Claimant testified that, following the unauthorized surgery performed by Dr. Poletti, he experienced some improvement of his neck and upper extremity problems. (Claimant's March 31, 2014 Depo. Tr. p. 13, 16, 40, 44). At the Hearing, which was conducted on June 23, 2014 before Commissioner Barden, Claimant reiterated that the pain and numbness and symptoms improved following the unauthorized surgery performed by Dr. Poletti. (APA p. 865).

As mentioned above, Dr. Lozanne testified that a determination of paraplegia can be diagnosed via physical examination and/or diagnostic testing. (Dr. Lozanne's Depo. Tr. pp. 6-8). Dr. Lozanne testified that, based on the physical examination contained in his initial January 22, 2013 report, for which the November 15, 2012 MRI of the cervical spine and the November 3, 2011 EMG/NCS were available for his review, Claimant is not a plegic. (Dr. Lozanne's Depo. Tr. pp. 9-10). Dr. Lozanne then reviewed an EMG/NCS performed at Grand Strand Spine and Neurosurgery, performed on March 26, 2015 by Dr. Sandoz. Upon review of the diagnostic study, Dr. Lozanne testified that he saw nothing in the study that would indicate plegia. (Dr.

Lozanne's Depo. Tr. p. 11). Dr. Lozanne then reviewed an MRI of the cervical spine performed on April 13, 2015. Dr. Lozanne confirmed that nothing in the MRI would be consistent with a plegia. (Dr. Lozanne's Depo. Tr. p. 12). Dr. Lozanne was then presented with an MRI of the lumbar spine performed on October 19, 2015. Dr. Lozanne indicated that the report did not reveal any finding indicative of a plegia in Claimant. (Dr. Lozanne's Depo. Tr. p. 13). Dr. Lozanne was then presented with a copy of a report from Dr. Poletti's office, dated October 2, 2015, wherein Claimant underwent a physical examination performed by a physician's assistant. Again, Dr. Lozanne indicated that the findings present in the physical exam of Claimant on or about October 2, 2015 were not indicative or reflective of a plegia. (Dr. Lozanne's Depo. Tr. pp. 13-15). More specifically, Dr. Lozanne testified that a patient who has strength by definition cannot be plegic, and plegia is evidenced by lack of movement, specifically the movement of the extremities that are affected by the plegia, which was not evidenced in the physical examination. (Dr. Lozanne's Depo. Tr. pp. 14-15). Upon review of Dr. Poletti's letter to Claimant's attorney in which he references incomplete paraplegia on May 27, 2015, Dr. Lozanne testified that the above-referenced phrase is not appropriate to use in this instance. (Dr. Lozanne's Depo. Tr. p. 21). Dr. Lozanne explained that Claimant suffers from cervical myelopathy, including some difficulties with his balance because he had a spinal cord injury. (Dr. Lozanne's Depo. Tr. p. 21). However, Dr. Lozanne indicated that Claimant does not suffer from a quadriplegia and Dr. Lozanne has never heard a neurosurgeon use incomplete quadriplegia as a phrase. (Dr. Lozanne's Depo. Tr. p. 21). Dr. Lozanne further explained that Claimant suffers a spinal cord injury and has some weakness associated with that injury but is not a quadriparetic in the sense that he has normal motor strength in multiple extremities, though he has some decreased strength. (Dr. Lozanne's Depo. Tr. p. 22). Dr. Lozanne believed that Dr. Poletti was attempting

to convey that Claimant has some weakness but felt it was inappropriate to label Claimant as an incomplete or complete quadriplegic in any kind of way. (Dr. Lozanne's Depo. Tr. pp. 22-23).

Dr. Lozanne performed an evaluation of Claimant on July 22, 2016. (APA pp. 681-684). A physical examination revealed 5/5 strength in each lower extremity, 4/5 strength in the right upper extremity, and 5/5 strength in the left upper extremity. (APA p. 683). Cranial nerves were virtually intact and Claimant was awake, alert and answering questions appropriately. (APA p. 683). Claimant was able to walk and stand unassisted but used aid of 4-pronged cane for balance. (APA p. 683). Dr. Lozanne issued a 53% whole person impairment rating pursuant to Chapter 15 of the AMA Guidelines, Fifth Addition, but no separate impairment was included for bladder, erectile, sexual or respiratory function, nor was any separate impairment for lower extremity involvement included. (APA p. 684).

FINDINGS OF FACT

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

1. The South Carolina Workers' Compensation Commission has jurisdiction over the subject matter and parties of this claim.
2. Claimant's average weekly wage is One Thousand Four Hundred Sixty One Dollars ($1,461.40) and 40/100 with a corresponding compensation rate of Seven Hundred Four Dollars ($704.92) and 92/100.
3. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find that Claimant sustained compensable injuries to his neck, right

arm, brain (for initial closed head injury and resulting headaches and seizures), and psyche within the course and scope of his employment.

4. Claimant also alleges entitlement of lifetime benefits under the act based on a claim for incomplete paraplegia and brain damage as outlined in S.C. Code Ann. Section 42-9-10(C).

5. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant has failed to meet his burden of proving entitlement to lifetime benefits on the basis of "incomplete paraplegia". This finding is based on the preponderance of the evidence as a whole, including the deposition testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim.

6. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find I find Dr. Lozanne testified the suffix "plegia" refers to a complete lack of movement and that "paraplegia" is the complete inability to move your legs. (Depo. of Dr. Lozanne pp. 5-6). After review of Dr. Poletti's medical note diagnosing Claimant with "incomplete quadriparesis or a form of incomplete quadriplegia", Dr. Lozanne testified the phrase "incomplete quadriplegia" was inappropriate in this instance and that Claimant suffered from cervical myelopathy – spinal cord dysfunction that has led to some symptoms – including difficulty with balance. (Depo. of Dr. Lozanne pp. 21).

7. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the

Claimant's wife, I find Dr. Lozanne went on to state unequivocally Claimant does not suffer from quadriplegia and it would be inappropriate to describe him as an incomplete quadriplegic. (Depo. of Dr. Lozanne pp. 21-22).

8. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I give greater weight to the testimony and medical opinions of Dr. Lozanne, who is the authorized threating neurosurgeon in the claim.

9. Based on a preponderance of the evidence including the medical records of the Claimant, and the testimony of Dr. Lozanne, I find Dr. Lozanne's analysis of Claimant's physical examinations as well as the diagnostic studies including the EMG nerve conduction studies (conducted in 2013 & 2015) and MRI (both cervical and lumbar) as outlined in his deposition to be very persuasive and I gave it great weight. (Claimant's APA p. 550-551, 572-573, 689-695, 733-734, 774-779)

10. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant's motor functioning was tested by way of physical examinations throughout the course of Claimant's medical treatment. During Claimant's initial treatment with Dr. Lozanne on January 22, 2013, Claimant was noted to have motor strength in all of his extremities and even had resistance strength. (Claimant's APA p. 677-679).

11. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find the physical examination performed by Claimant's own

unauthorized physician revealed Claimant had motor strength in his lower extremities rated as 5 out of 5 with hip flexion and dorsiflexion, 4 out of 5 in knee flexion, extension and plantar flexion bilaterally. Claimant was also noted to have intact motor strength in the upper extremities. (Claimant's APA pp. 568-569).

12. *Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant's lack of consistent complaints regarding bowel and/or bladder dysfunction, while not dispositive, to be weighted evidence in the present case. (CITE TO APA)*

13. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant has failed to meet his burden of proving entitled to lifetime benefits on the basis of having sustained permanent and severe physical brain damage. This finding is based on the preponderance of the evidence including:

    a. Three brain scans performed by treating physicians including Dr. Meiere, Dr. Naso, and Dr. Sandoz (Claimant's APA pp. 91-92, 687-688, 660-661);

    b. Claimant's appearance at and participation in two depositions;

    c. Claimant's attendance at most of his medical appointments on his own to which he also drove himself on his own;

    d. Claimant's service as treasurer of his union at the time of his injury and continued service as treasurer through 2012 (at the time of the hearing he was still a member of the union);

e. The lack of any medical evidence stated to a reasonable degree of medical certainty that Claimant sustained brain damage that was permanent and severe.

14. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find there is insufficient evidence in the medical record to support a finding that Claimant sustained an injury to his lower back (and any resulting radiculopathy to the legs) as a result of his work injury. This finding is based on the preponderance of the evidence as a whole, including the deposition testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim.

15. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find that Claimant's allegation of separate injuries to his bilateral shoulders and left arm are denied as they are not supported by a preponderance of the medical evidence. This finding is based on the preponderance of the evidence as a whole, including the deposition testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim.

16. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant sustained an injury to his brain. This finding is based on Claimant's initial closed head injury and resulting headaches. Claimant's history of seizures weighed into this decision as well although Claimant is currently taking medication and having not had a seizure since February 19, 2012.

17. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant's injuries to his neck, right arm, brain (for initial closed head injury and resulting headaches and seizures) and psyche render him permanently and totally disabled. This finding is based on the medical evidence as a whole and the opinions on Claimant's employability offered by Dr. Sandoz, Dr. Poletti, Dr. Mills and Dr. Brabham. This finding is based on the preponderance of the evidence as a whole.

18. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find I find Claimant is entitled to lifetime causally-related medical treatment for his neck, right arm, brain (headaches & seizures) and depression.

19. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find I find Claimant is not entitled to a mobility scooter as there is insufficient evidence in the record causally-relating the need for the scooter to compensable injuries as outlined above. Specifically, Dr. Sandoz did not prescribe the mobility scooter until October 1, 2015 after Claimant alleged lower back and bilateral lower extremity symptoms associated with his 2011 work injury – claims which have been denied as noted above.

20. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find I find Claimant's request for a mobility scooter as a result of

causally-related medical treatment is not supported by a preponderance of the medical evidence and is denied.

21. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant is entitled to a lump-sum payment of the commuted value of 500 weeks of benefits less any amount previously paid to the Claimant in the form of temporary benefits. This finding is based on the preponderance of the evidence as a whole.

22. No hearing costs are assessed.

CONCLUSIONS OF LAW

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

1. Pursuant to S.C. Code Ann. Section 42-15-10 and Section 42-17-20, jurisdiction and venue are proper.
2. Pursuant to South Carolina Workers' Compensation Commission Rules and Regulations, Rule 67-210(B) and Rule 67-213(C), the parties were properly served with Notice of the Hearing.
3. Workers' Compensation awards may not be based upon surmise, conjecture, or speculation, but must be founded on evidence of sufficient substance to afford a reasonable basis for it. Tiller v. Nat'l Health Care Ctr. of Sumter, 334 S.C. 333, 339, 513 S.E.2d 843, 845 (1999) ; Sharpe v. Case Produce Co., 329 S.C. 534, 543, 495 S.E.2d 790, 794 (Ct.App.1997) rev'd on other grounds.

4. A workers' compensation claimant has the burden of proving facts that show the alleged injury arose out of and in the course and scope of employment. Clade v. Champion Laboratories, 330 S.C. 8, 496 S.E.2d 856 (S.C. 1998).

5. Only the facts and circumstances of the injury can determine whether it is compensable and, therefore, whether the employee's remedy is exclusively under the Compensation Law. Thompson v. J.A. Jones Const. Co., 199 S.C. 304, 19 S.E.2d. 226 (1942).

6. A "possibility" is not enough to show that a worker's injury arose out of and in the course and scope of his employment. Fowler v. Abbott Motor Co., 236 S.C. 226, 113 S.E.2d 737 (S.C. 1960).

7. The possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence. Tiller, 334 S.C. 333, 513 S.E.2d 843, rehearing denied (S.C. 1999).

8. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, Claimant sustained compensable injuries to his neck, right arm, brain (per Regulation 67-1101 for initial closed head injury and resulting headaches and seizures), and psyche within the course and scope of his employment.

9. Claimant also alleges entitlement of lifetime benefits under the act based on a claim for incomplete paraplegia and brain damage as outlined in S.C. Code Ann. Section 42-9-10(C).

10. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find Claimant has failed to meet his burden of proving entitlement to lifetime benefits pursuant to Section 42-9-10(C) on the basis of "incomplete paraplegia". This finding is based on the preponderance of the evidence as a whole, including the medical records of

the Claimant, the testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim, the Claimant's testimony and the testimony of the Claimant's wife.

11. In Reed-Richards v. Clemson University, the Single Commissioner held that the claimant was a paraplegic as a result of her work accident and, therefore, entitled to lifetime benefits. 37 S.C. 304, 638 S.E.2d 77 (S.C. App. 2007). This finding was based in large part on the deposition and notes of Dr. David Shallcross, one of the claimant's treating physicians, who labeled her an incomplete paraplegic. The Full Commission upheld the Single Commissioner's Order, and the Court of Appeals eventually upheld the Full Commission's finding based on the substantial evidence standard. The claimant required the use of a walker and lost control of her bowel and bladder and developed urinary retention.

12. I find the Reeds-Richards case is distinguishable from the present case. In Reeds-Richards, the Court of Appeals affirmed Claimant's lifetime benefits based on the grounds that there was substantial evidence in the record to support the finding by the Commission. In that case, the only medical opinion in evidence was that of Dr. Shallcross, who opined Claimant had incomplete paraplegia. There were no other medical opinions on the issue in the record and as such, there were no other medical opinions on which the Commission or the Court could rely.

13. Expert medical testimony is designed to aid the South Carolina Workers' Compensation Commission in coming to the correct conclusion; therefore, Commission determines the weight and credit to be given to expert testimony. Sharpe v. Case Produce, Inc., 336 S.C. 154, 519 S.E.2d 102 (1999)

14. In the present case, I give greater weight to the testimony and medical opinions of Dr. Lozanne, the authorized threating neurosurgeon in the claim. I find Dr. Lozanne's analysis of Claimant's physical examinations as well as the diagnostic studies including the EMG nerve conduction studies (2013 & 2015) and MRI (cervical and lumbar) as outlined in his deposition to be very persuasive and I gave it great weight.

15. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find Claimant has failed to meet his burden of proving entitled to lifetime benefits pursuant to Section 42-9-10(C) on the basis of having sustained permanent and severe physical brain damage as contemplated by S.C. Code Ann. Section 42-9-10(C) and the case law as outlined in Crisp and Sparks. This finding is based on the preponderance of the evidence including:

    a. Three brain scans performed by treating physicians including Dr. Meiere, Dr. Naso, and Dr. Sandoz (Claimant's APA pp. 91-92, 687-688, 660-661);

    b. Claimant's appearance at and participation in two depositions;

    c. Claimant's attendance at most of his medical appointments on his own to which he also drove himself on his own;

    d. Claimant's service as treasurer of his union at the time of his injury and continued service as treasurer through 2012 (at the time of the hearing he was still a member of the union);

    e. The lack of any medical evidence stated to a reasonable degree of medical certainty that Claimant sustained brain damage that was permanent and severe as required by case law and the Act.

16. Section 42-1-160 of the Act requires that, to be compensable, an injury by accident must be one "arising out of and in the course and scope of employment." Osteen v. Greenville County Sch. Dist., 333 S.C. 43, 49, 508 S.E.2d 21, 24 (1998).

17. For an injury to "arise out of" employment, the injury must be proximately caused by the employment. Fowler v. Abbott Motor Co., 236 S.C. 226, 113 S.E.2d 737 (1960). The injury arises out of employment when there is a causal connection between the conditions under which the work is required to be performed and the resulting injury. Douglas v. Spartan Mills, Startex Div., 245 S.C. 265, 140 S.E.2d 173 (1965).

18. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find there is insufficient evidence in the medical record to support a finding that Claimant sustained an injury to his lower back (and any resulting radiculopathy to the legs) as a result of his work injury. This finding is based on the preponderance of the evidence as a whole.

19. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find that Claimant's allegation of separate injuries to his bilateral shoulders and left arm are denied as I find they are not supported by a preponderance of the medical evidence. This finding is based on the preponderance of the evidence as a whole.

20. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find Claimant sustained an injury to his brain pursuant to Regulation 67-1101. This finding is based on Claimant's initial closed head injury and resulting headaches. Claimant's history of seizures weighed into this decision as well although Claimant is currently taking medication and has not had a seizure since February 19, 2012.

21. Pursuant to Section 42-9-10 and based on the preponderance of the evidence as a whole, I find Claimant's injuries to his neck, right arm, brain (Regulation 67-1101) and psyche render him permanently and totally disabled pursuant to S.C. Code Ann. Section 42-9-10(A). This finding is based on the medical evidence as a whole and the opinions on Claimant's employability offered by Dr. Sandoz, Dr. Poletti, Dr. Mills and Dr. Brabham. This finding is based on the preponderance of the evidence as a whole.

22. Pursuant to Section 42-15-60 and based on the preponderance of the evidence as a whole I find Claimant is entitled to lifetime causally-related medical treatment for his neck, right arm, brain (headaches & seizures per Regulation 67-1101) and depression.

23. Pursuant to Section 42-15-60 and based on the preponderance of the evidence as a whole I find Claimant is not entitled to a mobility scooter as there is insufficient evidence in the record causally-relating the need for the scooter to compensable injuries as outlined above. Specifically, Dr. Sandoz did not prescribe the mobility scooter until October 1, 2015 after Claimant alleged lower back and bilateral lower extremity symptoms associated with his 2011 work injury – claims which have been denied as noted above.

24. Pursuant to Section 42-15-60 and based on the preponderance of the evidence as a whole I find Claimant's request for a mobility scooter as a result of causally-related medical treatment is not supported by a preponderance of the medical evidence and is denied.

25. Pursuant to Section 42-9-301 and based on the preponderance of the evidence as a whole, I find Claimant is entitled to a lump-sum payment of the commuted value of 500 weeks of benefits less any amount previously paid to the Claimant in the form of temporary benefits. This finding is based on the preponderance of the evidence as a whole.

26. Claimant is entitled to James v. Anne's apportionment language in the Order.

27. No hearing costs are assessed.

ORDER

IT IS HEREBY ORDERED that Claimant sustained compensable injuries to his neck, right arm, brain (per Regulation 67-1101 for initial closed head injury and resulting headaches and seizures), and psyche within the course and scope of his employment.

IT IS FURTHER ORDERED that Claimant has failed to meet his burden of proving entitlement to lifetime benefits pursuant to Section 42-9-10(C) on the basis of "incomplete paraplegia".

IT IS FURTHER ORDERED that Claimant has failed to meet his burden of proving entitled to lifetime benefits pursuant to Section 42-9-10(C) on the basis of having sustained permanent and severe physical brain damage as contemplated by S.C. Code Ann. Section 42-9-10(C)

IT IS FURTHER ORDERED that I find there is insufficient evidence in the medical record to support a finding that Claimant sustained an injury to his lower back (and any resulting radiculopathy to the legs) as a result of his work injury.

IT IS FURTHER ORDERED that Claimant's allegation of separate injuries to his bilateral shoulders and left arm are denied as they are not supported by a preponderance of the medical evidence.

IT IS FURTHER ORDERED that Claimant sustained an injury to his brain pursuant to Regulation 67-1101.

IT IS FURTHER ORDERED that Claimant's injuries to his neck, right arm, brain (Regulation 67-1101) and psyche render him permanently and totally disabled pursuant to S.C. Code Ann. Section 42-9-10(A).

IT IS FURTHER ORDERED that Claimant is entitled to lifetime causally-related medical treatment for his neck, right arm, brain (headaches & seizures per Regulation 67-1101) and depression.

IT IS FURTHER ORDERED that Claimant is not entitled to a mobility scooter as there is insufficient evidence in the record causally-relating the need for the scooter to compensable injuries as outlined above.

IT IS FURTHER ORDERED Claimant is entitled to a lump-sum payment of the commuted value of 500 weeks of benefits less any amount previously paid to the Claimant in the form of temporary benefits. This finding is based on the preponderance of the evidence as a whole.

IT IS FURTHER ORDERED Claimant is entitled to James v. Anne's SSA apportionment language in the Order.

AND IT IS SO ORDERED.

Commissioner Aisha Taylor

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.
July 21, 2017

By: Renee Smith, Administrative Assistant to Commissioner Taylor

APPELLATE PANEL DECISION AND ORDER

OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1106789

Victor G. Benjamin — EMPLOYEE, CLAIMANT/APPELLANT

VS.

Rexam Beverage Can Company d/b/a Rexam Beverages — EMPLOYER,

AND

Hartford Insurance Company of the Midwest c/o Sedgwick CMS — CARRIER, DEFENDANTS/ RESPONDENTS,

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Appellate Panel Review held in Columbia, South Carolina, on October 16, 2017 per notices timely And properly served upon all parties of interest.

Appellate Panel Decision and Order Filed:

April 24, 2018

APPEARANCES: Claimant/Appellant represented by Jeffrey C. Chandler, Esquire

Defendants/Respondents represented by Jason W. Lockhart, Esquire

STATEMENT OF THE CASE

A Hearing was previously conducted on May 5, 2014 pursuant to a Form 50, filed by Claimant's attorney, who sought an order from Commissioner Barden designating Dr. Poletti of the Southeastern Spine Institute as the Claimant's authorized treating physician. In response, Defendants maintained, in light of the fact that the Claimant sustained an admitted injury to the neck; they were entitled to direct medical treatment pursuant to Section 42-15-60 of the Act. More specifically, Defendants maintained that the medical records of Claimant's physicians did not substantiate the Claimant's attorney's contention that the Claimant's need for medical treatment, which resulted in the Claimant undergoing surgery in February 2014, was the result of an emergency medical need. During the pre-hearing conference, Commissioner Barden stated that she would like to receive an opinion from Dr. Lozanne with regards to the issue of whether the Claimant's need for surgery in February 2014 was the result of an emergency medical need.

Following Dr. Lozanne's deposition, a Hearing was re-scheduled before Commissioner Barden for June 23, 2014. Commissioner Barden issued a Decision and Order on September 17, 2014 denying Claimant's request that Dr. Poletti be designated as Claimant's authorized treating physician. Commissioner Barden indicated that the substantial evidence, including the medical records of Claimant's treating physicians and the deposition testimony of Dr. Lozanne, did not support Claimant's contention that Claimant needed surgery on an emergency basis or even on an imminent need basis. Commissioner Barden also indicated that the substantial evidence indicated that the Employer/Carrier was providing Claimant with authorized causally-related medical treatment on a timely basis, and, therefore, Claimant did not satisfy his burden of proving, pursuant to Section 42-15-60, that the Employer/Carrier had failed to provide Claimant with authorized causally-related medical treatment. Claimant appealed the Decision and Order of Commissioner Barden. The Full Commission affirmed the Decision and Order of Commissioner Barden in its entirety on April 23, 2015.

A hearing was held before Commissioner Taylor on August 18, 2016 pursuant to a Form 50 filed by the Claimant's attorney on May 3, 2016. Claimant's attorney alleged that Claimant sustained multiple

injuries while in the course and scope of Claimant's employment with the Defendants on June 15, 2011. More specifically, Claimant's attorney alleged that Claimant sustained physical brain damage and/or incomplete quadriplegia as a result of the Claimant's work related accident and that, therefore, the Claimant was entitled to an award of lifetime compensation. In response, the Defendants admitted that Claimant sustained a compensable injury to the neck, psyche and/or right upper extremity, but denied that Claimant sustained physical brain damage and/or incomplete quadriplegia. Furthermore, Defendants asserted that the greater weight of the evidence of the record did not support that Claimant could sustain his burden of proving entitlement to lifetime benefits under the Act pursuant to Section 42-9-10(C).

Defendants also maintained that, if Commissioner Taylor were to determine that Claimant sustained a compensable injury to the lower back, Claimant had not reached maximum medical improvement for the lower back and, therefore, any award of permanent disability benefits would be premature. Claimant's attorney was also requesting a partial lump sum payment of any award of permanent disability benefits, and Defendants informed Commissioner Taylor that Defendants opposed any partial lump sum payment based on the lack of evidence to support Claimant's request for a partial lump sum payment.

On July 21, 2017, Commissioner Taylor issued a Decision and Order making the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACTS

1. The South Carolina Workers' Compensation Commission has jurisdiction over the subject matter and parties of this claim.

2. Claimant's average weekly wage is One Thousand Four Hundred Sixty One Dollars ($1,461.40) and 40/100 with a corresponding compensation rate of Seven Hundred Four Dollars ($704.92) and 92/100.

3. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find that Claimant sustained compensable injuries to his neck, right arm, brain (for initial closed head injury and resulting headaches and seizures), and psyche within the course and scope of his employment.

4. Claimant also alleges entitlement of lifetime benefits under the act based on a claim for incomplete paraplegia and brain damage as outlined in S.C. Code Ann. Section 42-9-10(C).

5. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant has failed to meet his burden of proving entitlement to lifetime benefits on the basis of "incomplete paraplegia". This finding is based on the preponderance of the evidence as a whole, including the deposition testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim.

6. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find I find Dr. Lozanne testified the suffix "plegia" refers to a complete lack of movement and that "paraplegia" is the complete inability to move your legs. (Depo. of Dr. Lozanne pp. 5-6). After review of Dr. Poletti's medical note diagnosing Claimant with "incomplete quadriparesis or a form of incomplete quadriplegia", Dr. Lozanne testified the phrase "incomplete quadriplegia" was inappropriate in this instance and that Claimant suffered from cervical myelopathy – spinal cord dysfunction that has led to some symptoms – including difficulty with balance. (Depo. of Dr. Lozanne pp. 21).

7. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Dr. Lozanne went on to state unequivocally Claimant does not suffer from quadriplegia and it would be inappropriate to describe him as an incomplete quadriplegic. (Depo. of Dr. Lozanne pp. 21-22).

8. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I give greater weight to the testimony and medical opinions of Dr. Lozanne, who is the authorized threating neurosurgeon in the claim.

9. Based on a preponderance of the evidence including the medical records of the Claimant, and the testimony of Dr. Lozanne, I find Dr. Lozanne's analysis of Claimant's physical examinations as well as the diagnostic studies including the EMG nerve conduction studies (conducted in 2013 & 2015) and MRI (both cervical and lumbar) as outlined in his deposition to be very persuasive and I gave it great weight. (Claimant's APA p. 550-551, 572-573, 689-695, 733-734, 774-779)

10. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant's motor functioning was tested by way of physical examinations throughout the

course of Claimant's medical treatment. During Claimant's initial treatment with Dr. Lozanne on January 22, 2013, Claimant was noted to have motor strength in all of his extremities and even had resistance strength. (Claimant's APA p. 677-679).

11. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find the physical examination performed by Claimant's own unauthorized physician revealed Claimant had motor strength in his lower extremities rated as 5 out of 5 with hip flexion and dorsiflexion, 4 out of 5 in knee flexion, extension and plantar flexion bilaterally. Claimant was also noted to have intact motor strength in the upper extremities. (Claimant's APA pp. 568-569).

12. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant's lack of consistent complaints regarding bowel and/or bladder dysfunction, while not dispositive, to be weighted evidence in the present case. *(CITE TO APA)*

13. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant has failed to meet his burden of proving entitled to lifetime benefits on the basis of having sustained permanent and severe physical brain damage. This finding is based on the preponderance of the evidence including:

    a. Three brain scans performed by treating physicians including Dr. Meiere, Dr. Naso, and Dr. Sandoz (Claimant's APA pp. 91-92, 687-688, 660-661);
    b. Claimant's appearance at and participation in two depositions;
    c. Claimant's attendance at most of his medical appointments on his own to which he also drove himself on his own;
    d. Claimant's service as treasurer of his union at the time of his injury and continued service as treasurer through 2012 (at the time of the hearing he was still a member of the union);
    e. The lack of any medical evidence stated to a reasonable degree of medical certainty that Claimant sustained brain damage that was permanent and severe.

14. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find there is insufficient evidence in the medical record to support a finding that Claimant sustained an injury to his lower back (and any resulting radiculopathy to the legs) as a result of his work injury. This finding is based on the preponderance of the evidence as a whole, including the deposition testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim.

15. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find that Claimant's allegation of separate injuries to his bilateral shoulders and left arm are denied as they are not supported by a preponderance of the medical evidence. This finding is based on the preponderance of the evidence as a whole, including the deposition testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim.

16. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant sustained an injury to his brain. This finding is based on Claimant's initial closed head injury and resulting headaches. Claimant's history of seizures weighed into this decision as well although Claimant is currently taking medication and having not had a seizure since February 19, 2012.

17. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find Claimant's injuries to his neck, right arm, brain (for initial closed head injury and resulting headaches and seizures) and psyche render him permanently and totally disabled. This finding is based on the medical evidence as a whole and the opinions on Claimant's employability offered by Dr. Sandoz, Dr. Poletti, Dr. Mills and Dr. Brabham. This finding is based on the preponderance of the evidence as a whole.

18. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find I find Claimant is entitled to lifetime causally-related medical treatment for his neck, right arm, brain (headaches & seizures) and depression.

19. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find I find Claimant is not entitled to a mobility scooter as there is insufficient evidence in the record causally-relating the need for the scooter to compensable injuries as outlined above. Specifically, Dr. Sandoz did not prescribe the mobility scooter until October 1, 2015 after Claimant alleged lower back and bilateral lower extremity symptoms associated with his 2011 work injury – claims which have been denied as noted above.

20. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, I find I find Claimant's request for a mobility scooter as a result of causally-related medical treatment is not supported by a preponderance of the medical evidence and is denied.

21. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony

and the testimony of the Claimant's wife, I find Claimant is entitled to a lump-sum payment of the commuted value of 500 weeks of benefits less any amount previously paid to the Claimant in the form of temporary benefits. This finding is based on the preponderance of the evidence as a whole.

22. No hearing costs are assessed.

CONCLUSIONS OF LAW

1. Pursuant to S.C. Code Ann. Section 42-15-10 and Section 42-17-20, jurisdiction and venue are proper.

2. Pursuant to South Carolina Workers' Compensation Commission Rules and Regulations, Rule 67-210(B) and Rule 67-213(C), the parties were properly served with Notice of the Hearing

3. Workers' Compensation awards may not be based upon surmise, conjecture, or speculation, but must be founded on evidence of sufficient substance to afford a reasonable basis for it. Tiller v. Nat'l Health Care Ctr. of Sumter, 334 S.C. 333, 339, 513 S.E.2d 843, 845 (1999); Sharpe v. Case Produce Co., 329 S.C. 534, 543, 495 S.E.2d 790, 794 (Ct.App.1997) rev'd on other grounds.

4. A workers' compensation claimant has the burden of proving facts that show the alleged injury arose out of and in the course and scope of employment. Clade v. Champion Laboratories, 330 S.C. 8, 496 S.E.2d 856 (S.C. 1998).

5. Only the facts and circumstances of the injury can determine whether it is compensable and, therefore, whether the employee's remedy is exclusively under the Compensation Law. Thompson v. J.A. Jones Const. Co., 199 S.C. 304, 19 S.E.2d. 226 (1942).

6. A "possibility" is not enough to show that a worker's injury arose out of and in the course and scope of his employment. Fowler v. Abbott Motor Co., 236 S.C. 226, 113 S.E.2d 737 (S.C. 1960).

7. The possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence. Tiller, 334 S.C. 333, 513 S.E.2d 843, rehearing denied (S.C. 1999).

8. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, Claimant sustained compensable injuries to his neck, right arm, brain (per Regulation 67-1101 for initial closed head injury and resulting headaches and seizures), and psyche within the course and scope of his employment.

9. Claimant also alleges entitlement of lifetime benefits under the act based on a claim for incomplete paraplegia and brain damage as outlined in S.C. Code Ann. Section 42-9-10(C).

10. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find Claimant has failed to meet his burden of proving entitlement to lifetime benefits pursuant to Section 42-9-10(C) on the basis of "incomplete paraplegia". This finding is based on the preponderance of the evidence as a whole, including the medical records of the Claimant, the testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim, the Claimant's testimony and the testimony of the Claimant's wife.

11. In Reed-Richards v. Clemson University, the Single Commissioner held that the claimant was a paraplegic as a result of her work accident and, therefore, entitled to lifetime benefits. 37 S.C. 304, 638 S.E.2d 77 (S.C. App. 2007). This finding was based in large part on the deposition and notes of Dr. David Shallcross, one of the claimant's treating physicians, who labeled her an incomplete paraplegic. The Full Commission upheld the Single Commissioner's Order, and the Court of Appeals eventually upheld the Full Commission's finding based on the substantial evidence standard. The claimant required the use of a walker and lost control of her bowel and bladder and developed urinary retention.

12. I find the Reeds-Richards case is distinguishable from the present case. In Reeds-Richards, the Court of Appeals affirmed Claimant's lifetime benefits based on the grounds that there was substantial evidence in the record to support the finding by the Commission. In that case, the only medical opinion in evidence was that of Dr. Shallcross, who opined Claimant had incomplete paraplegia. There were no other medical opinions on the issue in the record and as such, there were no other medical opinions on which the Commission or the Court could rely.

13. Expert medical testimony is designed to aid the South Carolina Workers' Compensation Commission in coming to the correct conclusion; therefore, Commission determines the weight and credit to be given to expert testimony. Sharpe v. Case Produce, Inc., 336 S.C. 154, 519 S.E.2d 102 (1999)

14. In the present case, I give greater weight to the testimony and medical opinions of Dr. Lozanne, the authorized threating neurosurgeon in the claim. I find Dr. Lozanne's analysis of Claimant's physical examinations as well as the diagnostic studies including the EMG nerve conduction studies (2013 & 2015) and MRI (cervical and lumbar) as outlined in his deposition to be very persuasive and I gave it great weight.

15. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find Claimant has failed to meet his burden of proving entitled to lifetime benefits pursuant to Section 42-9-10(C) on the basis of having sustained permanent and severe physical brain damage as

contemplated by S.C. Code Ann. Section 42-9-10(C) and the case law as outlined in Crisp and Sparks. This finding is based on the preponderance of the evidence including:

a. Three brain scans performed by treating physicians including Dr. Meiere, Dr. Naso, and Dr. Sandoz (Claimant's APA pp. 91-92, 687-688, 660-661);
b. Claimant's appearance at and participation in two depositions;
c. Claimant's attendance at most of his medical appointments on his own to which he also drove himself on his own;
d. Claimant's service as treasurer of his union at the time of his injury and continued service as treasurer through 2012 (at the time of the hearing he was still a member of the union);
e. The lack of any medical evidence stated to a reasonable degree of medical certainty that Claimant sustained brain damage that was permanent and severe as required by case law and the Act.

16. Section 42-1-160 of the Act requires that, to be compensable, an injury by accident must be one "arising out of and in the course and scope of employment." Osteen v. Greenville County Sch. Dist., 333 S.C. 43, 49, 508 S.E.2d 21, 24 (1998).

17. For an injury to "arise out of" employment, the injury must be proximately caused by the employment. Fowler v. Abbott Motor Co., 236 S.C. 226, 113 S.E.2d 737 (1960). The injury arises out of employment when there is a causal connection between the conditions under which the work is required to be performed and the resulting injury. Douglas v. Spartan Mills, Startex Div., 245 S.C. 265, 140 S.E.2d 173 (1965).

18. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find there is insufficient evidence in the medical record to support a finding that Claimant sustained an injury to his lower back (and any resulting radiculopathy to the legs) as a result of his work injury. This finding is based on the preponderance of the evidence as a whole.

19. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find that Claimant's allegation of separate injuries to his bilateral shoulders and left arm are denied as I find they are not supported by a preponderance of the medical evidence. This finding is based on the preponderance of the evidence as a whole.

20. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, I find Claimant sustained an injury to his brain pursuant to Regulation 67-1101. This finding is based on Claimant's initial closed head injury and resulting headaches. Claimant's history of

seizures weighed into this decision as well although Claimant is currently taking medication and has not had a seizure since February 19, 2012.

21. Pursuant to Section 42-9-10 and based on the preponderance of the evidence as a whole, I find Claimant's injuries to his neck, right arm, brain (Regulation 67-1101) and psyche render him permanently and totally disabled pursuant to S.C. Code Ann. Section 42-9-10(A). This finding is based on the medical evidence as a whole and the opinions on Claimant's employability offered by Dr. Sandoz, Dr. Poletti, Dr. Mills and Dr. Brabham. This finding is based on the preponderance of the evidence as a whole.

22. Pursuant to Section 42-15-60 and based on the preponderance of the evidence as a whole I find Claimant is entitled to lifetime causally-related medical treatment for his neck, right arm, brain (headaches & seizures per Regulation 67-1101) and depression.

23. Pursuant to Section 42-15-60 and based on the preponderance of the evidence as a whole I find Claimant is not entitled to a mobility scooter as there is insufficient evidence in the record causally-relating the need for the scooter to compensable injuries as outlined above. Specifically, Dr. Sandoz did not prescribe the mobility scooter until October 1, 2015 after Claimant alleged lower back and bilateral lower extremity symptoms associated with his 2011 work injury – claims which have been denied as noted above.

24. Pursuant to Section 42-15-60 and based on the preponderance of the evidence as a whole I find Claimant's request for a mobility scooter as a result of causally-related medical treatment is not supported by a preponderance of the medical evidence and is denied.

25. Pursuant to Section 42-9-301 and based on the preponderance of the evidence as a whole, I find Claimant is entitled to a lump-sum payment of the commuted value of 500 weeks of benefits less any amount previously paid to the Claimant in the form of temporary benefits. This finding is based on the preponderance of the evidence as a whole.

26. Claimant is entitled to James v. Anne's apportionment language in the Order.

27. No hearing costs are assessed.

Following the Decision and Order, Claimant filed a Form 30 and asserted several exceptions to the Decision and Order. According to Claimant's Appellant's Brief, these exceptions were consolidated as follows:

a. THE COMMISSIONER COMMITTED ERROR IN FINDING THAT THE CLAIMANT FAILED TO PROVE THAT HE IS ENTITLED TO

LIFETIME BENEFITS RELATED TO HIS SPINAL CORD INJURY DESPITE HIS DIAGNOSIS OF INCOMPLETE QUADRIPLEGIA, PURSUANT TO §42-9-10(C) AND REED-RICHARDS V. CLEMSON UNIVERSITY, 37 S.C. 304, 638 S.E.2D 77(S.C. APP. 2007).

b. THE COMMISSIONER COMMITTED ERROR WHEN SHE DETERMINED THAT THE CLAIMANT FAILED TO SUSTAIN HIS BURDEN OF PROVING THAT HE SUFFERED FROM PERMANENT AND SEVERE PHYSICAL BRAIN DAMAGE CONSISTENT WITH §42-9-10(C).

c. THE COMMISSIONER COMMITTED ERROR WHEN SHE DETERMINED THAT THE CLAIMANT FAILED TO MEET HIS BURDEN OF PROVING THE MOBILITY SCOOTER ORDERED BY DR. SANDOZ WAS CAUSALLY RELATED TO HIS SPINAL CORD INJURY.

EVIDENCE OF THE CASE

The Claimant testified on his behalf. The Claimant stated that he is currently 54-years of age, and resides in Sumter, South Carolina with his wife and son. The Claimant indicated that he worked with the Defendants for approximately 29 years, and sustained multiple injuries while in the course and scope of his employment with the Defendants on June 15, 2011 when the Claimant was struck by a protective guard which fell from above the Claimant, striking the Claimant on the head and right shoulder. The Claimant, who was wearing a neck brace and utilizing a cane at the hearing, indicated that he had sought and received medical treatment for his work related injuries with a variety of physicians including Dr. Lozanne, Dr. Naso, Dr. Poletti, and Dr. Sandoz. The Claimant testified that he continues to receive treatment from Dr. Sandoz in the form of prescription medications due to a variety of ongoing problems, including dizziness and migraine headaches. The Claimant stated that he is also utilizing anti-seizure medication which was prescribed by Dr. Sandoz, but that he has not experienced a seizure in the last few years. The Claimant testified that he is also currently receiving psychological treatment with Dr. Bergmann of Post Trauma Resources and receives treatment from Dr. Bergmann in the form of counseling. Based on review of the medical records, Dr. Lozanne, who provided the Claimant with authorized causally related medical treatment with regards to the neck, determined that the Claimant

reached maximum medical improvement on July 22, 2016. The Claimant sought and received unauthorized medical treatment for the neck with Dr. Poletti.

The Claimant testified that he currently experiences a variety of physical and psychological problems as a result of his work related accident. The Claimant stated that his work related injuries have rendered the Claimant incapable of performing personal hygiene, including bathing, and that the Claimant's wife both bathes the Claimant on a daily basis as well as assists the Claimant with dressing. The medical records of the Claimant's authorized treating physicians do not indicate that the Claimant is in need of daily assistance with regards to bathing and/or dressing. The Claimant indicated he also currently experiences weakness in both hands, which prevent the Claimant from utilizing utensils without problem. The Claimant testified that he also experiences weakness in both his left lower extremity and right lower extremity that requires the Claimant to utilize a cane, which was prescribed by Dr. Sandoz. The Claimant indicated that Dr. Sandoz has also prescribed a motorized scooter for the Claimant due to Claimant's lack of mobility. The Claimant stated that he spends the majority of his day at home watching TV or sleeping, and that the Claimant is incapable of preparing meals on his behalf, requiring his wife to prepare meals each day prior to her leaving to go to work.

On cross-examination, the Claimant testified that he does engage in driving on an infrequent basis, and has driven to a medical appointment within the last 30 days. The Claimant stated that he was physically capable of driving an automobile and also mentally capable of driving an automobile, but did experience some problems performing the above-referenced activity. Most notably, the Claimant indicated that he was a member of a labor union while employed with the Defendants, and that he actually served as the treasurer of the local chapter of his labor union from 2011 to 2013, which would have been following the date of his work related accident. Most notably, the Claimant testified that, while serving as treasurer from 2011 to 2013, he signed checks on behalf of the local chapter of his labor union. The Claimant stated that, on the date of his work related accident, he also operated a towing business known as Benjamin & Sons, but that Benjamin & Sons has not generated income since the date of the Claimant's work related accident. The Claimant stated that he also sustained an injury to the lower back as a result of

his June 2011 work related accident, but was presented with medical records, which were contemporaneous with the date of the accident, that made no mention of the Claimant providing his treating physicians with complaints of lower back pain and problems. Claimant testified he had no explanation as to why the above-referenced medical records made no mention of his alleged lower back injury.

Leta Benjamin testified on behalf of the Claimant. Ms. Benjamin testified that she is the Claimant's wife, and currently resides with the Claimant in Sumter, South Carolina. Ms. Benjamin indicated that she is currently employed with Wells Fargo, and has taken FMLA leave since March 2016 in order to provide the Claimant with care in light of the Claimant work related injuries. Ms. Benjamin indicated that the Claimant's work related injuries have placed significant physical and psychological limitations upon the Claimant. More specifically, Ms. Benjamin testified that she is required to provide the Claimant with both personal hygiene on a daily basis as well as dressing the Claimant and preparing the Claimant's food. Ms. Benjamin stated that she attends most, if not all of the Claimant's medical examination. Ms. Benjamin indicated that she had observed the Claimant's psychological problems, including anger and depression, as well as the Claimant's physical limitations, such as instability and loss of strength of the right upper extremity.

Medical Evidence

The parties conducted the deposition of Dr. Lozanne on July 7, 2016. Dr. Lozanne testified that the primary criteria used to establish a diagnosis of paraplegia is physical examination. (Depo. of Dr. Lozanne p. 6). Dr. Lozanne also testified that diagnostic testing, including MRIs and/or EMG/NCS are also helpful in reaching a determination of whether a patient is a paraplegic. (Depo. of Dr. Lozanne pp. 6-8). Furthermore, Dr. Lozanne testified that, generally, a plegic condition will manifest itself rather quickly following an acute injury. (Depo. of Dr. Lozanne p. 17).

On the date of the June 15, 2011 work accident, Claimant presented to McLeod Regional Medical Center with a head injury. (APA p. 658). On physical examination, Claimant was well-developed and fit-appearing, was awake/alert/conversant/fluent speech, had normal affect, had intact extraocular

movement, had 5/5 strength in both upper extremities and lower extremities with normal bulk and tone. (APA p. 658). Claimant later underwent right hand extensor tendon repair with Dr. Welsch. Following surgery, Claimant treated with Dr. Welsch from September 23, 2011 through October 14, 2013. (APA pp. 669-676). The records of Dr. Welsch indicate that Claimant presented with no acute distress and was alert and oriented. (APA pp. 669-676).

Defendants initially conducted Claimant's deposition on March 2, 2012. Regarding his right arm, Claimant testified that he experiences pain and stiffness in all four fingers and right wrist pain. (Claimant's March 2, 2012 Depo. Tr. pp. 26-28). Regarding his neck, Claimant testified that he suffered from neck pain radiating into his right arm that comes and goes on a daily basis. (Claimant's March 2, 2012 Depo. Tr. p. 28). Claimant testified that he also experiences dizziness and headaches. (Claimant's March 2, 2012 Depo. Tr. pp. 29-30). Claimant complained of sharp pains in different parts of his body which occur from time to time. (Claimant's March 2, 2012 Depo. Tr. p. 44). Claimant also stated that he gets "lost in thought" and "lost in conversation" resulting in his inability to participate in a conversation because he can no longer remember what he was talking about. (Claimant's March 2, 2012 Depo. Tr. pp. 45-48). When asked if he felt capable of returning to work, Claimant testified that he did not believe he could return to work. (Claimant's March 2, 2012 Depo. Tr. p. 51). Claimant did not feel that he could lift because he doesn't have the strength that he used to have, and that he would not feel comfortable returning to work because he would not want to be around the machine for fear of suffering a panic attack. (Claimant's March 2, 2012 Depo. Tr. p. 51). Claimant did not mention his cognitive difficulties, dizziness, headaches, etc., as an impediment to returning to work; nor did Claimant describe any physical symptoms consistent with plegia (i.e. complete loss of sensory or motor function).

Claimant sought unauthorized treatment with Dr. Poletti at Southeastern Spine Institute on November 5, 2012. (APA pp. 718-719). A review of Claimant's symptoms was positive for eye pain with headaches, ringing in both ears, joint pain in his arms or his hands, headaches, seizures, anxiety and depression. (APA p. 718). However, Claimant denied any fevers, chills, night sweats, changes in weight, changes in appetite, chest pain, palpitations, shortness of breath, dysmea, wheezing, kidney/bowel/bladder

dysfunction, paralysis, diabetes and hypothyroidism. (APA p. 718). A physical examination indicated that Claimant is a well-developed, well-nourished male alert and oriented and in no acute distress. (APA p. 719). Claimant also presented in an ambulatory fashion with a non-antalgic gait. (APA p. 719). Claimant had 5/5 strength and symmetry in the lower extremities. (APA p. 719).

Claimant underwent an initial evaluation with Dr. Lozanne on January 22, 2013. Claimant reported continued headaches, neck pain, right-sided intrascapular and shoulder pain radiating down the right arm, and also indicated that he had developed difficulties of balance and has had numbness and tingling worse on the right than the left. (APA p. 677). Claimant denied any urinary or bowel symptoms. (APA p. 677). His motor strength in the right deltoid, bicep, tricep and hand intrinsics were 4/5. (APA p. 677). However, all other muscle groups were 5/5 strength and his gait was normal. (APA p. 677). Dr. Lozanne diagnosed Claimant with cervical myelopathy and radiculopathy. (APA p. 677). Dr. Lozanne recommended, and later performed, an anterior cervical discectomy and plated fusion at the C4-5, C5-6 and C6-7 levels. (APA p. 679).

Claimant began treating with Dr. Sandoz on September 16, 2011. The initial report indicates that Claimant had no sensory loss, no motor weakness, intact coordination, intact balance and gait, and normal motor skills. (APA p. 742). Additional reports of Dr. Sandoz confirm these physical findings throughout Claimant's treatment. (APA pp. 745, 748, 749-750, 752, 754, 756, 769, 792).

Claimant followed up with Dr. Poletti on January 20, 2014. (APA p. 721). Claimant reported complaints of neck, shoulder and right arm pain, along with continued issues with difficulty walking and imbalance; however, he denied any bowel or bladder issues. (APA p. 721). Claimant continued to treat with Dr. Poletti's office from August 14, 2014 through December 17, 2015. (APA pp. 722-736). Most notably, there is no indication in the reports of Southeastern Spine Institute of a complete loss of sensory or motor function or any paralysis. Each of the reports of "Dr. Poletti" is signed off on by his physician's assistants. (APA pp. 722-736). As a result, it is unclear when, or if, Dr. Poletti actually examined Claimant. The only mention of an "incomplete quadriparesis" or "incomplete quadriplegia" was contained in a written letter of Dr. Poletti addressed to the Claimant's attorney on May 27, 2015. (APA

pp. 729-730). Dr. Poletti indicated that Claimant has a form of spinal cord injury or "incomplete quadriplegia." (APA p. 730).

Significantly, following the written letter of Dr. Poletti, on October 2, 2015, Claimant presented to Dr. Poletti's office and denied any focal muscle deficits, paralysis or changes in bowel and bladder function. (APA p. 731). A physical examination classified Claimant as "well-developed, well-nourished. . . alert and oriented x3 and in no acute distress." (APA p. 731). Furthermore, the physical examination indicated that Claimant was ambulatory with a slightly antalgic gait using the assistance of a cane primarily for fall prevention. (APA p. 731). Claimant had strength of the lower extremity between 4/5 and 5/5 and strength of the upper extremities was intact. (APA p. 731). Again, this visit was signed off on by a physician's assistant. (APA pp. 731-732). On December 17, 2015, Claimant again denied loss of bowel and bladder function, any focal muscle deficits or paralysis. Again, this visit was signed off on by a physician's assistant. (APA pp. 735-736). Finally, Claimant returned to Dr. Poletti's office on April 21, 2016. (APA p. 577). Claimant was evaluated for 15 minutes by a physician's assistant and denied any significant progression of his symptoms. (APA p. 577).

Defendants conducted the updated deposition of Claimant on March 31, 2014. Most notably, Claimant testified that, following the unauthorized surgery performed by Dr. Poletti, he experienced some improvement of his neck and upper extremity problems. (Claimant's March 31, 2014 Depo. Tr. p. 13, 16, 40, 44). At the Hearing which was conducted on June 23, 2014 before Commissioner Barden, Claimant reiterated that the pain and numbness and symptoms improved following the unauthorized surgery performed by Dr. Poletti. (APA p. 865).

As mentioned above, Dr. Lozanne testified that a determination of paraplegia can be diagnosed via physical examination and/or diagnostic testing. (Dr. Lozanne's Depo. Tr. pp. 6-8). Dr. Lozanne testified that, based on the physical examination contained in his initial January 22, 2013 report, for which the November 15, 2012 MRI of the cervical spine and the November 3, 2011 EMG/NCS were available for his review, Claimant is not a plegic. (Dr. Lozanne's Depo. Tr. pp. 9-10). Dr. Lozanne then reviewed an EMG/NCS performed at Grand Strand Spine and Neurosurgery, performed on March 26, 2015 by Dr.

Sandoz. Upon review of the diagnostic study, Dr. Lozanne testified that he saw nothing in the study that would indicate plegia. (Dr. Lozanne's Depo. Tr. p. 11). Dr. Lozanne then reviewed an MRI of the cervical spine performed on April 13, 2015. Dr. Lozanne confirmed that nothing in the MRI would be consistent with a plegia. (Dr. Lozanne's Depo. Tr. p. 12). Dr. Lozanne was then presented with an MRI of the lumbar spine performed on October 19, 2015. Dr. Lozanne indicated that the report did not reveal any finding indicative of a plegia in Claimant. (Dr. Lozanne's Depo. Tr. p. 13). Dr. Lozanne was then presented with a copy of a report from Dr. Poletti's office, dated October 2, 2015, wherein Claimant underwent a physical examination performed by a physician's assistant. Again, Dr. Lozanne indicated that the findings present in the physical exam of Claimant on or about October 2, 2015 were not indicative or reflective of a plegia. (Dr. Lozanne's Depo. Tr. pp. 13-15). More specifically, Dr. Lozanne testified that a patient who has strength by definition cannot be plegic, and plegia is evidenced by lack of movement, specifically the movement of the extremities that are affected by the plegia, which was not evidenced in the physical examination. (Dr. Lozanne's Depo. Tr. pp. 14-15). Upon review of Dr. Poletti's letter to Claimant's attorney in which he references incomplete paraplegia on May 27, 2015, Dr. Lozanne testified that the above-referenced phrase is not appropriate to use in this instance. (Dr. Lozanne's Depo. Tr. p. 21). Dr. Lozanne explained that Claimant suffers from cervical myelopathy, including some difficulties with his balance because he had a spinal cord injury. (Dr. Lozanne's Depo. Tr. p. 21). However, Dr. Lozanne indicated that Claimant does not suffer from a quadriplegia and Dr. Lozanne has never heard a neurosurgeon use incomplete quadriplegia as a phrase. (Dr. Lozanne's Depo. Tr. p. 21). Dr. Lozanne further explained that Claimant suffers a spinal cord injury and has some weakness associated with that injury but is not a quadriparetic in the sense that he has normal motor strength in multiple extremities, though he has some decreased strength. (Dr. Lozanne's Depo. Tr. p. 22). Dr. Lozanne believed that Dr. Poletti was attempting to convey that Claimant has some weakness but felt it was inappropriate to label Claimant as an incomplete or complete quadriplegic in any kind of way. (Dr. Lozanne's Depo. Tr. pp. 22-23).

Dr. Lozanne performed an evaluation of Claimant on July 22, 2016. (APA pp. 681-684). A physical examination revealed 5/5 strength in each lower extremity, 4/5 strength in the right upper extremity, and 5/5 strength in the left upper extremity. (APA p. 683). Cranial nerves were virtually intact and Claimant was awake, alert and answering questions appropriately. (APA p. 683). Claimant was able to walk and stand unassisted but used aid of 4-pronged cane for balance. (APA p. 683). Dr. Lozanne issued a 53% whole person impairment rating pursuant to Chapter 15 of the AMA Guidelines, Fifth Addition, but no separate impairment was included for bladder, erectile, sexual or respiratory function, nor was any separate impairment for lower extremity involvement included. (APA p. 684).

FULL COMMISSION FINDINGS OF FACT AND CONCLUSIONS OF LAW

FINDINGS OF FACTS

1. The South Carolina Workers' Compensation Commission has jurisdiction over the subject matter and parties of this claim.
2. Claimant's average weekly wage is One Thousand Four Hundred Sixty-One Dollars ($1,461.40) and 40/100 with a corresponding compensation rate of Seven Hundred Four Dollars ($704.92) and 92/100.
3. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find that Claimant sustained compensable injuries to his neck, right arm, brain (for initial closed head injury and resulting headaches and seizures), and psyche within the course and scope of his employment.
4. Claimant also alleges entitlement of lifetime benefits under the act based on a claim for incomplete paraplegia and brain damage as outlined in S.C. Code Ann. Section 42-9-10(C).
5. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant has failed to meet his burden of proving entitlement to lifetime benefits on the basis of "incomplete paraplegia". This finding is based on the preponderance of the evidence as a

whole, including the deposition testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim.

6. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Dr. Lozanne testified the suffix "plegia" refers to a complete lack of movement and that "paraplegia" is the complete inability to move your legs. (Depo. of Dr. Lozanne pp. 5-6). After review of Dr. Poletti's medical note diagnosing Claimant with "incomplete quadriparesis or a form of incomplete quadriplegia", Dr. Lozanne testified the phrase "incomplete quadriplegia" was inappropriate in this instance and that Claimant suffered from cervical myelopathy – spinal cord dysfunction that has led to some symptoms – including difficulty with balance. (Depo. of Dr. Lozanne pp. 21).

7. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Dr. Lozanne went on to state unequivocally Claimant does not suffer from quadriplegia and it would be inappropriate to describe him as an incomplete quadriplegic. (Depo. of Dr. Lozanne pp. 21-22).

8. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we give greater weight to the testimony and medical opinions of Dr. Lozanne, who is the authorized threating neurosurgeon in the claim.

9. Based on a preponderance of the evidence including the medical records of the Claimant, and the testimony of Dr. Lozanne, we find Dr. Lozanne's analysis of Claimant's physical examinations as well as the diagnostic studies including the EMG nerve conduction studies (conducted in 2013 & 2015) and MRI (both cervical and lumbar) as outlined in his deposition to be very persuasive and we gave it great weight. (Claimant's APA p. 550-551, 572-573, 689-695, 733-734, 774-779)

10. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant's motor functioning was tested by way of physical examinations throughout the course of Claimant's medical treatment. During Claimant's initial treatment with Dr. Lozanne on January 22, 2013, Claimant was noted to have motor strength in all of his extremities and even had resistance strength. (Claimant's APA p. 677-679).

11. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find the physical examination performed by Claimant's own unauthorized physician revealed Claimant had motor strength in his lower extremities rated as 5 out of 5 with hip flexion and dorsiflexion, 4 out of 5 in knee flexion, extension and plantar flexion bilaterally. Claimant was also noted to have intact motor strength in the upper extremities. (Claimant's APA pp. 568-569).

12. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant's lack of consistent complaints regarding bowel and/or bladder dysfunction, while not dispositive, to be weighted evidence in the present case. (Claimant's APA pp. 677, 718, 721, 731, 735).

13. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant has failed to meet his burden of proving entitled to lifetime benefits on the basis of having sustained permanent and severe physical brain damage. This finding is based on the preponderance of the evidence including:

    a. Three brain scans performed by treating physicians including Dr. Meiere, Dr. Naso, and Dr. Sandoz (Claimant's APA pp. 91-92, 687-688, 660-661);

    b. Claimant's appearance at and participation in two depositions;

c. Claimant's attendance at most of his medical appointments on his own to which he also drove himself on his own;

d. Claimant's service as treasurer of his union at the time of his injury and continued service as treasurer through 2012 (at the time of the hearing he was still a member of the union);

e. The lack of any medical evidence stated to a reasonable degree of medical certainty that Claimant sustained brain damage that was permanent and severe.

14. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find there is insufficient evidence in the medical record to support a finding that Claimant sustained an injury to his lower back (and any resulting radiculopathy to the legs) as a result of his work injury. This finding is based on the preponderance of the evidence as a whole, including the deposition testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim.

15. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find that Claimant's allegation of separate injuries to his bilateral shoulders and left arm are denied as they are not supported by a preponderance of the medical evidence. This finding is based on the preponderance of the evidence as a whole, including the deposition testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim.

16. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant sustained an injury to his brain. This finding is based on Claimant's initial closed head injury and resulting headaches. Claimant's history of seizures weighed into this decision as well although Claimant is currently taking medication and having not had a seizure since February 19, 2012.

17. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant's injuries to his neck, right arm, brain (for initial closed head injury and resulting headaches and seizures) and psyche render him permanently and totally disabled. This finding is based on the medical evidence as a whole and the opinions on Claimant's employability offered by Dr. Sandoz, Dr. Poletti, Dr. Mills and Dr. Brabham. This finding is based on the preponderance of the evidence as a whole.

18. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant is entitled to lifetime causally-related medical treatment for his neck, right arm, brain (headaches & seizures) and depression.

19. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant is not entitled to a mobility scooter as there is insufficient evidence in the record causally-relating the need for the scooter to compensable injuries as outlined above. Specifically, Dr. Sandoz did not prescribe the mobility scooter until October 1, 2015 after Claimant alleged lower back and bilateral lower extremity symptoms associated with his 2011 work injury – claims which have been denied as noted above.

20. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant's request for a mobility scooter as a result of causally-related medical treatment is not supported by a preponderance of the medical evidence and is denied.

21. Based on a preponderance of the evidence including the medical records of the Claimant, the testimony of Dr. Lozanne, the Claimant's testimony and the testimony of the Claimant's wife, we find Claimant is entitled to a lump-sum payment of the commuted value of 500 weeks of benefits

less any amount previously paid to the Claimant in the form of temporary benefits. This finding is based on the preponderance of the evidence as a whole.

22. No hearing costs are assessed.

CONCLUSIONS OF LAW

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

1. Pursuant to S.C. Code Ann. Section 42-15-10 and Section 42-17-20, jurisdiction and venue are proper.
2. Pursuant to South Carolina Workers' Compensation Commission Rules and Regulations, Rule 67-210(B) and Rule 67-213(C), the parties were properly served with Notice of the Hearing.
3. Workers' Compensation awards may not be based upon surmise, conjecture, or speculation, but must be founded on evidence of sufficient substance to afford a reasonable basis for it. Tiller v. Nat'l Health Care Ctr. of Sumter, 334 S.C. 333, 339, 513 S.E.2d 843, 845 (1999) ; Sharpe v. Case Produce Co., 329 S.C. 534, 543, 495 S.E.2d 790, 794 (Ct.App.1997) rev'd on other grounds.
4. A workers' compensation claimant has the burden of proving facts that show the alleged injury arose out of and in the course and scope of employment. Clade v. Champion Laboratories, 330 S.C. 8, 496 S.E.2d 856 (S.C. 1998).
5. Only the facts and circumstances of the injury can determine whether it is compensable and, therefore, whether the employee's remedy is exclusively under the Compensation Law. Thompson v. J.A. Jones Const. Co., 199 S.C. 304, 19 S.E.2d. 226 (1942).

6. A "possibility" is not enough to show that a worker's injury arose out of and in the course and scope of his employment. Fowler v. Abbott Motor Co., 236 S.C. 226, 113 S.E.2d 737 (S.C. 1960).

7. The possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence. Tiller, 334 S.C. 333, 513 S.E.2d 843, rehearing denied (S.C. 1999).

8. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, Claimant sustained compensable injuries to his neck, right arm, brain (per Regulation 67-1101 for initial closed head injury and resulting headaches and seizures), and psyche within the course and scope of his employment.

9. Claimant also alleges entitlement of lifetime benefits under the act based on a claim for incomplete paraplegia and brain damage as outlined in S.C. Code Ann. Section 42-9-10(C).

10. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, we find Claimant has failed to meet his burden of proving entitlement to lifetime benefits pursuant to Section 42-9-10(C) on the basis of "incomplete paraplegia". This finding is based on the preponderance of the evidence as a whole, including the medical records of the Claimant, the testimony of Dr. Lozanne, who was the authorized treating physician and surgeon in this claim, the Claimant's testimony and the testimony of the Claimant's wife.

11. In Reed-Richards v. Clemson University, the Single Commissioner held that the claimant was a paraplegic as a result of her work accident and, therefore, entitled to lifetime benefits. 37 S.C. 304, 638 S.E.2d 77 (S.C. App. 2007). This finding was based

in large part on the deposition and notes of Dr. David Shallcross, one of the claimant's treating physicians, who labeled her an incomplete paraplegic. The Full Commission upheld the Single Commissioner's Order, and the Court of Appeals eventually upheld the Full Commission's finding based on the substantial evidence standard. The claimant required the use of a walker and lost control of her bowel and bladder and developed urinary retention.

12. We find the Reeds-Richards case is distinguishable from the present case. In Reeds-Richards, the Court of Appeals affirmed Claimant's lifetime benefits based on the grounds that there was substantial evidence in the record to support the finding by the Commission. In that case, the only medical opinion in evidence was that of Dr. Shallcross, who opined Claimant had incomplete paraplegia. There were no other medical opinions on the issue in the record and as such, there were no other medical opinions on which the Commission or the Court could rely.

13. Expert medical testimony is designed to aid the South Carolina Workers' Compensation Commission in coming to the correct conclusion; therefore, Commission determines the weight and credit to be given to expert testimony. Sharpe v. Case Produce, Inc., 336 S.C. 154, 519 S.E.2d 102 (1999)

14. In the present case, we give greater weight to the testimony and medical opinions of Dr. Lozanne, the authorized threating neurosurgeon in the claim. We find Dr. Lozanne's analysis of Claimant's physical examinations as well as the diagnostic studies including the EMG nerve conduction studies (2013 & 2015) and MRI (cervical and lumbar) as outlined in his deposition to be very persuasive and we gave it great weight.

15. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, we find Claimant has failed to meet his burden of proving entitled to lifetime benefits pursuant to Section 42-9-10(C) on the basis of having sustained permanent and severe physical brain damage as contemplated by S.C. Code Ann. Section 42-9-10(C) and the case law as outlined in Crisp and Sparks. This finding is based on the preponderance of the evidence including:

    a. Three brain scans performed by treating physicians including Dr. Meiere, Dr. Naso, and Dr. Sandoz (Claimant's APA pp. 91-92, 687-688, 660-661);

    b. Claimant's appearance at and participation in two depositions;

    c. Claimant's attendance at most of his medical appointments on his own to which he also drove himself on his own;

    d. Claimant's service as treasurer of his union at the time of his injury and continued service as treasurer through 2012 (at the time of the hearing he was still a member of the union);

    e. The lack of any medical evidence stated to a reasonable degree of medical certainty that Claimant sustained brain damage that was permanent and severe as required by case law and the Act.

16. Section 42-1-160 of the Act requires that, to be compensable, an injury by accident must be one "arising out of and in the course and scope of employment." Osteen v. Greenville County Sch. Dist., 333 S.C. 43, 49, 508 S.E.2d 21, 24 (1998).

17. For an injury to "arise out of" employment, the injury must be proximately caused by the employment. Fowler v. Abbott Motor Co., 236 S.C. 226, 113 S.E.2d 737 (1960). The injury arises out of employment when there is a causal connection between the

conditions under which the work is required to be performed and the resulting injury. Douglas v. Spartan Mills, Startex Div., 245 S.C. 265, 140 S.E.2d 173 (1965).

18. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, we find there is insufficient evidence in the medical record to support a finding that Claimant sustained an injury to his lower back (and any resulting radiculopathy to the legs) as a result of his work injury. This finding is based on the preponderance of the evidence as a whole.

19. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, we find that Claimant's allegation of separate injuries to his bilateral shoulders and left arm are denied as we find they are not supported by a preponderance of the medical evidence. This finding is based on the preponderance of the evidence as a whole.

20. Pursuant to Section 42-1-160 and based on the preponderance of the evidence as a whole, we find Claimant sustained an injury to his brain pursuant to Regulation 67-1101. This finding is based on Claimant's initial closed head injury and resulting headaches. Claimant's history of seizures weighed into this decision as well although Claimant is currently taking medication and has not had a seizure since February 19, 2012.

21. Pursuant to Section 42-9-10 and based on the preponderance of the evidence as a whole, we find Claimant's injuries to his neck, right arm, brain (Regulation 67-1101) and psyche render him permanently and totally disabled pursuant to S.C. Code Ann. Section 42-9-10(A). This finding is based on the medical evidence as a whole and the opinions

on Claimant's employability offered by Dr. Sandoz, Dr. Poletti, Dr. Mills and Dr. Brabham. This finding is based on the preponderance of the evidence as a whole.

22. Pursuant to Section 42-15-60 and based on the preponderance of the evidence as a whole we find Claimant is entitled to lifetime causally-related medical treatment for his neck, right arm, brain (headaches & seizures per Regulation 67-1101) and depression.

23. Pursuant to Section 42-15-60 and based on the preponderance of the evidence as a whole we find Claimant is not entitled to a mobility scooter as there is insufficient evidence in the record causally-relating the need for the scooter to compensable injuries as outlined above. Specifically, Dr. Sandoz did not prescribe the mobility scooter until October 1, 2015 after Claimant alleged lower back and bilateral lower extremity symptoms associated with his 2011 work injury – claims which have been denied as noted above.

24. Pursuant to Section 42-15-60 and based on the preponderance of the evidence as a whole we find Claimant's request for a mobility scooter as a result of causally-related medical treatment is not supported by a preponderance of the medical evidence and is denied.

25. Pursuant to Section 42-9-301 and based on the preponderance of the evidence as a whole, we find Claimant is entitled to a lump-sum payment of the commuted value of 500 weeks of benefits less any amount previously paid to the Claimant in the form of temporary benefits. This finding is based on the preponderance of the evidence as a whole.

26. Claimant is entitled to James v. Anne's apportionment language in the Order.

27. No hearing costs are assessed.

ORDER

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the substantial evidence supports a finding that the Decision and Order of the Single Commissioner is **AFFIRMED** with amendments.

IT IS FURTHER ORDERED that Claimant sustained compensable injuries to his neck, right arm, brain (per Regulation 67-1101 for initial closed head injury and resulting headaches and seizures), and psyche within the course and scope of his employment.

IT IS FURTHER ORDERED that Claimant has failed to meet his burden of proving entitlement to lifetime benefits pursuant to Section 42-9-10(C) on the basis of "incomplete paraplegia".

IT IS FURTHER ORDERED that Claimant has failed to meet his burden of proving entitled to lifetime benefits pursuant to Section 42-9-10(C) on the basis of having sustained permanent and severe physical brain damage as contemplated by S.C. Code Ann. Section 42-9-10(C)

IT IS FURTHER ORDERED that we find there is insufficient evidence in the medical record to support a finding that Claimant sustained an injury to his lower back (and any resulting radiculopathy to the legs) as a result of his work injury.

IT IS FURTHER ORDERED that Claimant's allegation of separate injuries to his bilateral shoulders and left arm are denied as they are not supported by a preponderance of the medical evidence.

IT IS FURTHER ORDERED that Claimant sustained an injury to his brain pursuant to Regulation 67-1101.

IT IS FURTHER ORDERED that Claimant's injuries to his neck, right arm, brain (Regulation 67-1101) and psyche render him permanently and totally disabled pursuant to S.C. Code Ann. Section 42-9-10(A).

IT IS FURTHER ORDERED that Claimant is entitled to lifetime causally-related medical treatment for his neck, right arm, brain (headaches & seizures per Regulation 67-1101) and depression.

IT IS FURTHER ORDERED that Claimant is not entitled to a mobility scooter as there is insufficient evidence in the record causally-relating the need for the scooter to compensable injuries as outlined above.

IT IS FURTHER ORDERED Claimant is entitled to a lump-sum payment of the commuted value of 500 weeks of benefits less any amount previously paid to the Claimant in the form of temporary benefits. This finding is based on the preponderance of the evidence as a whole.

IT IS FURTHER ORDERED Claimant is entitled to James v. Anne's apportionment language in the Order.

IT IS SO ORDERED.

Commissioner B. Michael Campbell, II
For the Appellate Panel

WE CONCUR:

Commissioner Susan S. Barden

Commissioner Avery B. Wilkerson, Jr.

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Valerie Deller on April 24, 2018

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

WCC File #: Unassigned
Carrier File #: YYC51304
Carrier Code #: 428
Employer FEIN #: Unassigned

Claimant's Name: Victor Benjamin SSN: [redacted]
Address: 1841 Holman Road
City: Sumter State: SC Zip: 29153
Home Phone: (803) 428-3352 Work Phone: ( ) -

Employer's Name: Rexam Beverage Can Company DBA Rexam Beverages
Address: 809 Cousar Street
City: Bishopville State: SC Zip: 29010
Insurance Carrier: Hartford Insurance Company of the Midwest

Preparer's Name: Jeff Chandler Law Firm: Chandler Law Firm Preparer's Phone #: (843) 448-4357

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: ☒ Injury ☐ Illness ☐ Repetitive Trauma **Date of Injury or Illness: 06-15-2011**

1a. The claimant sustained an injury to his Brain, right upper extremity, right shoulder, left shoulder, and spine on 06-15-2011 in Lee county, state of South Carolina.
1b. Body part(s) affected Brain, right upper extremity, right shoulder, left shoulder, and spine.

Briefly describe how the accident occurred. Claimant sustained injury when a protective Guard came off a cupper machine causing a piece of metal to hit him, thus sustaining injury by accident.

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 06-15-2011 in the following manner: verbally

☒ 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: Claimant need's continued treatment with an orthopaedic surgeon and a neurologist.

☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
From the date of injury until returning to full duty.

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

☒ 9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:
Claimant has severe disfigurement on the left side of his skull, right arm and left shoulder.

10a. At the time of the injury, the Claimant was paid weekly wages of To Be Determined 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:

11a. Further grounds or unusual aspects of claim:
Any and all grounds available under the Act including proration of lump sum Award when deemed necessary under James v Anne's Inc.

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: Lee County EMS – McLeod Regional Medical Center – P.O. Box 100567 Florence, SC 29501 – Florence Neurosurgery & Spine –901 East Cheves Street, Suite 420 Florence, SC 29505 – Pee Dee Orthopaedic Associates – 901 E Cheves Street, Ste 100 Florence, SC 29503

11c. To the best of your knowledge, did you have any prior permanent disability? No
If yes, describe: ____

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

☒ 13a. **I am filing a claim. I am not requesting a hearing at this time.**
☐ 13b. **I am requesting a hearing. A $25 fee is required.**

14. Estimated time needed for hearing: ____

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

Preparer's Signature | Attorney for the Claimant (Title) | Jeffchandler@aol.com (Email) | 06-20-2011 (Date)

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615.
Questions about the use of this form may be directed to the Commission's Claims Department.
WCC Form # 50

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

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

CC File #:	1106789
Carrier File #:	YYC51304
Carrier Code #:	428
Employer FEIN #:	

Claimant's Name: Victor Benjamin SSN: [redacted]

Address: 1841 Holman Road

City: Sumter State: SC Zip: 29153

Employer's Name: Recam Beverage Can Company DBA Recam Beverages

Address: 609 Cougar Street

City: Bishopville State: SC Zip: 29010

Home Phone: 803-428-3352 Work Phone: ( ) -

Insurance Carrier: Hartford Insurance Company of the Midwest

Preparer's Name: Jeff Chandler Law Firm: Chandler Law Firm Preparer's Phone #: (843) 448-4357

A claim for workers' compensation benefits is made based on the following grounds: **Date of Injury or Illness: 06-15-2011**

[x]Injury ☐ Illness ☐ Repetitive Trauma ☐Occupational Disease [x]Physical Brain Injury ☐Concurrent Jurisdiction

1. The claimant sustained an injury to his Brain, spine, right upper extremity, right shoulder, left shoulder, both lower extremities and psychological overlay on 06-15-2011 in Lee county, state of South Carolina.
2. Body part(s) affected are: Brain, spine- back and neck, right upper extremity, right shoulder, left shoulder, both lower extremities, has altered gait, and psychological overlay.

   Briefly describe how the accident occurred: Claimant sustained injury when a protective guard came off a cupper maching causing a piece of metal to hit him.
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on 06-15-2011 in the following manner:

   Verbally

[x]7. Due to injury, the claimant is in need of (check one):

☐(a) medical examination and treatment for: ____

[√] (b) additional medical examination and treatment for: Claimant will require lifetime maintenance of his surgical hardware, ongoing medication management to control his disability and ongoing psychological counseling to control his disability. Claimant also requests authorization of the motorized scooter, cervical collar and epidural lumbar steroid injection ordered by Dr. George Sandor.

[x]8. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:

From the date of injury until returning to full duty.

[x]9. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one): **Lifetime Benefit Case.**

[x](1) General Disability: [x]Total ☐ Partial ☐(2) Specific Disability: ☐Total ☐ Partial ☐ (3) Wage Loss

9a. ☐A determination of permanent disability is premature at this time.

☐10. 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 $1461.40, 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:

11. Further grounds or unusual aspects of claim:

Any and all grounds available under the Act including proration of lump sum Award when deemed necessary under James v Anne's Inc.

11a. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
Lee County EMS- Mcleod Regional Medical Center – Florence Neurosurgery & Spine – Pee Dee Orthopaedic Associates – Dynamic Physical Therapy – Grand Strand Spine & Neuro – Grand Strand Psychological Services – Post Trauma Resources - Southeastern Spine Institute – Conway Medical Group.

11b. To the best of your knowledge, did you have any prior permanent disability? No.
If yes, describe: ____

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

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

[√]13b. **I am requesting a hearing. A $25 fee is required.**

14. Estimated time needed for hearing: 1 Hour

☑ **Mediation**

☐a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐b. Mediation is required pursuant to Reg. 67-1802.
☐c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
[x]d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to SC Workers Compensation Commission / Jason Lockhart, Esquire address PO 1715 Columbia, SC 29202 / PO BOX 12619 Columbia, SC 29211 on the 3rd day of May 2016 by [x] first class postage ☐certified mail ☐personal service.

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

Preparer's Signature — **Attorney for the Claimant** (Title) — Jeffcchandler@aol.com (Email) — 05-03-2016 (Date)

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

50

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

WCC File #: 1106789
Carrier File #: YYCC/51304
Carrier Code #:
Employer FEIN #:

Claimant's Name: Victor G. Benjamin SSN [redacted]
Address: 1841 Holman Road, Sumter, South Carolina 29153
Home Phone: (803) 428-3352 Work Phone #: (803) 484-1560

Employer's Name: Rexam, Inc.
Address: 609 Cousar Street, Bishopville, South Carolina 29010

Date of Injury: 6/15/11
Insurance Carrier: Hartford Insurance Company of the Midwest c/o Sedgwick Claims Management Services, Inc.

Preparer's Name: Jason W. Lockhart Law Firm: McAngus Goudelock & Courie Preparer's Phone #: (803) 227-2283

Date of Injury or Illness: 6/15/11 **Estimated time for hearing:** 2 hours

Complete each information blank. Clearly specify when contentions are admitted in part and denied in part. The Employer-Carrier in answer to the claim, respectfully shows:

1. It is ☒ **Admitted** ☐ **Denied** the employee sustained an injury or illness on or about the date set forth in the application. The reasons for denial are: The Employer/Carrier admit that Claimant sustained a compensable injury to the neck, psyche and right upper extremity but deny that Claimant sustained a compensable injury to the back, brain, left shoulder, right shoulder, left lower extremity and/or right lower extremity. In addition, the Employer/Carrier maintain that Claimant's current problems with his back, brain, left shoulder, right shoulder, left lower extremity and/or right lower extremity are not causally connected to Claimant's 06/15/11 work-related accident.
2. It is ☒ **Admitted** ☐ **Denied** both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: See Number 1 above.
3. It is ☒ **Admitted** ☐ **Denied** the relationship of employer and employee existed at the time in question. The reasons for denial are: See Number 1 above.
4. It is ☐ **Admitted** ☒ **Denied** at the time in question the employee was performing service arising out of and in the course of employment. The reasons for denial are: See Number 1 above.
5. It is ☒ **Admitted** ☐ **Denied** notice of injury was given the employer. The reasons for denial are: See Number 1 above.
6. It is ☒ **Admitted** ☐ **Denied** the employee ☒ **needs/**☒ **is entitled to additional** medical care as a result of injury or illness. The reasons for denial are: The Employer/Carrier is currently providing Claimant with authorized causally-related medical treatment.
7. It is ☒ **Admitted** ☐ **Denied** the employee is entitled to temporary total disability for the period(s) of: The Employer/Carrier is currently providing Claimant with temporary total disability benefits.
8. It is ☐ **Admitted** ☒ **Denied** the employee is permanently disabled. The reasons for denial are: The Employer/Carrier maintain that Claimant cannot satisfy his burden of proving entitlement to lifetime compensation pursuant to Section 42-9-10 of the Act.
9. It is ☐ **Admitted** ☒ **Denied** the employee has serious disfigurement.
10. It is contended that an average weekly wage of **$ Form 20 to be submitted** applies, according to attached Form 20 as provided by law.
11. Further contentions, grounds of defense, or unusual aspects are: The Employer/Carrier maintain that Claimant cannot satisfy his burden of proving a compensable injury to the back, brain, left lower extremity, right lower extremity, left shoulder and/or right shoulder pursuant to Section 42-1-160 and/or Section 42-9-35 of the Act. In addition, the Employer/Carrier maintain that Claimant cannot satisfy his burden of proving a physical brain injury pursuant to Section 42-9-10 of the Act. Furthermore, the Employer/Carrier maintain that Claimant cannot satisfy his burden of proving entitlement to lifetime compensation pursuant to Section 42-9-10 of the Act.

☐ **Mediation**

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
- ☐ b. Mediation is required pursuant to Reg. 67.1802.
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov**.

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

Preparer's Signature	Attorney for Employer/Carrier Title	jlockhart@mcclaw.com Email	June 2, 2016 Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Refer to R. 67-1801 for mediation. 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.

WCC Form # 51
Revised 7/13

51

Employer's Answer to Request for Hearing

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5739 www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No: 1106789

Claimant's Name: Victor Benjamin
Address: 1841 Holman Road
City: Sumter State: SC Zip: 29153
Home Phone: 803-428-3362 Work Phone:
Preparer's Name: Jeff Chandler

Employer's Name: Rexam Beverage Can Company DBA Rexam Beverages
Address: 609 Cougar Street
City: Bishopville State: SC Zip: 29010
Carrier: Hartford Ins Co of the Midwest
Preparer's Phone #: 843-448-4357

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

1. Compensation Rate: $704.92 2. AWW: $ 1,461.40 Date of Injury: 6/15/2011
3. Type of injury and body part(s): Brain, spine, right shoulder, right upper extremity, left shoulder, both lower extremities, and psychological overlay.
4. Facts in controversy:
   SEE ATTACHMENT.
5. Legal issues involved:
   41-2-160; 42-9-10; 42-9-30; 42-15-60; 42-9-301; 67-1101; 67-1207.
6. Unusual aspects: None Anticipated.
7. Witnesses (designate if expert):*
   Claimant; Leila Benjamin; Dr. Karl Lozanne via Deposition.
8. Exhibits:
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
   SEE ATTACHED NOTICE OF APA SUBMISSIONS.
10. Name, address, and specialty, if any, of the treating physician:
    Dr. Steven Poletti – 1106 Chuck Dawley Blvd. Suite 200 Mt. Pleasant, SC 29464
    Dr. George Sandoz – 2376 Cypress Circle, Suite 200, Conway, SC 29528
11. Impairment rating(s); body part(s); physician and date of opinion: SEE ATTACHMENT.
12. I am amending my Form 50/51 in the following manner:

☑ **Mediation**
- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
- ☐ b. Mediation is required pursuant to Reg. 67-1802.
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☑ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov**.

I verify the contents of this form are accurate and true to the best of my knowledge.
I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to SC Workers' Compensation Commission / Jason Lockhart, Esquire
address PO BOX 1715 Columbia, SC 29202 / PO Box 12519 Columbia, SC 29211 **on the** 2nd **day of** August **20** 16,
by first class postage certified mail personal service.

Signature: [signature]
Email: jeffcchandler@aol.com
Date of hearing: 08-18-2016
Time needed for hearing: 1 hour

Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615; as well as Regulation 67- 1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. * Commissioners reserve the right to admit expert witnesses at hearings.

WCC Form # 58
Revised 7/13

58

ATTACHMENT

4. 1.)The claimant contends that he is entitled to lifetime medical and montary benefits pursuant to 42-9-10(c) and Reed-Richards v. Clemson University (S.C. App 2006) 37 S.C. 304, 638 S.E 2nd 77. This contention is supported by Dr. Steven Poletti (APA #10 pages 564-565), Dr. George Sandoz (APA # 12, page 612), Dr. William Mills (APA #14, pages 635-636), Dr. Robert Brabham (Exhibit A – pages 638-652).

2.) Compensability of lumbar spine is at issue. Causation provided by authorized treating physician, Dr. George Sandoz. Treatment for related care presently being funded by personal health insurance. Includes ESI's. Claimant's APA's #5, pages 172, 173 APA # 12 page 622.

3.)Entitlement to mobility scooter. Causation provided by Dr. George Sandoz. APA #12 page 622.

4.) Payment in lump sum with Utica Allocation language. Thompson v. South Carolina Steel Erectors (S.C. App. 2006) 369 S. C. 606, 632 S. E. 2d 874.

11. Claimant was assigned a 0% impairment rating to his shoulder by Dr. Matthew Welsch on January 13, 2015.

Claimant was assigned a 30% to the whole person by Dr. Lawrence Bergmann to his psyche on 02-15-2015.

Claimant was assigned a 4% impairment rating to the whole body for headaches. He was assigned a 29% impairment rating of the whole body for a traumatic brain injury and assigned a 34% impairment for seizures. Utilizing a combined value chart this translates to a 54% whole body impairment issued by Dr. George Sandoz on June 19, 2015.

Claimant was issued a 22% impairment rating based on his memory loss by Dr. Rob Brabham on August 01, 2015.

Claimant was assigned a 28% to the cervical spine by Dr. Steven Poletti on May 27, 2015. He was also assigned 39% to the whole person for his spinal cord injury or incomplete quadriplegia. This is added to the cervical impairment rating for a combined total rating of 67% to the whole person.

Claimant was was evaluated by Dr. William Mills on June 20, 2016. He concurred with the impairment ratings issued by Dr. Steven Poletti of 67% to the whole person. He concurred with the impairment rating issued by Dr. George Sandoz as having a greater than 50% whole person impairment.

HISTORY & PHYSICAL

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves St
Florence, SC 29501-0551

NAME: Benjamin, Victor
MED. REC. NO.: [redacted]
DR. DICTATING: William B Naso, MD
DOB:
PATIENT NO.: [redacted]
ADMIT DATE: 06/15/2011

TSCUTS1501

CHIEF COMPLAINT: Head injury.

HISTORY: The patient is a 49 –year-old black male who had an accident in which he was struck in the head with some sort of industrial belt and sustained lacerations to the scalp, right forearm and left shoulder. He was taken to the Emergency Room. He was evaluated by Dr. Lewis. A CT scan was performed and I was called to see the patient in Neurosurgical consultation. The patient is anesthetic to the events of the accident. He also has weakness in his right ulnar hand.

He denies any chronic medical problems other than hypertension and hypercholesterolemia although he is on no antihypertensive medications. He says that he controls his blood pressure with dietary supplements.

He does say that he is allergic to Demerol.

He denies tobacco or alcohol use or abuse.

REVIEW OF SYSTEMS: Otherwise as above. He denies chest pain or shortness of breath. He denies seizure activity.

ON PHYSICAL EXAMINATION: His blood pressure is 136/83. His heart rate is 72. Respirations 19. 100% saturation on room air. Temperature is 98.9.
General: This is a well developed, well nourished, fit appearing 49 –year-old black male. He is awake, alert, conversant, fluent speech. Normal affect. He has a headache. He complains of some dizziness. He is anesthetic to the events of his accident. His pupils are equal and reactive. His extraocular movements are intact. He has no nystagmus. His face is symmetric. His tongue is midline. Both upper and lower extremities have normal bulk and tone with 5/5 strength in the left grip, both biceps, triceps, deltoids, iliopsoas, quadriceps, hamstrings, gastroc, and anterior tibialis motor groups. His right hand, his fourth and fifth digits are flexed toward the wrist. The first through third digits work normally. He is unable to straighten his fingers. He has a sutured laceration of the right volar and radial forearm. He had sutured laceration of the left parietal scalp and a sutured laceration of the left posterior shoulder region.

CT scan of the brain is available for review. There is a comminuted fracture in the left parietal convexity with minimal depressed bone with also some bone that is projected toward the soft tissue.

I reviewed all of his laboratory values as well. His hemoglobin is 13.1.

ASSESSMENT:
1. Left parietal skull fracture as described.
2. Closed head injury with concussion.
3. Right forearm injury, possible tendon and nerve injury.

COMMENT: We are going to admit the patient to the Intensive Care Unit for close observation. We will maintain him on intravenous antibiotics. At this point I would recommend observation. We will obtain orthopedic consultation for his forearm injury. I discussed his diagnosis and our treatment plan at length

PRIVILEGED AND CONFIDENTIAL: This facsimile contains privileged and confidential information. If you are not the intended recipient, or the person responsible to deliver it to the intended recipient, you are hereby advised that any dissemination, distribution, or copying of this facsimile is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone.

IF PATIENT INFORMATION HAS BEEN DISCLOSED TO YOU, IT CAME FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. ANY FURTHER DISCLOSURE OF THIS PATIENT INFORMATION WITHOUT PRIOR CONSENT OF THE PERSON TO WHOM IT PERTAINS MAY BE PROHIBITED.

(1) COPY FOR William B Naso, MD

HISTORY & PHYSICAL

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves St
Florence, SC 29501-0551

NAME: Benjamin, Victor
MED. REC. NO.: [redacted]
DR. DICTATING: William B Naso, MD
PATIENT NO.: [redacted]
ADMIT DATE: 06/15/2011

TSCUTS1501

with the patient.

Date/Time:_____(AM/PM)

Date/Time:_____(AM/PM)

William B Naso, MD

amc
DD : 06/15/2011 8:22 A
DT : 06/15/2011 9:50 A
Job #: 000008281
cc: William B Naso, MD

PRIVILEGED AND CONFIDENTIAL: This facsimile contains privileged and confidential information. If you are not the intended recipient, or the person responsible to deliver it to the intended recipient, you are hereby advised that any dissemination, distribution, or copying of this facsimile is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone.

IF PATIENT INFORMATION HAS BEEN DISCLOSED TO YOU, IT CAME FROM RECOI (2) ONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. ANY FURTHER DISCLOSURE OF THIS PATIENT INFORMATION WITHOUT PRIOR CC HE PERSON TO WHOM IT PERTAINS MAY BE PROHIBITED.

Benjamin, Victor Sex:M BD:04/19/1962 MR#:000000324683 Print this Page
PT#:119754182

Hist & Phys P

Jun 15, 2011 09:50

NAME: Benjamin, Victor
MED. REC. NO.: [redacted]
DR. DICTATING: William B Naso, MD
DOB: [redacted]
PATIENT NO.: [redacted]
ADMIT DATE: 06/15/2011

TSCUTS1501

CHIEF COMPLAINT: Head injury.

HISTORY: The patient is a 49 -year-old black male who had an accident in which he was struck in the head with some sort of industrial belt and sustained lacerations to the scalp, right forearm and left shoulder. He was taken to the Emergency Room. He was evaluated by Dr. Lewis. A CT scan was performed and I was called to see the patient in Neurosurgical consultation. The patient is anesthetic to the events of the accident. He also has weakness in his right ulnar hand.

He denies any chronic medical problems other than hypertension and hypercholesterolemia although he is on no antihypertensive medications. He says that he controls his blood pressure with dietary supplements.

He does say that he is allergic to Demerol.
He denies tobacco or alcohol use or abuse.

REVIEW OF SYSTEMS: Otherwise as above. He denies chest pain or shortness of breath. He denies seizure activity.

ON PHYSICAL EXAMINATION: His blood pressure is 136/83. His heart rate is 72. Respirations 19. 100% saturation on room air. Temperature is 98.9.

General: This is a well developed, well nourished, fit appearing 49 -year-old black male. He is awake, alert, conversant, fluent speech. Normal affect. He has a headache. He complains of some dizziness. He is anesthetic to the events of his accident. His pupils are equal and reactive. His extraocular movements are intact. He has no nystagmus. His face is symmetric. His tongue is midline. Both upper and lower extremities have normal bulk and tone with 5/5 strength in the left grip, both biceps, triceps, deltoids, iliopsoas, quadriceps, hamstrings, gastroc and anterior tibiales motor groups. His right hand, his fourth and fifth digits are flexed toward the wrist. The first through third digits work normally. He is unable to straighten his fingers. He has a sutured laceration of the right volar and radial forearm. He had sutured laceratio of the left parietal scalp and a sutured laceration of the left posterior shoulder region.

CT scan of the brain is available for review. There is a comminuted fracture in the left parietal convexity with minimal depressed bone with also some bone that is projected toward the soft tissue.

I reviewed all of his laboratory values as well. His hemoglobin is 13.1.

ASSESSMENT:
1. Left parietal skull fracture as described.

2. Closed head injury with concussion.
3. Right forearm injury, possible tendon and nerve injury.

COMMENT: We are going to admit the patient to the Intensive Care Unit for close observation. We will maintain him on intravenous antibiotics. At thi point I would recommend observation. We will obtain orthopedic consultatio for his forearm injury. I discussed his diagnosis and our treatment plan a length with the patient.

Date/Time:_____(AM/PM)
Date/Time:_____(AM/PM)

William B Naso, MD

amc
DD : 06/15/2011 8:22 A
DT : 06/15/2011 9:50 A
Job #: 000008281
cc: William B Naso, MD

CONSULTATION REPORT

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves St
Florence, SC 29501-0551

NAME: Benjamin, Victor
MED. REC. NO.: [redacted]
DR. DICTATING: Matthew D. Welsch, MD
DOB
PATIENT NO [redacted]
DATE OF CONSULT 06/15/2011

TSCUTS1501

178641
#34

CHIEF COMPLAINT: Right forearm laceration

HISTORY OF PRESENT ILLNESS Victor is a 49-year-old left hand dominant gentleman who was injured at work on 06/14/11 while he was performing a coil change. He is amnestic to the event but some type of belt or object hit him in the head, causing loss of consciousness. He was aroused and taken to the ED There was a noted laceration over the right forearm. He was evaluated by the ED team and admitted by the neurosurgical team due to a skull fracture and concussion

He was noted to have dysfunction in his right hand with inability to extend his ring and small fingers. He has pain in the forearm The wound in the ED was irrigated and closed primarily

PAST MEDICAL HISTORY: Hypertension, hypercholesterolemia.

PAST RELEVANT SURGICAL HISTORY: None

MEDICATIONS: None.

ALLERGIES: Demerol

SOCIAL HISTORY: He works full-time Denies alcohol or tobacco use.

REVIEW OF SYSTEMS is as above, otherwise negative.

PHYSICAL EXAMINATION: Temperature is 99.2, BP is stable, pulse 72, satting 100% on room air. On exam, he is well-developed, well-nourished alert and oriented x 3, conversant. Right upper extremity exam: There is a 7 cm. transverse laceration over the distal portion of the mid forearm overlying the dorsal and radial forearm, stitched closed, minimal swelling, no drainage. His median/ulnar/radial nerves are intact distally. The superficial branch of the radial nerve is intact to the first dorsal web space He has some dysesthesias over the radial dorsal thumb. He has full composite grip. He has active extension of the wrist with ECRB and ECRL intact. EPL is intact. EDC to the index and middle fingers intact EDC to the ring and small fingers nonfunctional He has brisk capillary refill in all digits less than 2 seconds He is nontender about the elbow He has mild tenderness about the shoulder with full passive range of motion The most tenderness is posteriorly He has 4+/5 strength of his supraspinatus.

X-RAYS were reviewed of his right forearm – no bony abnormalities.

ASSESSMENT AND PLAN: Victor is a 49-year-old gentleman with a right forearm laceration who sustained an injury to the extensor tendons to his ring and small fingers. It is at the musculotendinous junction of his muscle belly

He also has some dysesthesias over the lateral interbrachial cutaneus nerve

I have discussed the options with him, and he has acknowledged understanding. At this point, he will require

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COPY FOR Matthew D. Welsch, MD

(5)

CONSULTATION REPORT

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves St
Florence, SC 29501-0551

NAME: Benjamin, Victor
MED REC. NO.: [redacted] TSCUTS1501
DR. DICTATING: Matthew D. Welsch, MD
PATIENT NO.: [redacted]
DATE OF CONSULT 06/15/2011

exploration of his laceration and repair of the tendons and nerves as necessary. I have discussed surgery with him and the risks, which include bleeding, infection, pain, stiffness, damage to surrounding structures, tendon adhesions, possible re-rupture of tendon, and possible need for future surgeries, and he has acknowledged understanding. We have also discussed the postoperative protocol associated with extensor tendon repairs and he has acknowledged understanding.

Pending surgical clearance by the primary team, we will plan for surgical exploration of his right forearm at the next earliest convenience. This may be performed as an inpatient if able to proceed.

Thank you for this interesting consult

Date/Time:_____(AM/PM) Date/Time:_____(AM/PM)

_____
Matthew D. Welsch, MD

cgi
DD : 06/15/2011 5:45 P
DT : 06/16/2011 12:20 P
Job #: 000008554
cc William B Naso, MD
Matthew D. Welsch, MD

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Operative Report

NAME: Benjamin, Victor
MED. REC. NO.: [redacted]
DR. DICTATING: Matthew D. Welsch, MD
DOB: [redacted]
PATIENT NO.: [redacted]
DATE OF SURGERY: 06/16/2011

Jun 17, 2011 10:46
1187110701

PREOPERATIVE DIAGNOSIS: Right forearm laceration.

POSTOPERATIVE DIAGNOSES: 1. Right forearm laceration, extensor digitorum communis lacerations to the middle finger, ring finger, and small finger, zone 7.
2. Right index finger extensor digitorum communis partial laceration, zone 7.

PROCEDURE: Irrigation and debridement of skin and subcutaneous tissue with repair of extensor digitorum communis tendons index, middle, ring, and small finger.

SURGEON: Matthew D. Welsch, M.D.

ANESTHESIA: General endotracheal.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: Less than 10 mL.

BRIEF HISTORY: Victor is a 49-year-old gentleman who suffered a laceration to his right forearm at work from an undetermined object. Workup has revealed likely extensor tendon injuries. The risks, benefits and alternatives to the above-mentioned procedure were explained to the patient and informed consent was obtained.

The expected outcome is definitive diagnosis and repair of injured tissue.

DESCRIPTION OF PROCEDURE: The patient was seen in the preoperative area and his operative site marked. He was then brought back to the operating room. He was placed supine and under general anesthesia, the right hand and arm were prepped and draped in the normal sterile fashion. Preoperative antibiotics were given 30 minutes prior to the incision. A time-out occurred and the correct operation site was confirmed.

A nonsterile tourniquet was inflated to 250 mmHg. The transverse dorsal forearm laceration was explored. The incisions were made proximally and distally to allow for full exposure of the injury. The underlying skin and subcutaneous tissue was dissected in a full-thickness flap off of the underlying extensor retinaculum. There was a violation of the dorsal finger extensors, resulting in lacerations of the extensor digitorum communis tendons to the small finger, ring finger, and middle finger. There was a 70% laceration to the extensor digitorum communis to the index finger. The adjacent EPL and thumb abductors were not violated. The adjacent superficial radial nerve sensory nerve branch was not violated.

After full exposure of the extensor injuries, it was noted that the mechanism of injury was not a sharp laceration, but more of a tearing.

laceration of the tendons. Primary repair was able to be performed, however, tissue quality was not ideal. There was no gross contamination.

Perfuse irrigation and debridement of the wound was then performed using bulb syringe and normal saline. A curette was used to remove a minimal amount of debris. The rongeur was used to excise the devitalized tissue.

With the wrist in extension and the fingers in extension, sequential repair of the tendons was performed after identification was made. Repair of each tendon was performed using a 3-0 Surgilon suture in a locked Kessler fashion. Two additional figure-of-eight sutures were thrown at each tendon repair site in a figure-of-eight fashion in order to assist with reapproximation of tendon ends.

After the repair of tendon, brisk irrigation of the wounds was performed. The tourniquet was taken down and adequate hemostasis obtained. The tourniquet was then reinflated. The skin tissue was then closed using 4-0 Prolene in a simple and horizontal mattress fashion.

Sterile dressing was placed with Xeroform, gauze, burn dressing, and a well-padded volar wrist and hand splint was then placed with the wrist in 60 degrees of extension, the MP joints in full extension and the IP joints in an slight flexion.

The patient was extubated in operating room and tolerated the procedure well. He was transferred to PACU in stable condition.

PLAN: Postop, Victor will be readmitted to the hospital under the neurosurgical team. He will continue observation under their direction.

In regards to his right upper extremity, he is to elevate it all times and to keep his splint clean and dry. He has no use of the right extremity.

Date/Time:_____(AM/PM)
Date/Time:_____(AM/PM)

Matthew D. Welsch, MD

Eeq
DD : 06/17/2011 12:36 P
DT : 06/17/2011 7:45 P
Job #: 000009064
cc: William R Naso, MD
Matthew D. Welsch, MD

Page created: Monday, June 20, 2011 9:09 AM

Benjamin, Victor Sex:M BD:04/19/1962 MR# [redacted] Print this Page

Disch Summary P PT#:119754182

Jun 17, 2011 16:34

NAME: Benjamin, Victor
MED. REC. NO.: [redacted]
DR. DICTATING: William B Naso, MD
DOB: [redacted]
PATIENT NO.: [redacted]
ADMIT DATE: 06/15/2011
DISCHARGE DATE: 06/17/2011

FINAL DIAGNOSES:
1. Closed head injury.
2. Skull fracture.
3. Scalp laceration.
4. Right forearm laceration with tendon lacerations.

PROCEDURE:
1. Repair of right forearm extensor tendons.
2. Irrigation and debridement and closure of scalp laceration.

HISTORY: Patient is a 49-year-old black male who presents after an industrial accident.

Please see my history and physical for full details.

HOSPITAL COURSE: The patient was admitted. He was observed in the intensive care unit. His scalp laceration was closed in the Emergency Room He was seen in orthopedic consultation because of a right forearm tendon laceration and underwent surgery. By the time of this dictation the patient was afebrile. His vital signs were stable. Neurologically he is doing well. His wound looked fine. He was subsequently discharged home. I gave him a prescription of Lortab to use as needed as well as a 10-day course of his Keflex. We kept him on Ancef during his hospitalization. H has been given detailed discharge instructions. He will see me back in th office in one week.

Date/Time:_____(AM/PM)
Date/Time:_____(AM/PM)

William B Naso, MD

bkw
DD: 06/17/2011 8:44 A
DT: 06/17/2011 4:34 P Job #: 000008972
cc: William B Naso, MD
Priscilla L Welch, MD

Page created: Thursday, June 23, 2011 2:47 PM

Top of Page

DISCHARGE SUMMARY

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves St
Florence, SC 29501-0551

NAME: Benjamin, Victor
MED. REC. NO.: [redacted]
DR. DICTATING: William B Naso, MD
DOB: [redacted]
PATIENT NO.: [redacted]
ADMIT DATE: 06/15/2011
DISCHARGE DATE: 06/17/2011

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1. Closed head injury.
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Date/Time:_____(AM/PM) Date/Time:_____(AM/PM)

_____
William B Naso, MD

bkw
DD: 06/17/2011 8:44 A
DT: 06/17/2011 4:34 P Job #: 000008972
cc: William B Naso, MD
Priscilla L Welch, MD

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COPY FOR William B Naso, MD

Florence Neurosurgery & Spine
1204 E. Cheves Street ~ Florence, S.C. 29506
ph: 843 673 0122 ~ fax: 843 673 0227
www.florenceneurosurgery.com

Andrew H. Rhea, M.D. James J. Brennan, M.D. Elizabeth A. Snoderly, D.O.
William B. Naso, M.D. Christopher G. Paramore, M.D.

Patient Name: VICTOR BENJAMIN [redacted]
DOB: [redacted]
Date of Service: 06/24/2011

HISTORY

Chief Complaint: Headache

History of Present Illness: Mr. Benjamin is a 49-year-old black male was involved in an industrial accident in which he sustained a scalp laceration, a left parietal skull fracture, a closed head injury with concussion, and the right forearm tendon injury. We observed in the hospital. He underwent surgery for his tendon injury. He returns in follow-up today. He says he is having significant headaches. He complains of lightheadedness and dizziness. He also complains of some neck discomfort. He has pain in his right scapular region radiating into his right arm. He says he is supposed to start occupational therapy for his hand. He denies seizure activity.

Past Medical History: Hypercholesterolemia

Past Surgical History: As above

Social History: He is married and has two children. He works as a frontend maintainer. He denies tobacco or alcohol use or abuse.

Review of Systems: The patient denies chest pain, shortness of breath, or bowel or bladder incontinence. Please see the health history questionnaire for full details of the patient's review of systems, past medical history, and family and social history. The patient is to follow-up with his family physician for any positive review of systems.

PHYSICAL EXAMINATION

VITAL SIGNS: BP 139/87 HR 66 RR 14 Temp. 97.9 Ht. 6-foot Wt. 190

NEURO/MUSCULOSKELETAL EXAM

Cognitive: The patient is awake alert and conversant, with fluent speech, normal affect, and fully oriented.

Cranial nerves: Pupils are equal and reactive. Extraocular movements are intact. The face is symmetric. The tongue is midline.

Motor exam: Both upper and lower extremities have normal bulk and normal tone with 5/5 strength throughout, including the left grip and both biceps, triceps, deltoids, iliopsoas, quadriceps, hamstrings, gastrocnemius, and anterior tibialis motor groups with good range of motion throughout. His right forearm and hand are in a splint.

Gait: No ataxia.

Florence Neurosurgery & Spine
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www.florenceneurosurgery.com

Andrew H. Rhea, M.D. James J. Brennan, M.D. Elizabeth A. Snoderly, D.O.
William B. Naso, M.D. Christopher G. Paramore, M.D.

Patient Name: VICTOR BENJAMIN [redacted]
DOB: [redacted]
Date of Service: 06/24/2011

MEDICAL DECISION MAKING

Assessment/Diagnoses: 1. Postconcussive syndrome 2. Parietal skull fracture 3. Neck pain with cervical myofascitis

Recommendations/Management Options: We will proceed with cervical spine x-rays with flexion-extension views. Given his head injury and persistent headache and postconcussive symptoms I would recommend an MRI of the brain to make sure there has been no interval development of any extra-axial collections (particularly given his skull fracture) but also to see if there is any evidence for parenchymal injury. I think he would be a good candidate for vestibular rehab. We have also given him a prescription for Skelaxin may help with his myofascial complaints. We removed his scalp staples and left shoulder sutures as well. We will otherwise see him back in the office in 3 to 4 weeks. I discussed at length with the patient's case manager the patient's diagnosis, prognosis, and treatment plan. This was done in the patient's presence.

Addendum: AP, lateral, flexion and extension cervical spine x-rays were obtained. There is loss of the normal lordosis. There is degenerative disc disease throughout the cervical spine but no significant C5-6. There is an anterior osteophyte at C3-4. There is maintained in alignment from C1 to C7-T1. There is no gross instability with flexion and extension. I do not see any obvious fractures.

cc:

Electronically Signed by: William B. Naso, M.D. on Friday, June 24, 2011 1:22 pm

Florence Neurosurgery & Spine
1204 E. Cheves Street ~ Florence, S.C. 29506
ph: 843 673 0122 ~ fax: 843 673 0227
www.florenceneurosurgery.com

Andrew H. Rhea, M.D. James J. Brennan, M.D. Elizabeth A. Snoderly, D.O.
William B. Naso, M.D. Christopher G. Paramore, M.D.

Patient Name: VICTOR BENJAMIN [redacted]
DOB: [redacted]
Date of Service: 06/24/2011

XRAY REPORT

AP, lateral, flexion and extension cervical spine x-rays were obtained. There is loss of the normal lordosis. There is degenerative disc disease throughout the cervical spine but no significant C5-6. There is an anterior osteophyte at C3-4. There is maintained in alignment from C1 to C7-T1. There is no gross instability with flexion and extension. I do not see any obvious fractures.

Florence Neurosurgery & Spine
1204 East Cheves Street
Florence, SC 29506
Phone (843) 673-0122
Fax (843) 673-0227

NAME: BENJAMIN, VICTOR
DOB: [redacted]
Physician: NASO

DATE OF EXAM: 06/27/2011
Patient No: [redacted]

BRAIN WO

FINDINGS:
Multiplanar images obtained, routine pulse sequences. Retention cysts in the floor of both maxillary sinuses. No sinus fluid levels. Orbits normal. Normal ventricles. No mass effect. Looks like prior left parietal craniotomy. No hemorrhage and restricted diffusion. No extraaxial collections.

IMPRESSION:
See above.

Scott Allen, MD

Electronic Signature

DD: 06/27/2011/DT: 06/28/2011/mes

Florence Neurosurgery & Spine
1204 E. Cheves Street ~ Florence, S.C. 29506
ph: 843 673 0122 ~ fax: 843 673 0227
www.florenceneurosurgery.com

Andrew H. Rhea, M.D. **James J. Brennan, M.D.** **Elizabeth A. Snoderly, D.O.**
William B. Naso, M.D. **Christopher G. Paramore, M.D.**

Patient Name: VICTOR BENJAMIN (45677E)
DOB: [redacted]
Date of Service: 08/03/2011

HISTORY

Chief Complaint: Previous head injury

History of Present Illness: Mr. Benjamin seems to be some better. He still has trouble with headache and short-term memory issues. He continues with rehab.

Review of Systems: Please see the health history questionnaire for full details of the patient's review of systems, past medical history, and family and social history. The patient is to follow-up with their family physician for any positive review of systems.

PHYSICAL EXAMINATION

The patient is awake, alert, in no distress. The face is symmetric. The tongue is midline. Speech is clear. The patient seems to have good strength in both upper and lower extremities. Gait is steady.

MEDICAL DECISION MAKING

Assessment/Diagnoses: 1. Postconcussive syndrome

Recommendations/Management Options: I would advise continued conservative management. We will see him back the office in two to 3 months.

cc: **PETER HYMAN MD**

Electronically Signed by: William B. Naso, M.D. on Wednesday, August 03, 2011 9:57 am

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

Physician's Statement

Claimant's Name: Victor Benjamin
Physician's Name: Matthew D. Wetsch, MD
Practice/Clinic: Pee Dee Orthopaedic Associates
Preparer's Name: Rhonda Robinson
Phone: 843-432-1807

Employer's Name: Rexam Beverages
Insurance Carrier: Hartford Ins Co of the Midwest
SCWCC File No: 1108788

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: 6/16/2011

Date of first office visit: 10/14/2013 Date of last visit: 6/18/2014

Diagnosis or nature of injury or illness: Right shoulder and neck pain

Body part(s) injured: Right Shoulder Body part(s) affected: Right Shoulder

Date of **Maximum Medical Improvement:** 6/18/2014

Based on the **AMA Guidelines**, the claimant has sustained a 0 **% medical impairment** to Right Shoulder 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.

☐ Claimant **possesses retained hardware** casually related to this injury.

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 deg 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 reasc degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follow

Treating Physician

1/13/2015
Date

9/13

01/13/2015 11:35 Pee Dee Orthopaedic 8438789983 P12 NO.631 0002

GRAND STRAND
SPECIALTY ASSOCIATES
NEUROLOGY

Neurology:
Jeff A. Benjamin, D.O.
Barbara L. Sarb, D.O.
Michael McCaffrey, M.D.

Neurology & Ophthalmology:
George M. Sandoz, M.D.

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 09/16/2011 11:00 AM
VISIT TYPE: Consultation

Chief Complaint/Reason for visit:
This 49 year old male presents with head injury, neck pain and dizziness.

History of Present Illness
1. head injury
Onset: sudden. The severity of the symptoms is moderate. The symptoms have not changed. Ventilator support was not used in the hospital. The location of the injury is in the left parietal region. The location of pain is facial, head and neck. The mechanical force causing the injury was coup. Context includes metal guard hit head. The patient does not use alcohol. There are no risk factors. Aggravating factors include exertion, lying down, sound and touch. Denies relieving factors. Associated symptoms include confusion, headache, incoordination, irritability, loss of consciousness, memory difficulty, personality change, restlessness, speech difficulty, stiff neck, unusual behavior, visual disturbance and weakness. Additional information: event on 6-15-11, was control panel, amnestic for event and skull fracture left.
2. neck pain
Onset: sudden. The severity of the problem is moderate. The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There was radiation of pain to the left upper arm, left elbow and left forearm. The patient describes the pain as aching and burning. The event(s) surrounding the occurrence of the symptom include 30 lbs metal guard hit head. Trauma occurred on 08/15/2011. Aggravating factors include climbing stairs, flexion, hyperextension, kneeling, lifting, lying down, walking and working. Denies relieving factors. Associated symptoms include difficulty sleeping, disequilibrium, muscle spasm, numbness, other joint pain, tenderness and tingling. Pertinent negatives include bladder retention.
3. dizziness
Onset was sudden. Severity is moderate. The duration of each episode is Month(s). The problem is unchanged. It occurs persistently. The patient describes it as (an) imbalance and spinning. It occurs while. The patient has sustained a head injury in the past. Symptom is aggravated by rapid rise and turning. Relieving factors include position change. Associated symptoms include hearing loss, loss of consciousness, neck stiffness, paresthesias and tinnitus. Pertinent negatives include diplopia or ear ache.

Vital Signs
Height

Time	Ft	In	Cm	Last Measured	Method	%
12:07 PM	6.0					

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
12:07 PM	184.00					24.95	

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
12:07 PM	140/78	sitting				

Measured By
Time
12:07 PMPenny Powers

Physical Exam
Constitutional:
Level of distress is moderate distress. Well nourished. Well developed.
Eyes:
Right
Fundus is benign.
Left
Fundus is benign.
Ears:
Right
Normal tympanic membrane.
Left
Normal tympanic membrane.
Vascular:
Bruits
Carotid bruits: absent.
Musculoskeletal:
Cervical spine has muscle spasm, moderately reduced ROM
Lumbar spine has muscle spasm
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Trigeminal:
Motor and Reflexes: normal.
Facial: normal.
Acoustic: Weber test abnormal, lateralizes to the right
Glossopharyngeal: normal.
Vagus: normal.
Spinal Accessory: normal.
Hypoglossal: normal.
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Biceps deep tendon reflex is 2+ on the right and 1+ on the left.
Brachioradialis deep tendon reflex is 2+ bilaterally.
Triceps deep tendon reflex is 2+ bilaterally.
Patellar reflex is 2+ bilaterally.
Achilles reflex is 2+ bilaterally.
Brudzinski's sign: Negative.

Clinical Assessment
The patient is a 49-year old male who presents with head injury, neck pain and dizziness. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan
Intracranial injury of other and unspecified natur (854.01)
From traumatic injury will check mri brain perform neuropsych testing and trial with Lamictal for moodstabilazer.
Memory loss (780.93)
Due to injury or ptsd, eeg will be perform.
Dizziness (780.4)
Due to injury causing damage on innerr ear, will give meclizine and exercisses, will check nystagmogram.
Headache (784.0)

Post rauma in nature, trial with Nucynta.
Pain-neck (723.1)
Due to trauma, ncs and mri cervical spine as well for pt, pain control with nucynta.
Pain-limb (729.5)
Due to trauma, consult with orthopedic surgeons.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	09/21/2011	Risks/ benefits of treatment plan	
completed	09/21/2011	Reviewed medications	
completed	09/21/2011	Activity as tolerated	
completed	09/21/2011	Take new medication as prescribed	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
scheduled	Office visit	Continue current treatment	854.01	-today	09/21/2011	
ordered	MRI C- SPINE W/O DYE		854.01		09/21/2011	
ordered	MRI BRAIN W/O & W/DYE		854.01		09/21/2011	
ordered	AUDITOR EVOKE POTENT, COMPRE			780.4	09/21/2011	
ordered	SPONTANEOUS NYSTAGMUS TEST			780.4	09/21/2011	
completed	Follow-up if symptoms persist / worsen			854.01	09/21/2011	
completed	Follow-up for increased symptoms		854.01	-today	09/21/2011	
ordered	EEG MONITORING/COMPUTER 24hr			780.03	09/21/2011	
ordered	MUSCLE TEST, ONE LIMB		854.01		09/21/2011	
scheduled	Office visit	Discuss test results		854.01	-today	09/21/2011
scheduled	Office Visit	Follow-up on medication		854.01	-today	09/21/2011
completed	Follow-up for medication side effect		854.01	-today	09/21/2011	

George M. Sandoz MD

Document generated by: George Sandoz 09/21/2011

Grand Strand Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

652-4603

GRAND STRAND SPECIALTY ASSOCIATES

☐ 6170 Rourk St., Myrtle Beach, SC 29572 • (843) 449-2336
☐ 4367 Riverwood Dr., Suite 120, Murrells Inlet, SC 29576 • (843) 357-8008
☐ 2376 Cypress Cir., Suite 200, Conway, SC 29526 • (843) 234-1710

Date Ordered: 9/16/11 Authorizing Signature: Benjamin Victor

Patient: _____

Phone #: _____ Date of Birth: _____ Social Security #: _____

Consult / Diagnosis Study (ies): Neuropsych test

Diagnosis code: _____ Diagnosis: _____

Clinical Information: TBI

Insurance Company: _____

Patient Preparation / Information: _____

Appointment: _____ Appointment Time: _____ Appointment Location: _____

Name: Benjamin Victor DT (87) 452 Date

Date: 9-21-11

Referring Physician: Dr. Sood

Patient Name: Victor Benjamin [redacted]

Address:

DOB: [redacted] Phone: 803 428-3352 803 428-3352

Reason for Consult: 780.93 memory, 854.01 intracranial injury

95812 EEG 41-60 min

Code	Description	Quantity
95816	EEG – Awake / Drowsy	
95819	EEG – Awake / Sleep	
95822	EEG – Sleep Only	
780.93 95953 ✓	EEG – Ambulatory 24hr	
95860 ✓	EMG x 1	
95861	EMG x 2	
95863	EMG x 3	
95864	EMG x 4	
854.01 95867	EMG – Cranial Unilateral	
95868	EMG – Cranial Bilateral	
95869	Thoracic Paraspinal	
95900	Motor w/o F-Wave	
95903 ✓	Motor w/o F-Wave	
95904 ✓	NCS – Sensory	
95934 ✓	H-Reflex	
95925	SSEP – Upper	
95926	SSEP - Lower	
95930	VEP	
95938	Blink Reflex	
95937	Repetitive Study	
780.4 92541	Vestibular Evaluation	
92543 ✓	ENG – Caloric Test	
95857	Tensilon	
92585 ✓	Auditory EP - Comprehensive	

DIAGNOSIS CODE:

Arm/Leg Pain	729.5
Carpal Tunnel	954.0
Cervical Disc Disease	722.4
Dementia	294.8
Guillain Barre Syndrome	357.0
Head Trauma	803.00
Low Back Pain	724.2
Lumbar Disc Disease	722.52
Multiple Sclerosis	340
Myasthenia Gravis	358.0
Myelopathy	336.9
Myopathy	359.9
Neuropathy	356.9
Paresthesia	782.0
Radiculopathy (Arm/Leg)	723.4
Radiculopathy (Lumbar)	724.4
Seizure Disorders	780.39
Syncope	780.2
Tarsal Tunnel	355.5
Vertigo/Dizziness ✓	780.4
Visual Loss (Sudden)	368.11
Visual Loss	369.9
Transient Visual Loss	368.12
Memory Disturbance	310.1
Muscle Weakness	728.9

- ☐ Right Upper Extremity
- ☐ Right Lower Extremity
- ☐ Left Upper Extremity
- ☐ Left Lower Extremity
- ☐ Additional Nerves

Total:$

Insurance: Southern SEB Claim
Office use

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805 South Irby Street
Florence, SC 29501
(843) 292-0400 - fax (843) 292-0470

PATIENT: Benjamin, Victor
DOB: [redacted]
MRN: [redacted]
PATIENT PHONE: 803-428-3352
PHYSICIAN: George Sandoz, MD
DATE: 10/10/2011

EXAM: CERVICAL SPINE MRI WITHOUT CONTRAST

TECHNIQUE: Routine sequences obtained through the cervical spine. No intravenous contrast administered. The following sequences were performed on a GE Signa 1.5 Tesla magnet: Sagittal T2, sagittal T2 FS, axial T2, axial T2 GRE and coronal T1.

HISTORY: Intracranial injury, right side neck pain

FINDINGS: There is loss of the cervical curve. The cervical cord of normal size and signal intensity and the cervicomedullary junction is normal. No abnormal signal identified in the cervical spine. There is some lobular mucosal thickening inferiorly in the left maxillary sinus.

C2-C3: No abnormality.

C3-C4: There is a bulge of annulus with discogenic anterior and posterior osteophytes, bilateral uncinate joint osteophytes and there is mild bilateral osseous foraminal stenosis. There is total effacement of the ventral CSF and the AP diameter of the canal at the level of the disc is 9 mm consistent with a mild stenosis.

C4-C5: There is a mild degenerative bulge of annulus with discogenic osteophytes. Uncinate joint osteophytes are present on the right and there is effacement of the ventral CSF and the AP diameter of the canal at the level of the disc is 8-9 mm. There is mild osseous foraminal stenosis on the right.

C5-C6: Degenerative annular bulge that is asymmetric to the right and uncinate joint osteophyte on the right and the disc osteophyte complex causes moderate foraminal stenosis on the right. There is a borderline central canal stenosis and the AP diameter of the canal at the level of the disc is 9 mm.

C6-C7: There is a prominent uncinate joint osteophyte on the left and there is moderate to severe osseous foraminal stenosis on the left. The disc is normal. There is a small uncinate process osteophyte on the right.

C7-T1: No abnormality.

IMPRESSION:
1. Multilevel cervical spondylosis. There is a mild central canal stenosis at C3-4, C4-5 and C5-C6. There is foraminal stenosis on the right which is predominately osseous at C3-C4, C4-C5 and C5-C6.
2. C6-C7 there is moderate to severe osseous foraminal stenosis on the left.
3. Lobular inflammatory mucosal thickening in the left maxillary sinus.

Patient: Benjamin, Victor
MRN: [redacted]
Exam: CERVICAL SPINE MRI WITHOUT CONTRAST

Thank you for this consultation.

Margaret Lee, M.D.
ML / dg

DD: 10/10/2011
DT: 10/10/2011
Job: 13726986

This document has been electronically reviewed and signed.

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PATIENT: Benjamin, Victor
DOB: [redacted]
MRN: [redacted]
PATIENT PHONE: 803-428-3352
PHYSICIAN: George Sandoz, MD
DATE: 10/10/2011

EXAM: MRI BRAIN WITH AND WITHOUT CONTRAST

HISTORY: Right-sided neck pain, right arm pain, intracranial injury, dizziness

COMPARISON STUDIES: None given.

TECHNIQUE: The following sequences were performed on a GE Signa 1.5 Tesla magnet: Sagittal T2, axial T2, axial FLAIR, diffusion, coronal T2 and axial T1 pre and post administration of IV gadolinium. Routine sequences obtained through the brain before and after the infusion of 17 mL Magnevist.

FINDINGS: There is metal artifact in the left parietal skull created by metal associated with craniotomy defect. Bilaterally there is lobular mucosal thickening in the inferior aspect of the paranasal sinuses consistent with chronic sinusitis. There is also some mucoinflammatory thickening in the ethmoid sinuses extending into the inferior frontal sinuses. The mastoid sinus and sphenoid sinus are clear.

Flow voids in the cavernous portion of the internal carotid and basilar artery are normal. Cerebellopontine angles are normal. There is no abnormal signal in the brain and no extraaxial fluid collections. Midline structures including the pituitary, corpus callosum, and cervicomedullary junction are normal. Axial diffusion sequence is negative for restricted diffusion.

Post administration of contrast there are no enhancing lesions or meningeal enhancement.

IMPRESSION:
1. Metal artifact in the left parietal skull secondary to craniotomy.
2. Mucoinflammatory disease involving the maxillary, ethmoid and frontal sinuses.

Thank you for this consultation.

Margaret Lee, M.D.
ML / rc

DD: 10/10/2011
DT: 10/10/2011
Job: 13727324

Patient: Benjamin, Victor
MRN: [redacted]
Exam: MRI BRAIN WITH AND WITHOUT CONTRAST

This document has been electronically reviewed and signed.

GRAND STRAND
SPECIALTY ASSOCIATES
NEUROLOGY

Neurology:
Jeff A. Benjamin, D.O.
Barbara L. Sarb, D.O.
Michael McCaffrey, M.D.

Neurology & Opthalmology:
George M. Sandoz, M.D.

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 10/26/2011 8:45 AM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 49 year old male presents with neck pain and head injury.

History of Present Illness
1. neck pain
Onset: sudden. The severity of the problem is moderate. The problem has not changed. The frequency of pain is daily. Location of pain is bilateral posterior neck. There was radiation of pain to the right upper arm. The patient describes the pain as aching, burning and throbbing. The event(s) surrounding the occurrence of the symptom include cervical compression. Trauma occurred on 06/15/2011. Aggravating factors include turning head, walking and working. Relieving factors tried include exercise and narcotic analgesics. Associated symptoms include difficulty sleeping, muscle spasm, numbness and tenderness. Pertinent negatives include bladder retention.
2. head injury
Onset: sudden. The severity of the symptoms is mild. The symptoms have not changed. The location of pain is head and neck. The mechanical force causing the injury was coup. Context includes hit head with metal object. The patient does not use alcohol. Aggravating factors include exertion and sitting up. Associated symptoms include headache, paralysis and stiff neck.

Vital Signs

Physical Exam
Constitutional:
No acute distress. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderately reduced ROM
No lumbar spine tenderness. Normal mobility and curvature.
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .

Clinical Assessment

The patient is a 49-year old r ho presents with neck pain and head injur .e patient is compliant with medication. Responding to cu t treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan

Intracranial injury of other and unspecified natur (854.01)
Noted on neuropsych testing, continue under Dr Goldshcmidt care.
Other and unspecified disc disorder of cervical re (722.91)
Noted on mri cervical spine, continue with meds and also will set for esi cervical spine continue to be off workuntil next visit and see response with treat ment.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	10/26/2011	Risks/ benefits of treatment plan	
completed	10/26/2011	Continue current medication	
completed	10/26/2011	Activity as tolerated	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
completed	Follow-up for medication side effect		854.01	-today	10/26/2011	
completed	Follow-up for increased symptoms		854.01	-today	10/26/2011	
completed	Follow-up if symptoms persist / worsen			854.01	10/26/2011	
scheduled	Office Visit	Follow-up on medication		854.01	-today	10/26/2011
scheduled	Office visit	Discuss test results		854.01	-today	10/26/2011
scheduled	Office visit	Continue current treatment		854.01	-today	10/26/2011

George M. Sandoz MD

Document generated by: George Sandoz 10/26/2011

CC Providers:
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4882 Socastee Blvd
Myrtle Beach, SC 29588

Grand Strand Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Benjamin, Victor

Strand Regional Specialty Associates
3 Maryland Farm Suite 250
Brentwood TN 37027
(843) 449-2336

Test Date: 10/27/2011

Patient:	Victor Benjamin	DOB:	[redacted]	Physician:	George Sandoz, M.D.
Sex:	Male	Height:	cm	Ref Phys:	Southern SPS
ID#:	[redacted]	Weight:	lbs.	Technician:	D.Ford

Patient Complaints:
Patient is a 49 year-old male who presents with neck pain radiating to the right arm

EMG & NCV Findings:
Evaluation of the Right median motor nerve showed prolonged distal onset latency (3.8 ms). The Right ulnar motor nerve showed decreased conduction velocity (A Elbow-B Elbow, 37 m/s). The Right ulnar motor inching nerve showed prolonged distal onset latency (7.4 ms), abnormal onset latency difference (-4 cm--5 cm, 1.1 ms), abnormal onset latency difference (-5 cm--4 cm, 1.0 ms), and abnormal onset latency difference (-1 cm--2 cm, 0.7 ms). All remaining nerves (as indicated in the following tables) were within normal limits.

All F Wave latencies were within normal limits.

All examined muscles (as indicated in the following table) showed no evidence of electrical instability.

Impression:
1. Moderate CTS of the right upper extremity.
2. Ulnar neuropathy at the elbow of the right upper extremity.
3. Clinical correlation is suggested.

Recommendations:
Right ulnar transposition

George Sandoz, M.D.

Patient: Benjamin, Victor Test Date: 10/27/2011 Page: 2

Nerve Conduction Studies

Anti Sensory Summary Table

Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (uV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Median Anti Sensory (2nd Digit)											
Wrist		0.7	<3.3	15.9	>10						
Elbow		2.3		29.6		Wrist	2nd Digit	0.7	14.0	200	>39
Axilla		2.3		28.1		Elbow	Wrist	1.6	8.0		>48
Erb's		2.3		28.9		Axilla	Elbow	0.0	0.0		
Right Ulnar Anti Sensory (5th Digit)						Erbs	Axilla	0.0	0.0		
Wrist		2.3	<3.7	22.8	>15.0						
B Elbow		2.3		19.3		Wrist	5th Digit	2.3	14.0	61	>38
A Elbow		2.6		18.6		B Elbow	Wrist	0.0	0.0		>47
						A Elbow	B Elbow	0.3	0.0		

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 Median Motor (Abd Poll Brev)											
Wrist		3.8	<3.6	8.3	>5						
Elbow		8.7		8.1		Elbow	Wrist	4.9	6.0		>50
Right Ulnar Motor (Abd Dig Minimi)											
Wrist		3.4	<4.2								
B Elbow		7.6		9.4	>5						
A Elbow		10.0		10.8		B Elbow	Wrist	4.2	34.0	57	>53
				8.9		A Elbow	B Elbow	2.4	9.0	37	>53

Motor Jitching Summary Table

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Norm Delta (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Ulnar Motor Jitching (Abd Dig Minimi)												
Wrist		7.4	<4.2	7.1	>3							
-6 cm		7.9		10.9		-5 cm	-6 cm	0.9	<0.4	6.0		
-5 cm		7.9		9.3		-4 cm	-5 cm	1.1	<0.4	8.0		
-4 cm		9.0		11.2		-3 cm	-4 cm	1.0	<0.4	8.0		
-3 cm		10.0		11.3		-2 cm	-3 cm	0.1	<0.4	8.0		
-2 cm		10.1		8.1		-1 cm	-2 cm	0.7	<0.4	8.0		
-1 cm		9.4		9.4						0.0		

F Wave Studies

NR	F-Lat (ms)	Lat Norm (ms)	L-R F-Lat (ms)	L-R Lat Norm
Right Median (Wrist) (Abd Poll Brev)				
30.13	<33			<2.1
Right Ulnar (Wrist) (Abd Dig Min)				
33.96	<36			<2.5

EMG

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Comment
Right	Biceps	Musculocut	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	PronatorTeres	Median	C6-7	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	Triceps	Radial	C6-7-8	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	Deltoid	Axillary	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	1stDorInt	Ulnar	C8-T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	FlexDigProf	Ulnar	C8,T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	Abd Poll Brev	Median	C8-T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	ABD Dig Min	Ulnar	C8-T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	

Patient: Benjamin, Victor

Test Date: 10/27/2011

Page: 3

Right	FlexCarpiUln	Ulnar	C8,T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml
Right	C5 Paraes	Rami	C5	Nml	Nml	Nml					

Nerve Conduction Studies

Anti Sensory Left/Right Comparison

Site	L Lat (ms)	R Lat (ms)	L-R Lat (ms)	L Amp (uV)	R Amp (uV)	L-R Amp (%)	Site1	Site2	L Vel (m/s)	R Vel (m/s)	L-R Vel (m/s)
Median Anti Sensory (2nd Digit)											
Wrist		2.7									
Elbow		2.3			15.9		Wrist	2nd Digit		200	
Axilla		2.3			29.6		Elbow	Wrist			
Erbs		2.3			28.1		Axilla	Elbow			
Ulnar Anti Sensory (5th Digit)					28.9		Erbs	Axilla			
Wrist		2.3									
B Elbow		2.3			22.8						
A Elbow		2.4			19.3		Wrist	5th Digit		61	
					18.6		B Elbow	Wrist			
							A Elbow	B Elbow			

Motor Left/Right Comparison

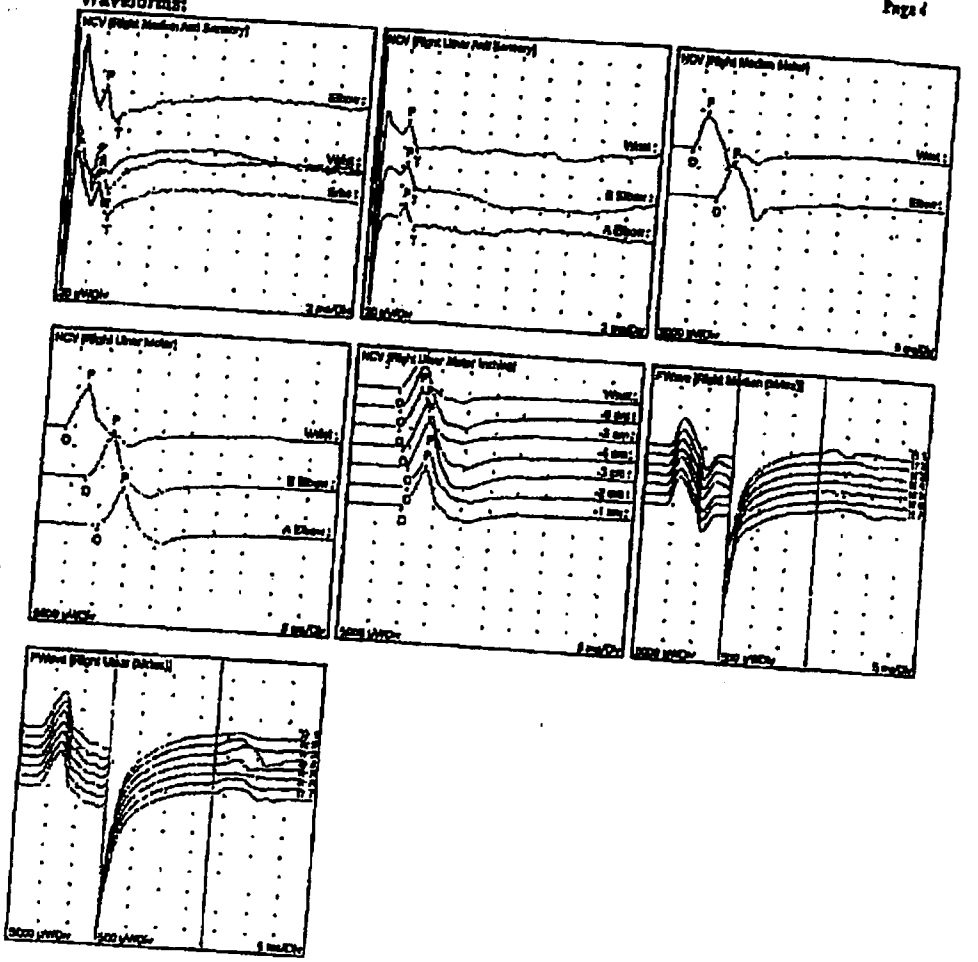
Site	L Lat (ms)	R Lat (ms)	L-R Lat (ms)	L Amp (mV)	R Amp (mV)	L-R Amp (%)	Site1	Site2	L Vel (m/s)	R Vel (m/s)	L-R Vel (m/s)
Median Motor (Abd Pol Brev)											
Wrist		3.8			8.3						
Elbow		8.7			8.1		Elbow	Wrist			
Ulnar Motor (Abd Dig Minimi)											
Wrist		3.6									
B Elbow		7.6			9.4		B Elbow	Wrist		57	
A Elbow		10.0			10.2		A Elbow	B Elbow		55	
					8.9						

Motor Inching Left/Right Comparison

Site	L Lat (ms)	R Lat (ms)	L-R Lat (ms)	L Amp (mV)	R Amp (mV)	L-R Amp (%)	Site1	Site2	L Vel (m/s)	R Vel (m/s)	L-R Vel (m/s)
Ulnar Motor Inching (Abd Dig Minimi)											
Wrist		7.4									
-6 cm		7.9			7.1						
-5 cm		7.9			10.9		-5 cm	-6 cm			
-4 cm		9.0			9.3		-4 cm	-5 cm			
-3 cm		10.0			11.2		-3 cm	-4 cm			
-2 cm		10.1			11.3		-2 cm	-3 cm			
-1 cm		9.4			8.1		-1 cm	-2 cm			
					9.4						

Patient: Benjamin, Victor Test Date: 10/27/2011

Waveforms: Page 4



GRAND STRAND
SPECIALTY ASSOCIATES

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☐ 4367 Riverwood Dr., Suite 120, Murrells Inlet, SC 29576 • (843) 357-8008
☐ 2876 Cypress Cr., Suite 200, Conway, SC 29526 • (843) 234-1710

Date Ordered: 10/27/11 Authorizing Signature: Stephen Victor

Patient: _____

Phone #: _____ Date of Birth: [redacted] Social Security #: [redacted]

Consult / Diagnosis Study (les): _____

Diagnosis code: _____ Diagnosis: Wt-St Sprain

Clinical Information: Dictated

Insurance Company: _____

Patient Preparation / Information: _____

Appointment: _____ Appointment Time: _____ Appointment Location: _____

(99)

p.1

Oct 28 11 08:10a

GRAND STRAND SPECIALTY ASSOCIATES

EPIDUAL STEROID INJECTION ORDER FORM
Grand Strand Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572
Phone: (843)449-2335 Fax: (843)692-2145

Date: 10/26/11
Location: ___ Grand Dunes Surgery Center Physician's Signature:
ICD-9: 722.81
CPT: ___ 62311 – Lumbar ESI ___ 62270 – Lumbar Puncture
___ 62310 – Cervical ESI ___ ___ Other: ___
___ First Epidural ___ Second Epidural ___ Third Epidural
Patient: Baker - Vick SS# ___ DOB: ___
Address: ___
Home Phone #: ___ Work Phone #: ___ Sex: ___M ___F

Primary Insurance Company: ___
Address: ___
Phone #: ___ Policy#: ___ Group#: ___
Policy Holder: ___ Phone#: ___
Policy Holder Address: ___
Relationship to Patient: ___ Self ___ Spouse ___ Child ___ Dependent
PRE-CERT NUMBER: ___

Secondary Insurance Company: ___
Address: ___
Phone #: ___ Policy#: ___ Group#: ___
Policy Holder: ___ Phone#: ___
Policy Holder Address: ___
Relationship to Patient: ___ Self ___ Spouse ___ Child ___ Dependent
PRE-CERT NUMBER: ___

WORKERS COMPENSATION
Insurance Company: ___
Address: ___
Phone #: ___ Claims#: ___
Adjuster: ___
PRE-CERT NUMBER if any: ___

****ATTACH COPY OF INSURANCE CARDS****
Date Scheduled: ___ Time Scheduled: ___ Scheduled By: ___
Surgery Center Notified: ___ Patient Notified: ___ By: ___

(100)



GRAND STRAND SPECIALTY ASSOCIATES

[redacted]

Victor Benjamin
DOB: [redacted]
Date: 11/21/2012
Level 3 New Patient

CHIEF COMPLAINT: Neck pain.

SUBJECTIVE: The patient is a 50-year-old male who injured himself at work a year and a half ago when a heavy object fell across his head and neck causing a skull fracture and apparently injuring his shoulder. He has had neck pain since with numbness, weakness, and tingling into the right arm and hand. No bowel or bladder dysfunction. He has been through a gamut of conservative measures. He has reportedly seen Dr. Poletti who has apparently suggested a posterior cervical decompression.

PAST MEDICAL HISTORY: Detailed in the patient database. We have reviewed it today and it is accurate.

PHYSICAL EXAMINATION:
VITAL SIGNS: Documented in the chart.

NEUROLOGIC EXAMINATION:
MENTAL STATUS: He is awake. He is alert. Speech is fluent. He appears cognitively intact.
CRANIAL NERVES: Cranial nerves II through XII are grossly intact.
MOTOR EXAM: He has some diffuse weakness in the right upper extremity.
SENSORY EXAM: Subjective light touch sensory loss in right upper extremity.
DTRs: Brisk and symmetrical.
CEREBELLAR EXAM: Finger-to-nose and rapid alternating movements are normal.
STATION/GAIT: Essentially normal.
MECHANICAL SPINE: Able to flex, extend, and laterally rotate.

X-RAY DATA: MRI scan shows narrowing of the spinal canal to a significant degree C3 through C6, worse at C4, C5, and C6. Has what appears to be a bony spur in the left neural foramen at C6-C7 with signal change at the cord at the C3-C4 level.

MEDICAL DECISION-MAKING: Cervical myelopathy with signal changes in the cord. Significant stenosis at multiple levels.

RECOMMENDATIONS: I think this patient should have a decompression and fusion. I will do this via anterior cervical discectomy and fusion at C3 through C6 and plating. I would like to get a CT scan to look little more closely at the bony anatomy. I will see him back afterwards.

Eugene Giddens, MD

EG/sss



GRAND STRAND
SPECIALTY ASSOCIATES

Orthopedic Surgery/Traumatology:
Christopher Bonfiglio, DO

Neurosurgery:
Thomas Anderson, MD
Eugene Gildene, MD

Neurology:
Jeff Benjamin, DO
Barbara Sarh, DO
Michael McCaffrey, MD

Neurology & Ophthalmology:
George Saniez, MD

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 01/04/2012 3:15 PM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 49 year old male presents with neck pain and head injury.

History of Present Illness
1. neck pain
Onset: gradual. The severity of the problem is moderate. The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There was radiation of pain to the right upper arm, right forearm and right interscapular. The patient describes the pain as aching and throbbing. The event(s) surrounding the occurrence of the symptom include injury. Aggravating factors include flexion, stooping, walking and working. Relieving factors tried include narcotic analgesics. Associated symptoms include difficulty sleeping, disequilibrium, muscle spasm, numbness and weakness. Pertinent negatives include bladder retention. Additional information: meds leave him drunk next morning.
2. head injury

Vital Signs

Physical Exam

Clinical Assessment
The patient is a 49-year old male who presents with neck pain and head injury. The patient is compliant with medication. Not responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan
Other and unspecified disc disorder of cervical re (722.91)
noted on mri and directly related to injury. Trial with esi if failure with next shot will set for surgical consult.
Intracranial injury of other and unspecified natur (854.01)
Continue with recomendation Dr Spring and Dr Goldschimdt. discussed with CNM.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agree with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
	Benjamin, Victor		

(1 [redacted]

completed	01/04/2012	Risks/ benefits of treatment plan
completed	01/04/2012	Activity as tolerated
completed	01/04/2012	Continue current medication

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
scheduled	Office visit	Discuss test results	722.91	-today	01/04/2012	
scheduled	Office visit	Continue current treatment	722.91	-today	01/04/2012	
scheduled	Office Visit	Follow-up on medication	722.91	-today	01/04/2012	
completed	Follow-up if symptoms persist / worsen		722.91	01/04/2012		
completed	Follow-up for increased symptoms		722.91	-today	01/04/2012	
completed	Follow-up for medication side effect		722.91	-today	01/04/2012	

George M. Sandoz MD

Document generated by: George Sandoz 01/04/2012

Grand Strand Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Benjamin, Victor (10[redacted]

GRAND STRAND
SPECIALTY ASSOCIATES

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Eugene Giddens, MD

Neurology:
Jeff Benjamin, DO
Barbara Sarb, DO
Michael Mccaffrey, MD

Neurology & Opthalmology:
George Sandez, MD

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 02/02/2012 8:30 AM
VISIT TYPE: Office Visit
HISTORIAN: self

Chief Complaint/Reason for visit:
This 49 year old male presents with dizziness and loss of consciousness.

History of Present Illness
1. dizziness
Onset was sudden. Severity is severe. The duration of each episode is Month(s). The problem is worsening. The patient describes it as (an) imbalance, severe and spinning. It occurs while. The patient has sustained a head injury in the past. Symptom is aggravated by turning. Relieving factors include position change. Associated symptoms include hearing loss, loss of consciousness, headache, neck stiffness, palpitations and tinnitus. Pertinent negatives include chest pain.
2. loss of consciousness
Onset: sudden. Severity: moderate. Duration: Minute(s). The problem is worse. The describes it as jerking movements. It occurred due to head trauma. Associated symptoms include vertigo. Pertinent negatives include bladder incontinence.

Vital Signs
Height

Time	Ft	In	Cm	Last Measured	Method	%
9:17 AM				09/16/2011		

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
9:17 AM	187.00						

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
9:17 AM	138/90	sitting				

Temp / Pulse / Respiration

Time	Temp F	Temp C	Temp Site	Pulse	Pattern	Resp
9:17 AM				60		

Measured By

Time	
9:17 AM	Katie Whittaker

Physical Exam
Constitutional:
Level of distress is moderate distress. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm
No lumbar spine tenderness. Normal mobility and curvature.
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.

Clinical Assessment
The patient is a 49-year old male who presents with dizziness and loss of consciousness. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan
Other and unspecified disc disorder of cervical re (722.91)
stressed need to take meds/esi to control his symptoms, stop tramadol due to n&v, trial with vicodin q 6 hrs and see response.
Dizziness and giddiness (780.4)
Etiology unclear, due to ptsd or cardiac in nature, trial with klonopin 1 mg qhs.
Alteration of consciousness, other (780.09)
Possible due to seizure, will check eeg and see if any paroxismal event.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	02/02/2012	Risks/ benefits of treatment plan	
completed	02/02/2012	Continue current medication	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
scheduled	EEG MONITORING/COMPUTER 24hr		780.09		02/13/2012	
completed	Follow-up for medication side effect		722.91	-today	02/02/2012	
scheduled	Office Visit	Follow-up on medication	722.91	-today	02/02/2012	02/02/2012
completed	Follow-up for increased symptoms		722.91	-today	02/02/2012	
scheduled	Office visit	Continue current treatment	722.91	-today	02/02/2012	
scheduled	Office visit	Discuss test results	722.91	-today	02/02/2012	02/02/2012
completed	Follow-up if symptoms persist / worsen		722.91	-today	02/02/2012	02/02/2012

George M. Sandoz MD

Document generated by: George Sandoz 02/09/2012

Benjamin, Victor [redacted]

CC Providers:
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Grand Strand Specialty Associates
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Barbara Scib, DO
Michael Mccaffrey, MD

Neurology & Ophthalmology:
George Sandoz, MD

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 02/06/2012 1:45 PM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 49 year old male presents with loss of consciousness.

History of Present Illness
1. loss of consciousness
Onset: sudden. Severity: moderate. Duration: Day(s). The patient describes it as crumpled to ground. It occurred due to head trauma. Pertinent negatives include bladder incontinence or neurological symptoms. Additional information: also since taking meds patient suffering ED.

Vital Signs

Physical Exam
Constitutional:
No acute distress. Well nourished. Well developed.
Musculoskeletal:
No cervical spine tenderness. Normal mobility and curvature.
No lumbar spine tenderness. Normal mobility and curvature.
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .

Clinical Assessment
The patient is a 49-year old male who presents with loss of consciousness. The patient is compliant with medication. Responding to current treatment. Needs some assistance with ADLs.

Assessment/ Plan
Intracranial injury of other and unspecified natur (854.01)
Continue with Vicodin 1/2 in am, noon and full at n[illegible] (108) ntinue with Klonopin 0.5 mg tid and for his ED trial

with Cialis 10 mg prn given, dis. d CNM.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	02/06/2012	Activity as tolerated	
completed	02/06/2012	Continue current medication	
completed	02/06/2012	Risks/ benefits of treatment plan	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
completed	Follow-up for increased symptoms		854.01	-today	02/06/2012	
completed	Follow-up if symptoms persist / worsen			854.01	02/06/2012	
scheduled	Office visit	Continue current treatment		854.01	-today	02/06/2012
scheduled	Office Visit	Follow-up on medication		854.01	-today	02/06/2012
completed	Follow-up for medication side effect		854.01	-today	02/06/2012	

George M. Sandoz MD

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Barbara Sarb, DO
Michael Mccaffrey, MD

Neurology & Ophthalmology:
George Sandez, MD

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 02/21/2012 3:30 PM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 49 year old male presents with loss of consciousness.

History of Present Illness
1. loss of consciousness
Onset: sudden. Severity: moderate. Duration: 1-4 minutes. The problem is unchanged. The patient describes it as staring. It occurred due to head trauma. Associated symptoms include neurological symptoms and performance changes. Pertinent negatives include bladder incontinence. Additional information: ED.

Vital Signs

Physical Exam
Constitutional:
No acute distress. Well nourished. Well developed.
Musculoskeletal:
No cervical spine tenderness. Normal mobility and curvature.
No lumbar spine tenderness. Normal mobility and curvature.
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .

Clinical Assessment
The patient is a 49-year old male who presents with loss of consciousness. The patient is compliant with medication. Not responding to current treatment.

Assessment/ Plan
Epilepsy, unspecified (345.90)
Noted on EEG trial withKeppra 500 mg bid, diectly re[illegible] (110) [redacted], ED still present last visit agreed upon intake of

meds still not given.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	02/21/2012	Activity as tolerated	
completed	02/21/2012	Handouts provided	
completed	02/21/2012	Potential for abuse	
completed	02/21/2012	Pain management	
completed	02/21/2012	Risks/ benefits of treatment plan	
completed	02/21/2012	Continue current medication	
completed	02/21/2012	Reviewed medications	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
completed	Follow-up if symptoms persist / worsen			345.90	02/21/2012	
completed	Follow-up for medication side effect		345.90	-today	02/21/2012	
scheduled	Office Visit	Follow-up on medication	345.90	-today	02/21/2012	02/21/2012
completed	Follow-up for increased symptoms		345.90	-today	02/21/2012	
scheduled	Office visit	Continue current treatment	345.90	-today		02/21/2012

George M. Sandoz MD

Document generated by: George Sandoz 02/21/2012

Grand Strand Specialty Associates
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Eugene Giddens, MD

Neurology:
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Barbara Sorly, DO
Michael Mccaffrey, MD

Neurology & Opthalmology:
George Sandor, MD

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 04/25/2012 11:45 AM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 50 year old male presents with seizure, follow up, headache and neck pain.

History of Present Illness
1. seizure, follow up
Date of last seizure was 02/2012. Date of last EEG was 02/22/2012. The type of seizure is Focal with secondary generalization. The context of the seizure includes TBI. Medication(s) used locosamide with good results; he is compliant with medication; there are no side effects of medication. Symptom is aggravated by and lack of sleep. Associated symptoms include altered level of consciousness and staring. Additional information: He is not driving.
2. headache
Onset: sudden. Severity: moderate. It occurs daily, has Month(s) duration, and is worse. Location was entire head. The patient describes it as sharp and throbbing. Timing of headache: daytime. Symptom is aggravated by bright lights and noise. Relieving factors include prescription drugs. Associated symptoms include LOC and neurological symptoms. Pertinent negatives include dizziness.
3. neck pain
Onset: sudden. The severity of the problem is moderate. The problem has improved. The frequency of pain is intermittent. Location of pain is bilateral posterior neck. There was radiation of pain to the bilateral upper arm. The patient describes the pain as aching and burning. The event(s) surrounding the occurrence of the symptom include being hit in the head witha metal object. Relieving factors tried include injection and narcotic analgesics. Associated symptoms include difficulty sleeping and muscle spasm. Pertinent negatives include bladder retention. Additional information: ed.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Vimpat every day	100 Mg	60	take 1 tablet (100MG) by oral route 2 times
Vimpat every day	50 Mg	60	take 1 tablet (50MG) by oral route 2 times

Vital Signs

Physical Exam
Constitutional:
Level of distress is mild distress. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm
No lumbar spine tenderness. Normal mobility and curvature.

Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .
Comments: +tinnels

Clinical Assessment
The patient is a 50-year old male who presents with seizure, follow up, headache and neck pain. The patient is compliant with medication. Responding to current treatment. Needs some assistance with ADLs.

Assessment/ Plan
Epilepsy, unspecified, without mention of intracta (345.90)
Other and unspecified disc disorder of cervical re (722.91)
Intracranial injury of other and unspecified natur (854.01)
Migraine, variants (346.20)
Carpal tunnel syndrome (354.0)
Continue with Vimpat 100 mg bid, tolerating est well, doing well with current management, treatment with botox for migraine is indicated, awaiting input by Dr Welsch for cts. Discussed with CNM.

George M. Sandoz MD

Document generated by: George Sandoz 04/25/2012

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Grand Strand Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Grand Strand Regional Medical Center
Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 06/07/2012 8:15 AM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 50 year old male presents with seizure, follow up and headache.

History of Present Illness
1. seizure, follow up
Date of last seizure was 02/19/2012. Date of last EEG was 02/22/2012. The type of seizure is Focal with secondary generalization. The context of the seizure includes TBI. Medication(s) used Levetiracetam with good results. Symptom is aggravated by and lack of sleep. Associated symptoms include automatic behaviors and unresponsiveness. Additional information: He is not driving.
2. headache
Onset: sudden. Severity: moderate. It occurs daily, has Month(s) duration, and is unchanged. Location was occipital. There was radiation to anterior. The patient describes it as blinding and throbbing. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by bright lights, head position and noise. Relieving factors include prescription drugs. Associated symptoms include neurological symptoms and stiff neck.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Ultracet as needed, for up to 5 days; do not exceed 8 tablets in 24hrs	37.5-325mg	60	take 2 tablet by oral route every 4 - 6 hours
Fioricet needed not to exceed 6 tablets per 24hrs	50-325-40	60	take 1 tablet by oral route every 4 hours as
Vimpat every day	100 Mg	60	take 1 tablet (100MG) by oral route 2 times
Vimpat every day	50 Mg	60	take 1 tablet (50MG) by oral route 2 times

Vital Signs

Physical Exam
Constitutional:
Level of distress is moderate distress. Well nourished. Well developed.
Musculoskeletal:
No cervical spine tenderness. Normal mobility and curvature.
No lumbar spine tenderness. Normal mobility and curvature.
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .

Coordination: Coordination inac... .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.

Clinical Assessment
The patient is a 50-year old male who presents with seizure, follow up and headache. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan
CH MGR WO ARA W NT WO ST (346.71)
Doing better after botox, will continue with meds.
Epilepsy, unspecified, without mention of intracta (345.90)
Tolerating meds, issue with concentration and performing complex task, continue with keppra, ED treated with meds, cpm.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	06/19/2012	Reviewed medications	
completed	06/19/2012	Avoid driving	
completed	06/19/2012	Continue current medication	
completed	06/19/2012	Avoid high risk activity due to seizures/LOC	
completed	06/19/2012	Risks of declining treatment	
completed	06/19/2012	Activity as tolerated	

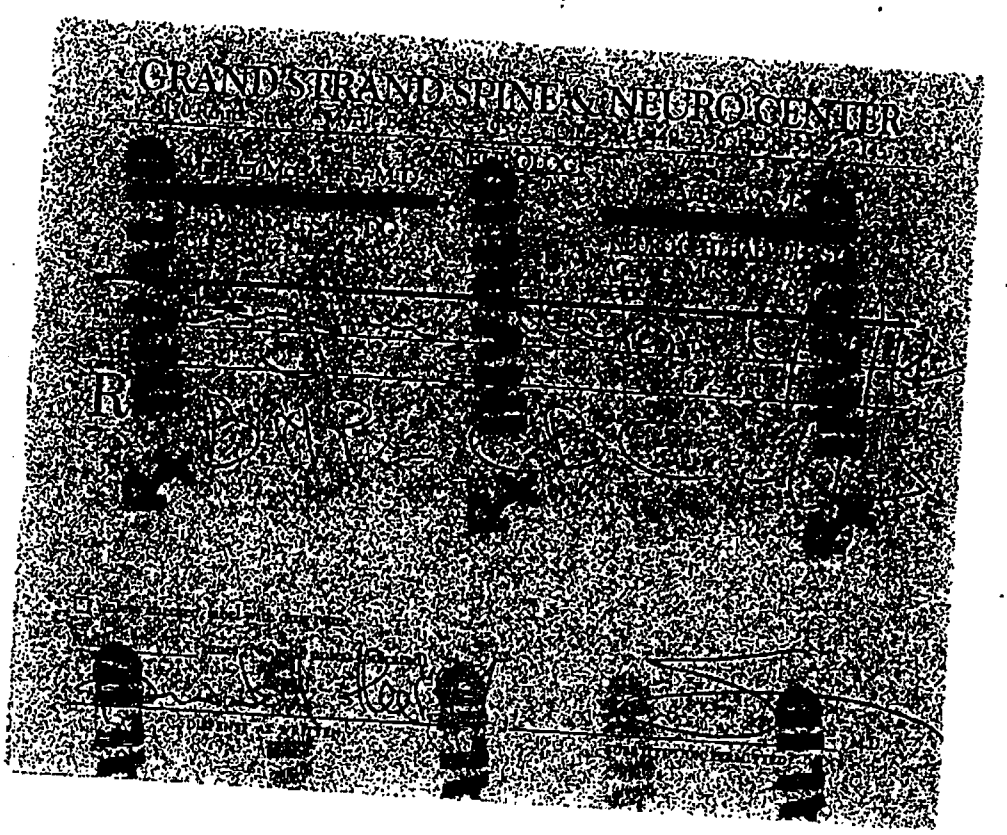
To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
scheduled	Office visit	Continue current treatment	346.71	-today	06/19/2012	
completed	Follow-up for medication side effect		346.71	-today	06/19/2012	
completed	Follow-up if symptoms persist / worsen			346.71	06/19/2012	
scheduled	Office Visit	Follow-up on medication		346.71	-today	06/19/2012
completed	Follow-up for increased symptoms		346.71	-today	06/19/2012	

George M. Sandoz MD

Document generated by: George Sandoz 06/19/2012

Grand Strand Spine & Neuro
8170 Rourk Street, Myrtle Beach, SC 29572
Phone: (843) 449-2336
Fax: (843) 497-2505


GRAND STRAND SPINE & NEURO CENTER

Grand Strand Regional Medical Center
Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 06/20/2012 11:45 AM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 50 year old male presents with head injury.

History of Present Illness
1. head injury
Onset: sudden. The symptoms have not changed. The location of pain is head. The mechanical force causing the injury was coup. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include exertion, light and touch. Associated symptoms include clumsiness, headache, irritability, memory difficulty, restlessness, seizure, stiff neck, vomiting and dizziness.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Ultracet	37.5-325mg	60	take 2 tablet by oral route every 4 - 6 hours as needed, for up to 5 days; do not exceed 8 tablets in 24hrs
Fioricet	50-325-40	60	take 1 tablet by oral route every 4 hours as needed not to exceed 6 tablets per 24hrs
Vimpat	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every day
Vimpat	50 Mg	60	take 1 tablet (50MG) by oral route 2 times every day

Vital Signs

Physical Exam
Constitutional:
Level of distress is moderate distress. Well nourished, Well developed.
Vascular:
Bruits
Carotid bruits: absent.
Musculoskeletal:
Cervical spine has muscle spasm
No lumbar spine tenderness. Normal mobility and curvature.
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3, Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Trigeminal:
Motor and Reflexes: normal.
Facial: normal.
Acoustic: Weber test abnormal, lateralizes to the left
Glossopharyngeal: normal.

Vagus: normal.
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .
Brudzinski's sign: Negative.

Clinical Assessment
The patient is a 50-year old male who presents with head injury. The patient is compliant with medication. Responding to current treatment. Needs some assistance with ADLs.

Assessment/ Plan
Late effect of intracranial injury without mention (907.0)
Continue with current management of migraine, dizziness, neck pain, ED, directly associated with mva.

Epilepsy, unspecified, without mention of intracta (345.90)
Six months since last event and remains seizure free, will restore his driving privilges as today, stressed compliance and continue with Keppra 500 mg bid.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	06/22/2012	Risks/ benefits of treatment plan	
completed	06/22/2012	Reviewed medications	
completed	06/22/2012	Activity as tolerated	
completed	06/22/2012	Continue current medication	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
completed	Follow-up if symptoms persist / worsen			907.0	06/22/2012	
scheduled	Office Visit	Follow-up on medication		907.0	-today	06/22/2012
scheduled	Office visit	Continue current treatment		907.0	-today	06/22/2012
completed	Follow-up for medication side effect		907.0	-today	06/22/2012	
completed	Follow-up for increased symptoms		907.0	-today	06/22/2012	

George M. Sandoz MD

Document generated by: George Sandoz 06/22/2012

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Phone: (843) 449-2336
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Grand Strand Regional Medical Center
Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 09/26/2012 9:30 AM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 50 year old male presents with migraine, head injury and neck pain.

History of Present Illness
1. migraine
Onset: sudden. Severity: moderate. Duration: Month(s). The patient describes it as superficial. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by bright lights, head position and noise. Relieving factors include prescription drugs. Associated symptoms include dizziness, head trauma, memory loss, neurological symptoms, performance changes, scintillations, stiff neck and vertigo.
2. head injury
Onset: sudden. The severity of the symptoms is moderate. The location of the injury is in the bilateral temporal region. The location of pain is head and neck. The mechanical force causing the injury was coup. Context includes metal hit him on the the head. The patient does not use alcohol. The patient does not use drugs. Associated symptoms include bruising around eye(s), headache, loss of consciousness, memory difficulty, restlessness, seizure, stiff neck and unusual behavior.
3. neck pain
Onset: sudden. The problem is severe. Duration: Month(s). The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There was radiation of pain to the left upper arm. The patient describes the pain as aching and burning. The event(s) surrounding the occurrence of the symptom include injury. Aggravating factors include prolonged sitting, pushing, rotation, straining, stress, walking and working. Relieving factors tried include muscle relaxation techniques and narcotic analgesics. Associated symptoms include difficulty sleeping, disequilibrium, numbness and tenderness. Pertinent negatives include bladder retention. Additional information: worsen after pt.

Social History
Primary language is English.
Tobacco:
Smoking status: Never smoker.

Use Status	Total Pk Yrs	Type	Per Day	Years Used	Pack Years	Year Quit
never						

Tried To Quit	Longest Tob Free	Relapse Reason	Passive Exposure
			no

Alcohol:
There is no history of alcohol use.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Ultracet	37.5-325mg	60	take 2 tablet by oral route every 4 - 6 hours as needed, for up to 5 days; do not exceed 8 tablets in 24hrs
Fioricet	50-325-40	60	take 1 tablet by oral route every 4 hours as

Vimpat every day	100 Mg	60		take 1 tablet (100MG) by oral route 2 times
Vimpat every day	60 Mg	60		take 1 tablet (50MG) by oral route 2 times

Vital Signs

Height

Time	ft	in	cm	Last Measured	Method	%
10:06 AM	6.0			09/16/2011		

Weight / BSA / BMI

Time	lb	oz	kg	Context	%	BMI kg/m2	BSA m2
10:06 AM	185.00					25.09	

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
10:06 AM	136/88	sitting				

Measured By

Time	
10:06 AM	Penny Powers

{sub_vs_condense: NOT FOUND}

Physical Exam

Constitutional:
No acute distress. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderately reduced ROM
No lumbar spine tenderness. Normal mobility and curvature.
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Optic Nerve: Optic normal.
Oculomotor: normal.
Trochlear: normal.
Abducens: normal.
Trigeminal:
Motor and Reflexes: normal.
Facial: normal.
Acoustic: normal.
Glossopharyngeal: normal.
Vagus: normal.
Spinal Accessory: normal.
Hypoglossal: normal.
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .

Clinical Assessment

The patient is a 50-year old male s/p head injury with after effect from it..

Assessment/ Plan

CH MGR WO ARA W NT WO ST (346.71)
Tolerating Vimpat well, no new seizure, headache controled with meds needs to take on a regular basis, consider use of Botox, dizziness persistent will consult ent, neck worsen, will repeat mri cervical spine and most likely is progression mof disease and might require surgical intervention, symptoms are controled with meds, still far from

Benjamin, Victor (120) [redacted]

going back to work to a gainful . oyment at the level that he was.
Intracranial injury of other and unspecified natur (854.01)
Late effect of intracranial injury without mention (907.0)
Dizziness (780.4)
Other and unspecified disc disorder of cervical re (722.91)
Tolerating Vimpat well, no new seizure, headache controled with meds needs to take on a regular basis, consider use of Botox, dizziness persistent will consult ent, neck worsen, will repeat mri cervical spine and most likely is progression mof disease and might require surgical intervention, symptoms are controled with meds, still far from going back to work to a gainfull employment at the level that he was.

Medications (added or continued this visit)

Drug Name	Dose	Qty	Description
Ultracet	37.5-325mg	60	take 2 tablet by oral route every 4 - 6 hours as needed, for up to 5 days; do not exceed 8 tablets in 24hrs
Fioricet	50-325-40	60	take 1 tablet by oral route every 4 hours as needed not to exceed 6 tablets per 24hrs
Vimpat	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every day
Vimpat	50 Mg	60	take 1 tablet (50MG) by oral route 2 times every day

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	09/26/2012	Continue current medication	
completed	09/26/2012	Activity as tolerated	
completed	09/26/2012	Reviewed medications	
completed	09/26/2012	Risks/ benefits of treatment plan	
completed	09/26/2012	Potential for abuse	

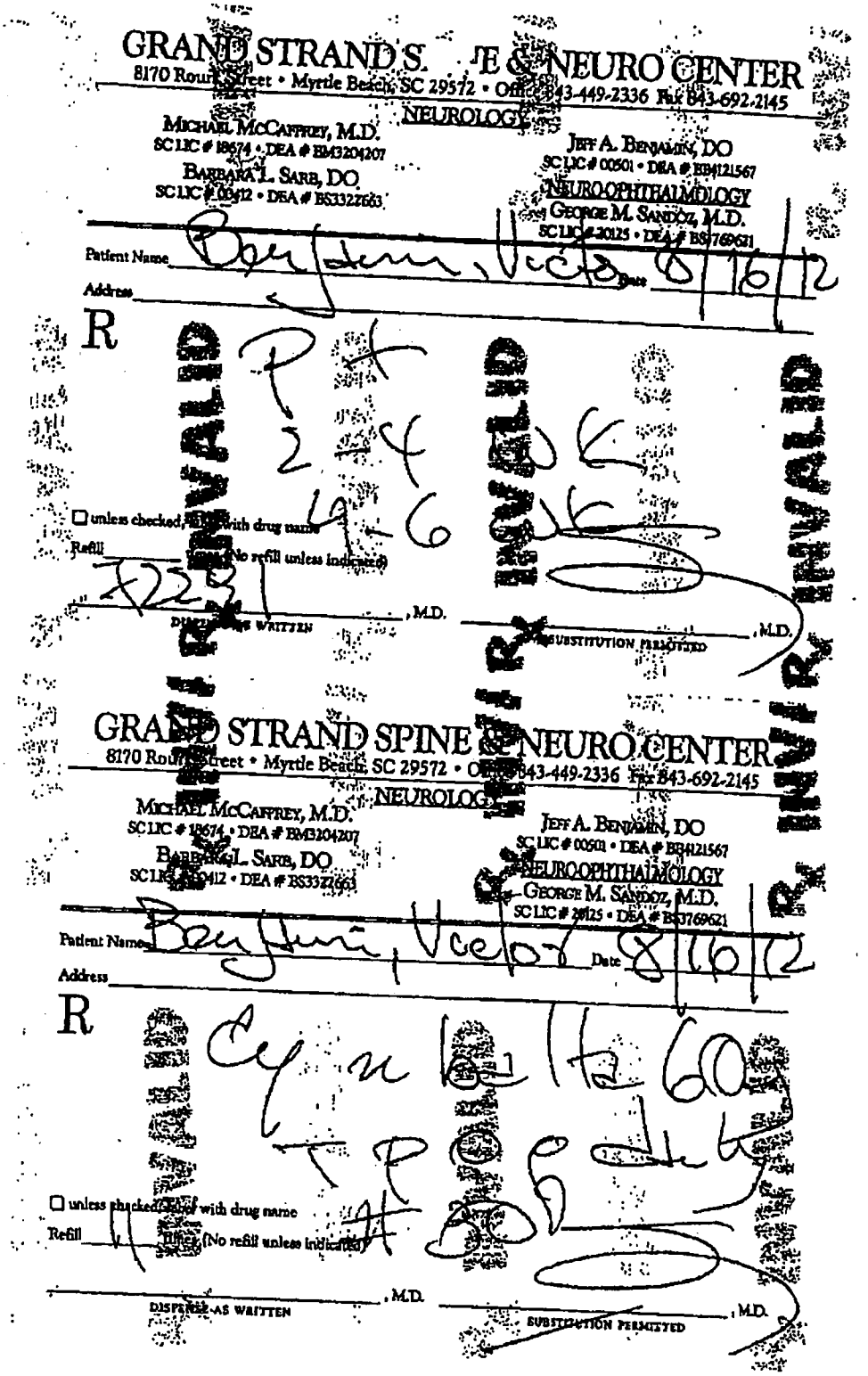
To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment
completed	Follow-up for increased symptoms		346.71	-today	09/26/2012
scheduled	Office visit	Continue current treatment	346.71	-today	09/26/2012
scheduled	Office visit	Discuss test results	346.71	-today	09/26/2012
completed	Follow-up for medication side effect		346.71	09/26/2012	09/26/2012
completed	Follow-up if symptoms persist / worsen			346.71	
scheduled	Office Visit	Follow-up on medication	346.71	346.71	-today 09/26/2012
ordered	MRI C- SPINE W/O DYE		346.71		09/26/2012
ordered	MRI C- SPINE W/O DYE		722.91		09/26/2012

Document generated by: George Sandoz 09/26/2012

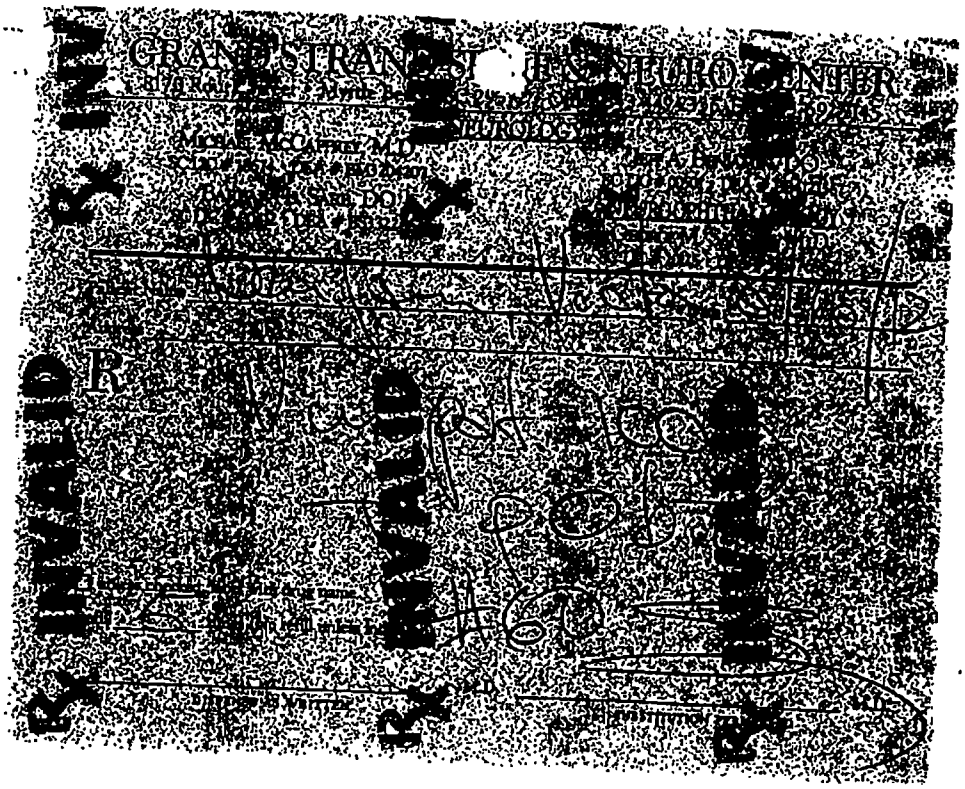
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8170 Rourk Street, Myrtle Beach, SC 29572
Phone: (843) 449-2336
Fax: (843) 497-2505



GRAND STRAND S[illegible]E & NEURO CENTER
8170 Rou[illegible]treet • Myrtle Beach, SC 29572 • Off[illegible]843-449-2336 Fax 843-692-2145
NEUROLOGY
MICHAEL MCCAFFREY, M.D.
SC LIC # 19674 • DEA # BM3204207
BARBARA L. SARB, DO
SC LIC # 00412 • DEA # BS3322663
JEFF A. BENJAMIN, DO
SC LIC # 00501 • DEA # BB4121567
NEURO-OPHTHALMOLOGY
GEORGE M. SANDOZ, M.D.
SC LIC # 20125 • DEA # BS3769621
Patient Name Benjamin, Victor Date 8/16/12
Address
R
unless checked, dispense with drug name
Refill Times (No refill unless indicated)
DISPENSE AS WRITTEN M.D.
SUBSTITUTION PERMITTED M.D.
INVALID Rx

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NEUROLOGY
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INVALID Rx



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805 South Irby Street
Florence, SC 29501
(843) 292-0400 - fax (843) 292-0470

PATIENT: Benjamin, Victor
DOB: [redacted]
MRN: [redacted]
PATIENT PHONE: 803-428-3352
PHYSICIAN: George Sandoz, MD
DATE: 10/15/2012

EXAM: MRI CERVICAL SPINE WITHOUT CONTRAST

HISTORY: 722.91-right sided neck pain. Right arm pain and tingling. Dizziness. Job injury 06/15/12.

COMPARISON STUDIES: Comparison made to 10/10/12.

TECHNIQUE: Sagittal T2 and FS-T2. Axial T2*-GRE and T2-FSE. Coronal T1.

FINDINGS: Polyps are present within the right maxillary sinus. Ethmoid sinus disease is also present. Mild thickening of the mucosa along the floor of the right maxillary sinus. Unremarkable paramidline brainstem and cerebellum.

Again seen is a developmentally small spinal canal. Decreased cord volume from C3 to C6-7. Mild increased signal within the left side of the cervical cord at C3-4.

C3-4: Moderate anterior endplate osteophytes. Mild annular bulge and moderate-sized Luschka joint osteophytes with narrowed C-4 neural foramina.

C4-5: Mild annular bulge with small endplate osteophytes. Small-moderate sized Luschka joint osteophytes with narrowed C-5 neural foramina, right greater than left.

C5-6: Mild degeneration of the disc and disc bulge. Small endplate osteophytes. Moderate right and small left-sided Luschka joint osteophytes.

C6-7: Severe narrowing of the left C-7 neural foramen secondary to large Luschka joint osteophytes. Mass effect on the extreme left lateral thecal sac anteriorly.

C7-T1 through T2-3: No disc displacements.

No facet arthritis. Mild edema of the endplates at C3-4 through C6-7.

IMPRESSION:
1. Cord compressive effects at C3-4 and C5-6 in particular. Bilateral C4 through C6 foraminal stenoses. Severe left C-7 bony neural foraminal stenosis.
2. Discogenic edema of the endplates at C3-4 through C6-7. Myelomalacia of the cervical cord at C3-4.
3. Again seen are left maxillary mucous retention cysts with some very mild interval improvement.

Patient: Benjamin, Victor
MRN: [redacted]
Exam: MRI CERVICAL SPINE WITHOUT CONTRAST

Thank you for this consultation.

Jeff Shramek, MD
JS / bl

DD: 10/15/2012
DT: 10/16/2012
Job: 16015130

This document has been electronically reviewed and signed.

Jeffrey K. Shramek, MD.
Neuroradiologist

Grand Strand Regional Medical Center
Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 10/23/2012 8:00 AM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 50 year old male presents with neck pain.

History of Present Illness
1. neck pain
Onset: sudden. The problem is severe. The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There was radiation of pain to the bilateral upper arm. The patient describes the pain as aching and throbbing. The event(s) surrounding the occurrence of the symptom include motor vehicle accident. Aggravating factors include Valsalva and working. Relieving factors tried include narcotic analgesics. Associated symptoms include difficulty sleeping, muscle spasm, numbness and tenderness. Pertinent negatives include bladder retention.

Social History
Reviewed, no changes. Last detailed document date: 09/26/2012.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Ultracet	37.5 Mg-325 Mg	60	take 2 tablet by oral route every 4 - 6 hours as needed, for up to 5 days; do not exceed 8 tablets in 24hrs
Floricet	50 Mg-325 Mg-40 Mg	60	take 1 tablet by oral route every 4 hours as needed not to exceed 6 tablets per 24hrs
Vimpat	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every day
Vimpat	50 Mg	60	take 1 tablet (50MG) by oral route 2 times every day

Allergies
New allergies added during this encounter. Active list below.

Allergen/Ingredient	Brand	Reaction:
Meperidine Hcl		

Vital Signs
Height

Time	ft	in	cm	Last Measured	Method	%
9:23 AM	6.0			09/16/2011		

Weight / BSA / BMI

Time	lb	oz	kg	Context	%	BMI kg/m2	BSA m2
9:23 AM	188.00					25.49	

Blood Pressure

Benjamin, Victor (126) [redacted]

Time	BP mm/Hg	Position	Site	Method	Cuff Size
9:23 AM	140/78	sitting			

Measured By
Time
9:23 AM Penny Powers

{sub_vs_condense: NOT FOUND}

Physical Exam
Constitutional:
Level of distress is moderate distress. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderate pain w/motion
Lumbar spine has muscle spasm
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Optic Nerve: Optic normal.
Trigeminal:
Motor and Reflexes: normal.
Facial: normal.
Acoustic: Weber test abnormal, lateralizes to the left
Glossopharyngeal: normal.
Vagus: normal.
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .

Clinical Assessment
The patient is a 50-year old male who presents with neck pain. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan
Other and unspecified disc disorder of cervical re (722.91)
Worsen since last visit, due to changes from work related injury, will need surgery, continue with meds, referral sent.

Medications (added or continued this visit)

Drug Name	Dose	Qty	Description
Ultracet	37.5 Mg-325 Mg	60	take 2 tablet by oral route every 4 - 6 hours as needed, for up to 5 days; do not exceed 8 tablets in 24hrs
Fioricet	50 Mg-325 Mg-40 Mg	60	take 1 tablet by oral route every 4 hours as needed not to exceed 6 tablets per 24hrs
Vimpat	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every day
Vimpat	50 Mg	60	take 1 tablet (50MG) by oral route 2 times every day

Office Services

Status	Order	Reason	Interpretation	Value
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	10/23/2012	Reviewed medications	
completed	10/23/2012	Risks/ benefits of treatment plan	
completed	10/23/2012	Activity as tolerated	
completed	10/23/2012	Continue current medication	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment
completed	Follow-up if symptoms persist / worsen		723.1		10/23/2012
scheduled	Office Visit	Follow-up on medication	723.1	-today	10/23/2012
scheduled	Office visit	Continue current treatment	723.1	-today	10/23/2012
scheduled	Office visit	Follow-up visit	723.1	10/23/2012	
completed	Follow-up for medication side effect		723.1	-today	10/23/2012
completed	Follow-up for increased symptoms		723.1	-today	10/23/2012

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Grand Strand Spine & Neuro
8170 Rourk Street, Myrtle Beach, SC 29572
Phone: (843) 449-2336
Fax: (843) 497-2505

Grand Strand Regional Medical Center
Spine & Neuro Center

Re: Victor Benjamin
DOB: [redacted]
Age:
Gender: male

Dear Colleague,

Victor Benjamin was seen in our office on October 23, 2012 for cervical disc disorder and is being referred to Southeastern Spine Institute. Please note our observations and findings below.

Results of these tests will be forwarded to your office as completed.

Thank you for your willingness to accept this patient. Please feel free to contact our office with any questions.

Sincerely,

George M. Sandoz MD

Grand Strand Spine & Neuro
8170 Rourk Street, Myrtle Beach, SC 29572
Phone: (843) 449-2336
Fax: (843) 497-2505

Grand Strand Regional Medical Center
Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 02/05/2013 11:45 AM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 50 year old male presents with neck pain and headache.

History of Present Illness
1. neck pain
Onset: sudden. The severity of the problem is incapacitating. The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There was radiation of pain to the bilateral upper arm. The patient describes the pain as aching and burning. The event(s) surrounding the occurrence of the symptom include injury. Aggravating factors include exertion, flexion, walking and working. Relieving factors tried include muscle relaxation techniques and narcotic analgesics. Associated symptoms include muscle spasm, numbness and sexual dysfunction. Pertinent negatives include bladder retention or disequilibrium.
2. headache
Onset: sudden. Severity: moderate. It occurs daily. Duration: Year(s). Location was occipital. There was radiation to anterior. The patient describes it as blinding, sharp and squeezing. It occurred due to recent head trauma. Symptom is aggravated by head position and noise. Relieving factors include prescription drugs. Associated symptoms include dizziness, memory loss, neurological symptoms, performance changes and stiff neck.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Ultracet	37.5 Mg-325 Mg	60	take 2 tablet by oral route every 4 - 6 hours as needed, for up to 5 days; do not exceed 8 tablets in 24hrs
Flonet	50 Mg-325 Mg-40 Mg	60	take 1 tablet by oral route every 4 hours as needed not to exceed 6 tablets per 24hrs
Vimpat every day	100 Mg	60	take 1 tablet (100MG) by oral route 2 times
Vimpat every day	50 Mg	60	take 1 tablet (50MG) by oral route 2 times

Allergies

Allergen/Ingredient	Brand	Reaction:
Meperidine Hcl		

Vital Signs
{sub_vs_condense: NOT FOUND}

Physical Exam
Constitutional:
Level of distress is moderate distress. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderate pain w/motion

No lumbar spine tenderness, [illegible], mobility and curvature.
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Sensory: decrease pp rue.
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.

Clinical Assessment
The patient is a 50-year old male who presents with neck pain and headache. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan
Cervical disc displacement w/o myelopathy (722.0)
For surgery 1-18-13.
CHR POST-TRAUMA HEADACHE (339.22)
Tolerating Ultracet qid, no relief after botox
Late effect of intracranial injury without mention (907.0)
Continue with Vimpat for seizure after TBI, stop tizanadine and Xanax, trial with Restoril 30 mg q hs, discussed CNM.

Medications (added or continued this visit)

Drug Name	Dose	Qty	Description
Ultracet	37.5 Mg-325 Mg	60	take 2 tablet by oral route every 4 - 6 hours as needed, for up to 5 days; do not exceed 8 tablets in 24hrs
Fioricet	50 Mg-325 Mg-40 Mg	60	take 1 tablet by oral route every 4 hours as needed not to exceed 6 tablets per 24hrs
Vimpat	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every day
Vimpat	50 Mg	60	take 1 tablet (50MG) by oral route 2 times every day

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	02/05/2013	Continue current medication	
completed	02/05/2013	Activity as tolerated	
completed	02/05/2013	Risks/ benefits of treatment plan	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment
completed	Follow-up if symptoms persist / worsen		722.0	722.0	02/05/2013
completed	Follow-up for medication side effect		722.0	-today	02/05/2013
scheduled	Office Visit	Follow-up on medication	722.0	722.0	-today 02/05/2013
completed	Follow-up for increased symptoms		722.0	-today	02/05/2013
scheduled	Office visit	Continue current treatment	722.0	-today	02/05/2013

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Phone: (843) 449-2336
Fax: (843) 497-2505

Grand Strand Regional Medical Center
Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 06/20/2013 8:45 AM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 51 year old male presents with headache, neck pain and head injury.

History of Present Illness
1. headache
Onset: sudden. Severity: moderate-severe. It occurs daily, has Year(s) duration, and is worse. Location was frontal right, ocular right and occipital. There was radiation to anterior. The patient describes it as pressure and throbbing. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by head position, noise and stress. Denies relieving factors. Associated symptoms include blurred vision, dizziness and head trauma.
2. neck pain
Onset: sudden. The severity of the problem is moderate. The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There was radiation of pain to the bilateral upper arm. The patient describes the pain as aching, burning and throbbing. The event(s) surrounding the occurrence of the symptom include axial loading. Aggravating factors include exertion, flexion, hyperextension, walking and working. Relieving factors tried include narcotic analgesics. Associated symptoms include difficulty sleeping, muscle spasm, sexual dysfunction not spinal related and tenderness. Pertinent negatives include bladder retention. Additional information: worsen and no relief of pain.
3. head injury
Onset: sudden. The severity of the symptoms is incapacitating. The symptoms have worsened. The location of the injury is in the bilateral frontal region. The location of pain is facial, head and neck. The mechanical force causing the injury was coup. Context includes metal object hit him in the head. The patient does not use alcohol. The patient does not use drugs. Denies relieving factors. Associated symptoms include clumsiness, gait disturbance, headache, incoordination, irritability, memory difficulty, nausea, personality change, restlessness, seizure, stiff neck and unusual behavior.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Lidoderm every day (May wear up to 12hours.)	5 % (700 Mg/patch)	30	apply 1 patch by transdermal route
Klonopin evening	1 Mg	60	take 1 - 2 Tablet (1MG) by oral route every
Restoril day at bedtime as needed	30 Mg	30	take 1 capsule (30MG) by oral route every
Vimpat every day	50 Mg	60	take 1 tablet (50MG) by oral route 2 times

Medication list reviewed

Allergies
Reviewed, no changes.

Allergen/Ingredient	Brand	Reaction:
Meperidine Hcl		

Vital Signs

Height

Time	ft	in	cm	Last Measured	Method	%
8:38 AM	6.0			09/16/2011		0

Weight / BSA / BMI

Time	lb	oz	kg	Context	%	BMI kg/m2	BSA m2
8:38 AM	183.00			dressed with shoes	0	24.82	

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
8:38 AM	163/97	sitting	left	brachial	manual	adult

Temp / Pulse / Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/min
8:38 AM				62		

Measured By

Time	
8:38 AM	Jaleesa Grant

{sub_vs_condense: NOT FOUND}

Physical Exam

Constitutional:
Level of distress is moderate distress, irritable, in pain. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm
No lumbar spine tenderness. Normal mobility and curvature.
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Facial: normal.
Acoustic: Weber test abnormal, lateralizes to the right
Glossopharyngeal: normal.
Vagus: normal.
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: using cane.
Coordination: Coordination intact. .
Fine Motor: inaccurate movements.
Deep Tendon Reflexes: symmetrically decreased.
Comments: frontal release sign, mms 28/30

Clinical Assessment

The patient is a 51-year old male who presents with headache, neck pain and head injury. The patient is compliant with medication. Not responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan

Cervical disc displacement w/o myelopathy (722.0)
CHR POST-TRAUMA HEADACHE (339.22)
Epilepsy, unspecified (345.90)
Subjective tinnitus (388.31)
Intracranial injury of other and unspecified natur (854.01)
Late effect of intracranial injury without mention (907.0)
S/p injury when a metal cover hit him in the head, s/p cervical surgery due to cervical dd worsen symptoms and no resolution of pain, new mri and evoked response order, injury cause epilepsy tolerating Vimpat 100 mg bid well no new event for mre than 6 months and reinstated driving priviliges, awaiting input by ENT for tinnitus continue with

Benjamin, Victor

Epilepsy, unspecified (345.9.
Subjective tinnitus (388.31)
Intracranial injury of other and unspecified natur (854.01)
Late effect of intracranial injury without mention (907.0)
S/p injury when a metal cover hit him in the head, s/p cervical surgery due to cervical dd worsen symptoms and no resolution of pain, new mri and evoked response order, injury cause epilepsy tolerating Vimpat 100 mg bid well no new event for mre than 6 months and reinstated driving privilges, awaiting input by ENT for tinnitus continue with psychiatic support for issue from TBI, lost income and anxiety/anger/frontal release issue, trial with Vibryd with starter pack then 40 mg daily, 3 months follow up for pain control and other after testing schedule.

Medications (added or continued this visit)

Drug Name	Dose	Qty	Description
Vimpat	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every day
Vibryd	40 Mg	30	take 1 tablet (40MG) by oral route every day with food
Lorcet 10-650	10 Mg-650 Mg	120	take 1 tablet by oral route every 6 hours as needed for pain
Lorcet 10-650	10 Mg-650 Mg	120	take 1 tablet by oral route every 4 - 6 hours as needed for pain
Vibryd	10 Mg (7)-20 Mg (7)-40 Mg (16)	1	
Lidoderm	5 % (700 Mg/patch)	30	apply 1 patch by transdermal route every day (May wear up to 12hours.)
Klonopin	1 Mg	60	take 1 - 2 Tablet (1MG) by oral route every evening
Restoril	30 Mg	30	take 1 capsule (30MG) by oral route every day at bedtime as needed
Vimpat	50 Mg	60	take 1 tablet (50MG) by oral route 2 times every day

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	06/20/2013	Risks/ benefits of treatment plan	
completed	06/20/2013	Reviewed medications	
completed	06/20/2013	Continue current medication	
completed	06/20/2013	Activity as tolerated	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
scheduled	Office visit	Discuss test results	722.0	-today	06/20/2013	
completed	Follow-up for medication side effect		722.0	-today	06/20/2013	
scheduled	Office visit	Follow-up on medication	722.0	-today	06/20/2013	
scheduled	Office visit	Continue current treatment	722.0	-today	06/20/2013	
completed	Follow-up for increased symptoms		722.0	-today	06/20/2013	
completed	Follow-up if symptoms persist / worsen			722.0	06/20/2013	
ordered	SOMATOSENSORY TESTING		722.0		06/20/2013	
ordered	MRI C-SPINE W/O & W/DYE		722.0		06/20/2013	

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8170 Rourk Street, Myrtle Beach, SC 29572
Phone: (843) 449-2336
Fax: (843) 497-2505

Benjamin, Victor [redacted]

Grand Strand Regional Medical Center
Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 09/10/2013 1:00 PM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 51 year old male presents with neck pain.

History of Present Illness
1. neck pain

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Vimpat every day	100 Mg	60	take 1 tablet (100MG) by oral route 2 times
Viibryd day with food	40 Mg	30	take 1 tablet (40MG) by oral route every
Lorcet 10-650 needed for pain	10 Mg-650 Mg	120	take 1 tablet by oral route every 6 hours as
Lidoderm every day (May wear up to 12hours.)	5 % (700 Mg/patch)		30 apply 1 patch by transdermal route
Klonopin evening	1 Mg	60	take 1 - 2 Tablet (1MG) by oral route every
Restoril day at bedtime as needed	30 Mg	30	take 1 capsule (30MG) by oral route every

Allergies

Allergen/Ingredient	Brand	Reaction:
Meperidine Hcl		

Vital Signs
{sub_vs_condense: NOT FOUND}

Physical Exam

Clinical Assessment
The patient is a 51-year old male who presents with neck pain.

Assessment/ Plan
Cervical disc displacement w/o myelopathy (722.0)
S/p emg with evidence of cervical disc disease, will need to undergo esi cervical spine.

Medications (added or continued this visit)

Drug Name	Dose	Qty	Description
Lorcet 10-650	10 Mg-650 Mg	120	take 1 tablet by oral route every 4 - 6 hours as needed for pain
Lorcet 10-650	10 Mg-650 Mg	120	take 1 tablet by oral route every 6 hours as needed for pain

Vimpat	100 M	60	take 1 tablet (100MG) by ora[illegible] 2 times every day
Vibryd	40 Mg	30	take 1 tablet (40MG) by oral route every day with food
Lidoderm	5 % (700 Mg/patch)	30	apply 1 patch by transdermal route every day (May wear up to 12hours.)
Klonopin	1 Mg	60	take 1 - 2 Tablet (1MG) by oral route every evening
Restoril	30 Mg	30	take 1 capsule (30MG) by oral route every day at bedtime as needed

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	10/08/2013	Risks/ benefits of treatment plan	
completed	10/08/2013	Continue current medication	
completed	10/08/2013	Activity as tolerated	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment
completed	Follow-up for medication side effect		722.0	-today	10/08/2013
completed	Follow-up if symptoms persist / worsen			722.0	10/08/2013
scheduled	Office visit	Discuss test results		722.0	-today 10/08/2013
completed	Follow-up for increased symptoms		722.0	-today	10/08/2013
scheduled	Office Visit	Follow-up on medication		722.0	-today 10/08/2013
scheduled	Office visit	Continue current treatment		722.0	-today 10/08/2013

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Grand Strand Spine & Neuro
8170 Rourk Street, Myrtle Beach, SC 29572
Phone: (843) 449-2338
Fax: (843) 497-2505

Grand S.. and
Regional Medical Center
Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 10/08/2013 4:29 PM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 51 year old male presents with neck pain, dizziness, headache, seizure and follow up.

History of Present Illness

1. neck pain
Onset: sudden. The severity of the problem is moderate. The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There was radiation of pain to the bilateral upper arm. The patient describes the pain as aching, burning and throbbing. The event(s) surrounding the occurrence of the symptom include axial loading. Aggravating factors include exertion, flexion, pushing, rotation and working. Relieving factors tried include narcotic analgesics. Associated symptoms include difficulty sleeping, muscle spasm, numbness, sexual dysfunction and tenderness. Pertinent negatives include bladder retention.

2. dizziness
Onset was sudden. Severity is moderate-severe. The duration of each episode is Month(s). The problem is worsening. It occurs persistently. The patient describes it as (an) unstable horizon. It occurs while. The patient has sustained a head injury in the past. Symptom is aggravated by turning. Relieving factors include position change. Associated symptoms include hearing loss, neck stiffness, paresthesias, seizures, tinnitus, vomiting and weakness. Pertinent negatives include diplopia.

3. headache
Onset: sudden. Severity: moderate-severe. It occurs daily, has Month(s) duration, and is worse. Location was occipital. There was radiation to posterior. The patient describes it as pressure and throbbing. Timing of headache: upon awakening. Symptom is aggravated by bright lights, head position and noise. Relieving factors include prescription drugs. Associated symptoms include dizziness, memory loss, neurological symptoms, performance changes, stiff neck and vertigo.

4. seizure, follow up
Date of last seizure was 02/19/2012. Date of last EEG was 02/22/2012. The type of seizure is Focal with secondary generalization. The context of the seizure includes TBI. Medication(s) used vimpat with good results.; he is compliant with medication; there are no side effects of medication Symptom is aggravated by and lack of sleep. Associated symptoms include aura, staring and unresponsiveness. Additional information: He is driving.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Vimpat	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every day
Vibryd	40 Mg	30	take 1 tablet (40MG) by oral route every day with food
Lorcet 10-650	10 Mg-650 Mg	120	take 1 tablet by oral route every 6 hours as needed for pain
Lidoderm (May wear up to 12hours.)	5 % (700 Mg/patch)	30	apply 1 patch by transdermal route every day

Allergies
Allergen/Ingredient | Brand | Reaction:
Meperidine Hcl

Vital Signs
{sub_vs_condense: NOT FOUND}

Physical Exam
Constitutional:
Level of distress is mild distress. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderate pain w/motion
No lumbar spine tenderness. Normal mobility and curvature.
Right shoulder has tenderness
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Optic Nerve: Optic normal.
Oculomotor: normal.
Trochlear: normal.
Abducens: normal.
Trigeminal:
Motor and Reflexes: normal.
Facial: normal.
Acoustic: normal.
Glossopharyngeal: normal.
Vagus: normal.
Spinal Accessory: normal.
Hypoglossal: normal.
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .

Clinical Assessment
The patient is a 51-year old male who presents with neck pain, dizziness, headache and seizure, follow up. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan
CHR POST-TRAUMA HEADACHE (339.22)
Continue with Lorcet for pain control, consider botox to relief symptoms.
Epilepsy, unspecified (345.90)
Tolerating Vimpat 100 bid well and without side effect, cpm.
Dizziness (780.4)
Due to inner damage as noted on nystagmogram, for tinnitus no treatment is available
Other and unspecified disc disorder of cervical re (722.91)
Still pending esi cervical spine to minimize impairment and maximize recovery.
Pain in joint involving shoulder region (719.41)
Noted on mri shoulder finally done not seen orthopedic surgeon.
Late effect of intracranial injury without mention (907.0)
causing significant anxiety issues, stressed compliance with meds, sleeping affected, will stp clonopin and trial with Trazodone 50-150 mg qhs and see response, discussed with cnm.

Benjamin, Victor [redacted]

Medications (added or contin... this visit)

Drug Name	Dose	Qty	Description
Trazodone Hcl	150 Mg	30	take 1 tablet (150MG) by ORAL route every day at bedtime
Lorcet 10-650	10 Mg-650 Mg	120	take 1 tablet by oral route every 4 - 6 hours as needed for pain
Lorcet 10-650	10 Mg-650 Mg	120	take 1 tablet by oral route every 6 hours as needed for pain
Vimpat	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every day
Vilbryd	40 Mg	30	take 1 tablet (40MG) by oral route every day with food
Lidoderm	5 % (700 Mg/patch)	30	apply 1 patch by transdermal route every day (May wear up to 12hours.)

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	10/08/2013	Risks/ benefits of treatment plan	
completed	10/08/2013	Continue current medication	
completed	10/08/2013	Activity as tolerated	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
scheduled	Office visit	Continue current treatment	339.22	-today	10/08/2013	
completed	Follow-up for medication side effect		339.22	-today	10/08/2013	
completed	Follow-up for increased symptoms		339.22	-today	10/08/2013	
completed	Follow-up if symptoms persist / worsen			339.22	10/08/2013	
scheduled	Office Visit	Follow-up on medication		339.22	-today	10/08/2013

Document generated by: George Sandoz 10/08/2013

CC Providers:
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4882 Socastee Blvd
Myrtle Beach, SC 29588

Grand Strand Spine & Neuro
8170 Rourk Street, Myrtle Beach, SC 29572
Phone: (843) 449-2336
Fax: (843) 497-2505

Grand Strand Regional Medical Center
Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 01/14/2014 4:45 PM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:
This 51 year old male presents with head injury.

History of Present Illness
1. head injury
Onset: gradual. The severity of the symptoms is moderate. The location of the injury is in the bilateral frontal region. The mechanical force causing the injury was coup. Context includes struck over head. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include touch. Associated symptoms include irritability, memory difficulty and seizure.

Social History
Reviewed, no changes. Last detailed document date: 09/26/2012.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Lorcet 10-650 needed for pain	10 Mg-650 Mg	120	take 1 tablet by oral route every 6 hours as
Vimpat day	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every
Lidoderm (May wear up to 12hours.)	5 % (700 Mg/patch)	30	apply 1 patch by transdermal route every day

Medication list reviewed.

Allergies
Reviewed, no changes.

Allergen/Ingredient	Brand	Reaction:
Meperidine Hcl		

Vital Signs
Height

Time	ft	in	cm	Last Measured	Method	%
1:17 PM	6.0			09/16/2011		0

Weight / BSA / BMI

Time	lb	oz	kg	Context	%	BMI kg/m2	BSA m2
1:17 PM	181.00			dressed with shoes	0	24.65	

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
1:17 PM	141/86	sitting	left	brachial	manual	adult

Temp / Pulse / Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/min
1:17 PM				76	regular	

Measured By

Time	
1:17 PM	Jalessa Grant

{sub_vs_condense: NOT FOUND}

Physical Exam

Constitutional:
Level of distress is moderate distress. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.

Clinical Assessment

The patient is a 51-year old male who presents with head injury.

Assessment/ Plan

Late effect of intracranial injury without mention (907.0)
Causing post trauma headache and taking lorcet, seizure controled with vimpat, mood disorder discussed with wife significant disruption due to anger/control issues issue address by psychiatry and s/p cervical surgery with persistent c/o pain and worsening clinically.

Medications (added or continued this visit)

Drug Name	Dose	Qty	Description
Lorcet 10-650	10 Mg-650 Mg	120	take 1 tablet by oral route every 4 - 6 hours as needed for pain
Vimpat	100 Mg	60	take 1 tablet (100MG) by oral route 2 times every day
Lorcet 10-650	10 Mg-650 Mg	120	take 1 tablet by oral route every 6 hours as needed for pain
Lidoderm	5 % (700 Mg/patch)	30	apply 1 patch by transdermal route every day (May wear up to 12hours.)

Document generated by: George M. Sandoz MD 01/14/2014

CC Providers:

Benjamin, Victor [redacted]

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Grand Strand Spine & Neuro
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Benjamin, Victor [redacted]

[redacted]

Grand Strand
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Date Ordered: _____ Authorizing Signature: _____

Patient: _____

Phone #: _____ Date of Birth: [redacted] Social Security #: [redacted]

Consult / Diagnosis Study (fee): Victor Bautista

Diagnosis code: _____ Diagnosis: _____

Clinical Information: EVC pain Weight Wt Gain

Insurance Company: _____

Patient Preparation / Information: _____

Appointment: _____ Appointment Time: _____ Appointment Location: _____

Patient: Victor Benjamin
Date of Birth: [redacted]
Date: 04/15/2014 03:50 PM
Visit Type: Office Visit
Document Type: Chart Note

The patient is a 51 year old male who presents with neck pain and head injury.

History of Present Illness:
1. neck pain
Onset: sudden. The problem is severe. Duration: year. The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There is radiation of pain to the bilateral upper arm. The patient describes the pain as aching and burning. The event(s) surrounding the occurrence of the symptom include injury and sudden movement. Aggravating factors include bending, driving, pushing, walking and working. Relieving factors tried include narcotic analgesics. Associated symptoms include decreased mobility, difficulty sleeping, muscle spasm and tingling. Pertinent negatives include bladder retention.
2. head injury
Onset: gradual. The severity of the symptoms is moderate. The symptoms have not changed. The location of the injury is in the bilateral frontal region. The location of pain is neck. Context includes trauma. The patient does not use drugs. Aggravating factors include sound. Relieving factors tried include narcotic analgesics. Associated symptoms include confusion, irritability, personality changes, somnolence and weakness.

Past Medical/Surgical History
Diagnostics History:

Test	Ordered	Status	Result
MRI BRAIN W/O & W/DYE	09/21/2011	ordered	
MRI C- SPINE W/O DYE	09/21/2011	ordered	
MUSCLE TEST, ONE LIMB	09/21/2011	ordered	
SPONTANEOUS NYSTAGMUS TEST	09/21/2011	ordered	
AUDITOR EVOKE POTENT, COMPRE	09/21/2011	ordered	
EEG MONITORING/COMPUTER 24hr	09/21/2011	scheduled	
MUSCLE TEST, ONE LIMB right arm	10/17/2011	scheduled	
EEG MONITORING/COMPUTER 24hr	02/02/2012	scheduled	
MRI C- SPINE W/O DYE	09/26/2012	ordered	
MRI C- SPINE W/O DYE	09/26/2012	ordered	
MRI C-SPINE W/O & W/DYE	06/20/2013	ordered	
SOMATOSENSORY TESTING	06/20/2013	scheduled	

Allergies

Ingredient	Reaction	Medication Name	Comment
MEPERIDINE HCL		Demerol	

Review of Systems

System	Neg/Pos	Details
Constitutional	Positive	Irritability.
GU	Negative	Urinary retention.
Neuro	Positive	Confusion, Somnolence, Tingling.
Psych	Positive	Difficulty sleeping, Personality changes.
MS	Positive	Decreased mobility, Muscle spasms, Weakness.

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress - moderate distress.
Constitutional	Normal	Well Nourished. Well developed.
Eyes	Normal	Fundus - Right: Normal, Left: Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Extremities - No edema.
Musculoskeletal	*	Cervical spine - muscle spasm.
Musculoskeletal	Normal	Lumbar spine - Normal.
Neurological	*	DTRs - symmetrically increased.
Neurological	Normal	Level of consciousness - Normal. Orientation - Normal. Memory - Normal. II. Optic - Grossly intact. III. Oculomotor - Grossly intact. IV. Trochlear - Grossly intact. V. Trigeminal - Grossly intact. VI. Abducens - Grossly intact. VII. Facial - Grossly intact. VIII. Acoustic - Grossly intact. IX. Glossopharyngeal - Grossly intact. X. Vagus - Grossly intact. XI. Spinal accessory - Grossly intact. XII. Hypoglossal - Grossly intact. Sensory - Normal. Motor - Normal. Balance & gait - Normal. Coordination - Normal. Fine motor skills - Normal. Brudzinski's sign - Negative.

Assessment/Plan

Late effect of intracranial injury without mention (907.0)
Doing fair, continue with current therapy, stressed compliance.

CHR POST-TRAUMA HEADACHE (339.22)
Doing well with meds,strssed compliance.

Displacement of cervical intervertebral disc without myelopathy (722.0)
S/p surgery, continue with surgery recomendation.

Dizziness (780.4)
Due to inner ear damage injury.

Medications *(Started, Stopped or Renewed this visit)*

Started	Medication	Directions	Comment	Stopped
04/25/2013	Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)		
01/14/2014	Lorcet 10/650 10-650 mg tablet	take 1 tablet by oral route every 4 - 6 hours as needed for pain		
06/20/2013	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day		

Provider: George M. Sandoz MD 04/15/2014

Grand Strand Spine & Neuro
8170 Rourk Street
Myrtle Beach, SC 29572
Phone: 843-449-2336
Fax: 843-497-2505

Patient: Victor Benjamin
Date of Birth: [redacted]
Date: 07/15/2014 05:22 PM
Visit Type: Office Visit
Document Type: Chart Note

The patient is a 52 year old male who presents with head injury.

History of Present Illness:

1. head injury

Onset: sudden. The symtoms are severe. The symptoms have worsened. The location of the injury is in the bilateral cervical region, bilateral frontal region and bilateral parietal region. The location of pain is facial, head and neck. The patient describes the pain as aching, dull, stabbing and throbbing. The mechanical force causing the injury was coup. Context includes metal cover hit him head. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include bending over, exertion, sound and touch. Relieving factors tried include narcotic analgesics. Associated symptoms include clumsiness, confusion, gait disturbance, hearing loss, incoordination, irritability, loss of consciousness, lucid intervals, memory difficulty, personality changes, restlessness, seizures, speech difficulty, stiff neck, unusual behavior and weakness. Pertinent negatives include loss of sensation, mastoid ecchymosis and paralysis.

Past Medical/Surgical History

Diagnostics History:

Test	Ordered	Status	Result
MRI BRAIN W/O & W/DYE	09/21/2011	ordered	
MRI C- SPINE W/O DYE	09/21/2011	ordered	
MUSCLE TEST, ONE LIMB	09/21/2011	ordered	
SPONTANEOUS NYSTAGMUS TEST	09/21/2011	ordered	
AUDITOR EVOKE POTENT, COMPRE	09/21/2011	ordered	
EEG MONITORING/COMPUTER 24hr	09/21/2011	scheduled	
MUSCLE TEST, ONE LIMB right arm	10/17/2011	scheduled	
EEG MONITORING/COMPUTER 24hr	02/02/2012	scheduled	
MRI C- SPINE W/O DYE	09/26/2012	ordered	
MRI C- SPINE W/O DYE	09/26/2012	ordered	
MRI C-SPINE W/O & W/DYE	06/20/2013	ordered	
SOMATOSENSORY TESTING	06/20/2013	scheduled	

Allergies

Ingredient	Reaction	Medication Name	Comment
MEPERIDINE HCL		Demerol	

Review of Systems

System	Neg/Pos	Details
Constitutional	Positive	Irritability, Restlessness.

ENMT	Positive	Hearing loss.
Neuro	Positive	Clumsiness, Confusion, Gait disturbance, Incoordination, Loss of consciousness, Memory difficulty, Seizures, Speech difficulty.
Neuro	Negative	Loss of sensation and paralysis.
Psych	Positive	Lucid intervals, Personality changes, Unusual behavior.
MS	Positive	Neck stiffness, Weakness.
Hema/Lymph	Negative	Mastoid ecchymosis.

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress - moderate distress.
Constitutional	Normal	Well Nourished. Well developed.
Eyes	Normal	Fundus - Right: Normal, Left: Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Extremities - No edema.
Musculoskeletal	*	Cervical spine - muscle spasm. Lumbar spine - muscle spasm.
Neurological	*	VIII. Acoustic - Findings: Weber test abnormal, lateralizes to the left. Motor - spastic quadraparesis. Balance & gait - unsteady gait. DTRs - symmetrically increased.
Neurological	Normal	Level of consciousness - Normal. Orientation - Normal. Memory - Normal. II. Optic - Grossly intact. III. Oculomotor - Grossly intact. IV. Trochlear - Grossly intact. V. Trigeminal - Grossly intact. Motor and reflexes: Grossly intact. Sensation: Grossly intact. VI. Abducens - Grossly intact. VII. Facial - Grossly intact. IX. Glossopharyngeal - Grossly intact. X. Vagus - Grossly intact. XI. Spinal accessory - Grossly intact. XII. Hypoglossal - Grossly intact. Sensory - Normal. Coordination - Normal. Fine motor skills - Normal.

Assessment/Plan

CHR POST-TRAUMA HEADACHE (339.22)
Continue with pain management using hydrocodone

Displacement of cervical intervertebral disc without myelopathy (722.0)
S/p surgery doing fair on chronic pain management

Dizziness (780.4)
Due to inner ear damage, continue with current management

Epilepsy, unspecified, without mention of intractable epilepsy (345.90)
Tolerating vimpat well, cpm.

Late effect of intracranial injury without mention of skull fracture (907.0)
Causing PTSD and damage from injury.

Medications *(Started, Stopped or Renewed this visit)*

Started	Medication	Directions	Comment	Stopped
07/15/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain		07/15/2014
07/15/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain		
07/15/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain		
04/25/2013	Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)		
01/14/2014	Lorcet 10/650 10-650 mg tablet	take 1 tablet by oral route every 4 - 6 hours as needed for pain		
07/15/2014	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day		
06/20/2013	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day		07/15/2014

Provider: George M. Sandoz MD 07/15/2014

Grand Strand Spine & Neuro
8170 Rourk Street
Myrtle Beach, SC 29572
Phone: 843-449-2336
Fax: 843-497-2505

Patient:	Victor Benjamin
Date of Birth:	[redacted]
Date:	10/16/2014 01:25 PM
Historian:	self
Visit Type:	Office Visit
Document Type:	Chart Note

The patient is a 52 year old male who presents with neck pain.

History of Present Illness:

1. neck pain

Onset: sudden. The severity of the problem is incapacitating. Duration: year. The problem has worsened. The frequency of pain is constant. Location of pain is bilateral posterior neck. There is radiation of pain to the bilateral upper arm. The patient describes the pain as aching and burning. The event(s) surrounding the occurrence of the symptom include injury. Aggravating factors include driving, exertion, flexion, hyperextension, kneeling, pushing, rotation, running, stooping, straining, stress, turning head, walking and working. Relieving factors tried include narcotic analgesics. Associated symptoms include decreased mobility, difficulty sleeping, joint pain, loss of balance, muscle spasm, numbness, sexual dysfunction, tenderness, tingling and weakness. Pertinent negatives include bladder incontinence.

Past Medical/Surgical History

Diagnostics History:

Test	Ordered	Status	Result
MRI BRAIN W/O & W/DYE	09/21/2011	ordered	
MRI C- SPINE W/O DYE	09/21/2011	ordered	
MUSCLE TEST, ONE LIMB	09/21/2011	ordered	
SPONTANEOUS NYSTAGMUS TEST	09/21/2011	ordered	
AUDITOR EVOKE POTENT, COMPRE	09/21/2011	ordered	
EEG MONITORING/COMPUTER 24hr	09/21/2011	scheduled	
MUSCLE TEST, ONE LIMB right arm	10/17/2011	scheduled	
EEG MONITORING/COMPUTER 24hr	02/02/2012	scheduled	
MRI C- SPINE W/O DYE	09/26/2012	ordered	
MRI C- SPINE W/O DYE	09/26/2012	ordered	
MRI C-SPINE W/O & W/DYE	06/20/2013	ordered	
SOMATOSENSORY TESTING	06/20/2013	scheduled	

Allergies

Ingredient	Reaction	Medication Name	Comment
MEPERIDINE HCL		Demerol	

Review of Systems

System	Neg/Pos	Details

GU	Positive	Sexual dysfunction.
GU	Negative	Urinary incontinence.
Neuro	Positive	Loss of balance, Numbness, Tingling.
Psych	Positive	Difficulty sleeping.
MS	Positive	Decreased mobility, Joint pain, Muscle spasms, Musculoskeletal tenderness, Weakness.

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress - moderate distress.
Constitutional	Normal	Well Nourished. Well developed.
Eyes	Normal	General - Right: Normal, Left: Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Extremities - No edema.
Musculoskeletal	*	Cervical spine - muscle spasm, Range of motion: severe pain w/ motion. Lumbar spine - muscle spasm, Range of motion: mild pain w/ motion.
Neurological	*	Motor - quadriparesis. Balance & gait - spastic. DTRs - symmetrically increased.
Neurological	Normal	Level of consciousness - Normal. Orientation - Normal. Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact. Sensory - Normal. Coordination - Normal. Fine motor skills - Normal.

Assessment/Plan

CH MGR WO ARA W NT WO ST (346.71)
Doing well with current therapy, stressed compliance with meds.

Epilepsy, unspecified, without mention of intractable epilepsy (345.90)
Controled with Vimpat, stressed compliance.

Cervical disc displacement w/ myelopathy (722.71)
S/p injury s/p surgery x 2 due to delay in surgery and perform in other areas before the one recommended worsen of myelopathy syndrome with significant pain control decrease ambulation sexual dysfunction PTSD from injury will continue with hydrocodone, unable to tolerate SSRI's NeSRI's or combination will continue with clonazepam bid and valium for muscle spasm.

Medications *(Started, Stopped or Renewed this visit)*

Started	Medication	Directions	Comment	Stopped
10/08/2014	amitriptyline 50 mg tablet	take 1 - 2 tablet by oral route every day at bedtime		10/16/2014
10/16/2014	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening		10/16/2014

10/16/2014	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening	
10/08/2014	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening	10/16/2014
10/16/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	
10/16/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	
10/16/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 6 hours as needed for pain	
07/15/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	10/16/2014
07/15/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	10/16/2014
04/25/2013	Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)	
01/14/2014	Lorcet 10/650 10-650 mg tablet	take 1 tablet by oral route every 4 - 6 hours as needed for pain	10/16/2014
09/25/2014	Medrol (Pak) 4 mg tablets in a dose pack	take by Buccal route every day take as directed	
10/16/2014	Valium 10 mg tablet	take 1 tablet by oral route every 8 hours	
07/15/2014	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day	

Provider: George M. Sandoz MD 10/16/2014

Grand Strand Spine & Neuro
8170 Rourk Street
Myrtle Beach, SC 29572
Phone: 843-449-2336
Fax: 843-497-2505

Patient: Victor Benjamin
Date of Birth: [redacted]
Date: 01/13/2015 02:57 PM
Historian: self
Visit Type: Office Visit
Document Type: Chart Note

The patient is a 52 year old male who presents with head injury.

History of Present Illness:

1. head injury

Onset: sudden. The severity of the symptoms is incapacitating. The symptoms have not changed. The location of the injury is in the bilateral frontal region, bilateral parietal region and bilateral temporal region. The location of pain is head and neck. The mechanical force causing the injury was coup. Context includes struck by cover. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include exertion, lying down, pressure and touch. Associated symptoms include bruising around eyes, clumsiness, gait disturbance, headache, irritability, prolonged loss of consciousness, restlessness, stiff neck and unusual behavior.

Past Medical/Surgical History

Diagnostics History:

Test	Ordered	Status	Result
MRI BRAIN W/O & W/DYE	09/21/2011	ordered	
MRI C- SPINE W/O DYE	09/21/2011	ordered	
MUSCLE TEST, ONE LIMB	09/21/2011	ordered	
SPONTANEOUS NYSTAGMUS TEST	09/21/2011	ordered	
AUDITOR EVOKE POTENT, COMPRE	09/21/2011	ordered	
EEG MONITORING/COMPUTER 24hr	09/21/2011	scheduled	
MUSCLE TEST, ONE LIMB right arm	10/17/2011	scheduled	
EEG MONITORING/COMPUTER 24hr	02/02/2012	scheduled	
MRI C- SPINE W/O DYE	09/26/2012	ordered	
MRI C- SPINE W/O DYE	09/26/2012	ordered	
MRI C-SPINE W/O & W/DYE	06/20/2013	ordered	
SOMATOSENSORY TESTING	06/20/2013	scheduled	

Allergies

Ingredient	Reaction	Medication Name	Comment
MEPERIDINE HCL		Demerol	

Review of Systems

System	Neg/Pos	Details
Constitutional	Positive	Irritability, Restlessness.

Neuro	Positive	Clumsiness, Gait disturbance, Headache, Prolonged loss of consciousness.
Psych	Positive	Unusual behavior.
MS	Positive	Neck stiffness.
Hema/Lymph	Positive	Bruising around eye(s).

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress - moderate distress.
Constitutional	Normal	Well Nourished. Well developed.
Eyes	Normal	Fundus - Right: Normal, Left: Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Extremities - No edema.
Musculoskeletal	*	Cervical spine - muscle spasm, Range of motion: moderate pain w/motion. Thoracic spine - muscle spasm. Lumbar spine - muscle spasm, Range of motion: moderate pain w/motion.
Neurological	Normal	Level of consciousness - Normal. Orientation - Normal. Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact. Sensory - Normal. Motor - Normal. Balance & gait - Normal. Coordination - Normal. Fine motor skills - Normal. DTRs - Normal.

Assessment/Plan

Late effect of intracranial injury without mention of skull fracture (907.0)
Causing HTN neck pain that required surgery seizure PTSD, continue with pain meds intake seizure meds valium clonazepam stressed compliance with therapy.

Medications *(Started, Stopped or Renewed this visit)*

Started	Medication	Directions	Comment	Stopped
10/16/2014	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening		01/13/2015
01/13/2015	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening		
10/16/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain		01/13/2015
10/16/2014	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain		01/13/2015
10/16/2014	hydrocodone 10 mg-acetaminophen	take 1 Tablet by oral route every 6 hours as needed for		01/13/2015

01/13/2015	325 mg tablet hydrocodone 10 mg-acetaminophen	pain take 1 Tablet by oral route every 6 hours as needed for pain	
01/13/2015	325 mg tablet hydrocodone 10 mg-acetaminophen	take 1 Tablet by oral route every 12 hours as needed for pain	
01/13/2015	325 mg tablet hydrocodone 10 mg-acetaminophen	take 1 Tablet by oral route every 12 hours as needed for pain	
04/25/2013	Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours)	
09/25/2014	Medrol (Pak) 4 mg tablets in a dose peck	take by Buccal route every day take as directed	01/13/2015
01/13/2015	Valium 10 mg tablet	take 1 tablet by oral route every 8 hours	
10/16/2014	Valium 10 mg tablet	take 1 tablet by oral route every 8 hours	01/13/2015
10/28/2014	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day	

Provider: George M. Sandoz MD 01/13/2015

Grand Strand Spine & Neuro
8170 Rourk Street
Myrtle Beach, SC 29572
Phone: 843-449-2336
Fax: 843-497-2505

Grand Strand HEALTH SYSTEM

Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 02/13/2015 12:30 PM
VISIT TYPE: Office Visit
Historian: self

This 52 year old male presents for neck pain.

History of Present Illness:

1. neck pain

Onset: sudden. The problem is severe. Duration: year. The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There is radiation of pain to the right face, right upper arm, right elbow and right forearm. The patient describes the pain as aching. The event(s) surrounding the occurrence of the symptom include injury. Aggravating factors include flexion, hyperextension, stooping, straining and working. Relieving factors include narcotic analgesics. Associated symptoms include difficulty sleeping, muscle atrophy, muscle spasm and tenderness. Pertinent negatives include bowel dysfunction not spinal related. Additional information: Doing fair until 1 week ago developed pain 10/10 worse from elbow down.

Medications (active prior to today)

Medication Name	Sig Desc	Start Date	Stop Date	Refilled	Elsewhere
Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours)	04/25/2013			N
Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day	10/28/2014		10/28/2014	N
hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 6 hours as needed for pain	01/13/2015		01/13/2015	N
hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	01/13/2015		01/13/2015	N
hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	01/13/2015		01/13/2015	N
Valium 10 mg tablet	take 1 tablet by oral route every 8 hours	01/13/2015		01/13/2015	N
clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening	01/13/2015		01/13/2015	N

Allergies:

Ingredient	Reaction	Medication Name	Comment
MEPERIDINE HCL		Demerol	

REVIEW OF SYSTEMS

System	Neg/Pos	Details
GI	Negative	Bowel dysfunction not spinal related.
Psych	Positive	Difficulty sleeping.
MS	Positive	Muscle spasms, Muscular atrophy, Musculoskeletal tenderness.

Physical Exam

Exam	Findings	Details
Constitutional	Normal	No acute distress. Well nourished. Well developed.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Extremities - No edema.
Musculoskeletal	*	Cervical spine - muscle spasm. Elbow - Right: pain. Hands - Right: + Tinel's Sign.
Musculoskeletal	Normal	Elbow -Left: Normal.
Neurological	*	Motor - weak r triceps. DTRs - symmetrically increased.
Neurological	Normal	Level of consciousness - Normal. Orientation - Normal. Memory - Normal. II. Optic - PERRL. III. Oculomotor - Grossly intact. IV. Trochlear - Grossly intact. V. Trigeminal - Grossly intact, Motor and reflexes: Grossly intact, Sensation: Grossly intact. VI. Abducens - Grossly intact. VII. Facial - Grossly intact. VIII. Acoustic - Grossly intact. IX. Glossopharyngeal - Grossly intact. X. Vagus - Grossly intact. XI. Spinal accessory - Grossly intact. XII. Hypoglossal - Grossly intact. Sensory - Normal. Balance & gait - Normal. Coordination - Normal. Fine motor skills - Normal. Hand dominance - Right-handed.

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Intervertebral disc disorder with myelopathy, cervical region (722.71).
	Impression	Worsen will see response to Butrans tens unit, mri cervical spine ncs rue order.
	Plan Orders	Further diagnostic evaluations ordered today include(s) MRI C-SPINE W/O & W/DYE, NCS 3-4 Studies Right arm and SOMATOSENSORY TESTING Bilateral leg/arm to be performed.

Medications *(added, continued or stopped this visit)*:

Started	Medication	Directions	Instruction	Stopped
02/13/2015	Butrans 10 mcg/hour transdermal patch	apply 1 patch by transdermal route every 7 days		
01/13/2015	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening		
01/13/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 6 hours as needed for pain	Do not fill until 2-12-15	
01/13/2015	hydrocodone 10 mg-acetaminophen	take 1 Tablet by oral route every 12 hours as needed for	Do not fill until 3-12-15	

01/13/2015	325 mg tablet hydrocodone 10 mg-acetaminophen 325 mg tablet	ain take 1 Tablet by oral route every 12 hours as needed for pain
04/25/2013	Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)
01/13/2015	Valium 10 mg tablet	take 1 tablet by oral route every 8 hours
10/28/2014	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day

Provider: George M. Sandoz MD 02/13/2015 12:53 PM
Document generated by: George Sandoz 02/13/2015 12:53 PM

Grand Strand Spine and Neuro
9170 Rourk Street
Myrtle Beach, SC 29572
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PATIENT: [redacted] BENJAMIN, VICTOR
MRN: 546740
PHONE: 803-428-3352(Home)
PHYSICIAN: MICHAEL MCCAFFREY, MD
EXAM DATE: 04/13/2015

EXAM: MR-Cervical Spine With and Without Contrast

REASON FOR EXAM: intervertebral disc d/o w/ myelopathy

COMPARISON: 10/18/2012.

TECHNIQUE: 1.5T MRI cervical spine utilizing sagittal and axial T1 and T2 sequences. Following uneventful IV contrast administration additional sagittal and axial T1 sequences were obtained.

CONTRAST: 15 mL Magnevist IV.

FINDINGS: No deformity of the cervicomedullary junction. There is again demonstration of extensive mucosal thickening in the paranasal sinuses.

The C2-C3 level is unremarkable.

At C3-C4, progressive degenerative disc disease although there may have been prior discectomy. There is evidence of posterior decompression and posterior fusion with posterior hardware present. The central canal is overall patent with mild stenosis to the left of midline. Mild hypertrophic endplate spur formation greater in paracentral locations. Abnormal increased T2 signal in the cord dorsolateral on the left is again noted, unchanged, and without abnormal contrast enhancement. Moderate left and mild right neural foraminal stenosis.

The patient is status post anterior cervical discectomy and fusion at the C4-C5-C6 levels with anterior hardware present and solid interbody fusion demonstrated. There is also continuation of this fusion to C6-C7 but without confirmation of osseous fusion across the disc space. The central canal is now patent through these levels as are the respective neural foramina other than moderate to severe bony stenosis of the left C7 neural foramen.

At C7-T1, there is a mild disc bulge with minimal central canal stenosis; Mild left and minimal right neural foraminal stenosis.

IMPRESSION:

1. Status post posterior decompression and posterior fusion at C3-C4. Minimal central canal stenosis asymmetric to the left due to hypertrophic spur formation. Persistent abnormal signal with no abnormal enhancement in the spinal cord on the left dorsolaterally suggests probable myelomalacia. Moderate left and mild right neural foraminal stenosis.
2. Status post ACDF at C4-C5-C6-C7. The central canal is patent through these levels. There is solid interbody fusion at C4-C5 and C5-C6 but not

Name: Benjamin, Victor DC (160) Date:

PATIENT: BENJAMIN, VICTOR
[redacted]
EXAM: MR-Cervical Spine With and Without Contrast
EXAM DATE: 04/13/2015

confirmed at C6-C7. There is at least moderate and potentially severe bony stenosis of the left C7 neural foramen.
3. Mild left C8 neural foraminal stenosis.
4. No unusual contrast enhancement.

James Thesing, DO

JAT/llb
DD: 04/13/2015 02:22 P
DT: 04/13/2015 05:34 P
Accession#: 08-2050985 VS#: 120319899 CS#: 1342767
cc:

Electronically Signed and Reviewed by James Thesing, DO 04/13/2015 08:59 P

Grand Strand HEALTH SYSTEM

Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 04/14/2015 10:15 AM
VISIT TYPE: Office Visit

This 52 year old male presents for neck pain.

History of Present Illness:

1. neck pain

Onset: sudden. The problem is severe. Duration: year. The problem has not changed. The frequency of pain is constant. Location of pain is bilateral posterior neck. There is radiation of pain to the bilateral upper arm. The patient describes the pain as aching and burning. The event(s) surrounding the occurrence of the symptom include injury. Aggravating factors include driving, exertion, flexion, prolonged sitting, pushing, standing, stooping, walking and working. Relieving factors include injection, muscle relaxation techniques, narcotic analgesics and NSAIDs. Associated symptoms include difficulty sleeping, dysphagia, joint pain, muscle atrophy, muscle spasm, numbness, sexual dysfunction, tenderness, tingling and weakness. Pertinent negatives include bladder dysfunction not spinal related, bladder incontinence, bladder retention, bowel dysfunction not spinal related, bowel incontinence, bowel retention, decreased mobility, dermatomic rash, incoordination, loss of balance, rash, sexual dysfunction (not spinal related) and weight loss.

PAST SYSTEMIC HISTORY
Patient reported no relevant past medical/surgical history.

Medications (active prior to today)

Medication Name	Sig Desc	Start Date	Stop Date	Refilled	Elsewhere
Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)	04/25/2013			N
Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day	10/28/2014		10/28/2014	N
hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 6 hours as needed for pain	01/13/2015	04/14/2015	04/14/2015	N
hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	01/13/2015	04/14/2015	04/14/2015	N
hydrocodone 10 mg-acetaminophen 325	take 1 Tablet by oral route every 12 hours as needed	01/13/2015	04/14/2015	04/14/2015	N

mg tablet	for p...				
Valium 10 mg tablet	take 1 tablet by oral route every 8 hours	01/13/2015		01/13/2015	N
clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening	01/13/2015	04/14/2015	04/14/2015	N
Butrans 10 mcg/hour transdermal patch	apply 1 patch by transdermal route every 7 days	02/13/2015	04/14/2015		N
promethazine 25 mg tablet	take 1 tablet by oral route every 8 hours prn nausea	02/18/2015			N

Allergies:

Ingredient	Reaction	Medication Name	Comment
MEPERIDINE HCL		Demerol	

REVIEW OF SYSTEMS

System	Neg/Pos	Details
Constitutional	Negative	Weight loss.
ENMT	Positive	Dysphagia.
GI	Negative	Bowel dysfunction not spinal related, fecal incontinence and fecal retention.
GU	Negative	Bladder dysfunction not spinal related, sexual dysfunction not spinal related, urinary incontinence and urinary retention.
Neuro	Positive	Numbness, Tingling.
Neuro	Negative	Incoordination and loss of balance.
Psych	Positive	Difficulty sleeping.
Integumentary	Negative	Dermatomic rash and rash.
MS	Positive	Joint pain, Muscle spasms, Muscular atrophy, Musculoskeletal tenderness, Weakness.
MS	Negative	Decreased mobility.
Reproductive	Positive	Sexual dysfunction.

VITAL SIGNS

Time	BP mm/Hg	Pulse /min	Resp /min	Temp F	Ht ft	Ht in	Ht cm	Wt lb	Wt kg	BMI kg/m2	BSA m2	O2 Sat%
10:20 AM	139/88	73		98.70	6.0		182.88	163.00	73.936	22.10	1.94	

MEASURED BY

Time	Measured by
10:20 AM	Barbara Browning

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress - moderate distress.
Constitutional	Normal	Well nourished. Well developed.
Eyes	Normal	Fundus - Right: Normal, Left: Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Extremities - No edema.
Musculoskeletal	*	Cervical spine - muscle spasm, Range of motion: severely reduced ROM. Lumbar spine - muscle spasm, Range of motion: mild pain w/ motion.
Neurological	*	Motor - Quadriparesis. Balance & gait - using a cane/ unsteady gait. Fine motor skills - past pointing. DTRs - symmetrically increased.
Neurological	Normal	Level of consciousness - Normal. Orientation - Normal. Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact. Sensory - Normal. Coordination - Normal. Hand dominance - Right-handed.

Assessment/Plan

#	Detail Type	Description
1.	Assessment Impression	Displacement of cervical intervertebral disc without myelopathy (722.0). Causing pain mri review by my shows surgical changes spondylosis and cervical DD noted on L c-7 which might require surgery in the future, ED from cervical injury radiculitis might benefit from RF continue with meds stressed compliance for his back pain will set for ESI with Dr Sarb.

Medications *(added, continued or stopped this visit)*:

Started	Medication	Directions	Instruction	Stopped
02/13/2015	Butrans 10 mcg/hour transdermal patch	apply 1 patch by transdermal route every 7 days		04/14/2015
01/13/2015	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening		04/14/2015
04/14/2015	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening		
04/14/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain		
04/14/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	Do not fill until 5-13-15	
04/14/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 6 hours as needed for pain	Do not fill until 2-12-15	04/14/2015
04/14/2015	hydrocodone 10	take 1 Tablet by oral route	Do not fill until	

	mg-acetamino, 325 mg tablet	in every 6 hours as needed for pain	6-12-15	
01/13/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 6 hours as needed for pain	Do not fill until 2-12-15	04/14/2015
01/13/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	Do not fill until 3-12-15	04/14/2015
01/13/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain		04/14/2015
04/25/2013	Udoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)		
02/18/2015	promethazine 25 mg tablet	take 1 tablet by oral route every 8 hours prn nausea		
01/13/2015	Valium 10 mg tablet	take 1 tablet by oral route every 8 hours		
10/28/2014	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day		

Provider: George M. Sandoz MD 04/14/2015 11:01 AM
Document generated by: George Sandoz 04/14/2015 11:01 AM

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Grand Strand HEALTH SYSTEM
Spine & Neuro Center

Patient MRN: [redacted]

Date: 05/15/2015

Category: Dictation

Description: Sarb dictation

Provider ID:C706AC9B-07A5-4436-9BD0-99AC04AF5CE2

Transcription Date: May 15, 2015

Victor Benjamin
DOB: [redacted]
Chart: [redacted]
Date: 5/15/2015
Neurology New Patient Evaluation

HISTORY OF PRESENT ILLNESS: Mr. Benjamin is seen in evaluation at the request of Dr. Sandoz. He has had epidurals back in November and did really well. He has a back injury related to work injury four years ago. He states a steel guard 35 feet and hit him on his head and he fell backward injuring his back. He fell on to his right side. He has disc L4-L5 with moderate facet disease, disc protrusion with moderate-to-severe recess stenosis. He did really well with his epidural for about three to four months. He has return of low back pain radiating down the right buttock on lateral aspect right to the foot with numbness. He has tried physical therapy in the past with little relief. He is using a cane. Pain is worst on the right. He does not reflex his activities of daily living. He describes it is moderately severe and did waxes and wanes depending on his activity. He still to continue his leakage worse. He would like to proceed with epidural for pain management.

MEDICATIONS: He is on citalopram, Vimpat, clonazepam, hydrocodone, Diovan, Norvasc.

ALLERGIES: Unchanged DEMEROL.

PHYSICAL EXAM:
VITAL SIGNS: Blood pressure 130/74, pulse 68, temperature 98.3, and weight 167 pounds.
HEENT: Patient is normocephalic.
LUNGS: Clear.
HEART: Regular rate and rhythm. No carotid, orbital or cranial bruits.
ABDOMEN: Soft.
EXTREMITIES: Without clubbing, cyanosis or edema.

NEUROLOGICAL EXAMINATION:
MENTAL STATUS: Patient is awake, alert and oriented to person, place, and time. Speech is clear and fluent. Mentation is appropriate for age. Conversation is fluent.
CN II-XII: PERRLA. EOMI. Full visual fields with confrontation. Funduscopic exam is normal with no evidence of papilledema or hemorrhage. Spontaneous venous pulsations are seen. Facial sensation is intact to pinprick. Muscle of mastication are strong with symmetrical facial expressions. Hearing is intact to conversation. Soft palate elevated symmetrically with midline protrusion of the tongue. Gag is intact. Sternocleidomastoid and trapezius strength is symmetric.
MOTOR: Strength is 5/5 in the upper and lower extremities with normal muscle bulk and tone. There is no evidence of tremor or abnormal involuntary movement.
SENSORY: Sensation is intact totemperature, vibration and position sense. There is no truncal sensory level. The patient has decreased sensation pinprick diffusely over right leg. SLR testing mildly positive with complaint of pain in the right leg down the lateral aspect of the leg.
DTRs: 2/4 in the upper and lower extremities with downgoing plantar response.
CEREBELLAR: There is an intact finger-nose-finger, rapid alternating movements and heel-to-shin testing.
MECHANICAL SPINE: Spine is normal, no evidence of curvaturae or tenderness to palpation. Negative straight leg, cross straight leg, popliteal compression, and femoral stretch.
GAIT: Antalgic.

MEDICAL DECISION MAKING: The patient with right *L4-L5* radiculopathy. I recommend repeat lumbar epidural injection for pain management. He responded well to it in the past. He is on pain medicines and he has tried physical therapy in the past without relief. Risks and benefits were discussed. The patient will need transportation home and limited activity 48 hours postinjection.

Victor Benjamin
DOB: [redacted]
Chart: [redacted]
Date: 5/15/2015
Page 3

Barbara L. Sarb, DO

BS/feh

Electronically Signed on 05/21/2015 10:54 AM

The End.

Barbara Sarb

Grand Strand HEALTH SYSTEM

Spine & Neuro Center

Patient:	Victor Benjamin
Date of Birth:	[redacted]
Date:	05/15/2015
Historian:	self
Visit Type:	Office Visit
Document Type:	Chart Note

This 53 year old male presents for back pain.

History of Present Illness:

1. back pain

Onset: sudden with injury. Severity level is moderate-severe. Duration: year. The problem is fluctuating. It occurs persistently. Location of pain is lower back. Pain is radiated to the dermatome anteriorly.The patient describes the pain as an ache and burning. Context: trauma. Symptoms are aggravated by daily activities.The patient denies relieving factors.

Allergies

Ingredient	Reaction	Medication Name	Comment
MEPERIDINE HCL		Demerol	

VITAL SIGNS

Time	BP mm/Hg	Pulse /min	Resp /min	Temp F	Ht ft	Ht in	Ht cm	Wt lb	Wt kg	BMI kg/m2	BSA m2	O2 Sat%
11:38 AM	130/74	63		98.20	6.0		182.88	167.00	75.750	22.65	1.96	

MEASURED BY

Time	Measured by
11:38 AM	Barbara Browning

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress - moderate distress.
Constitutional	Normal	Well nourished, Well developed.
Eyes	Normal	Fundus - Right: Normal, Left: Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Extremities - No edema.
Musculoskeletal	*	Cervical spine - muscle spasm. Lumbar spine - muscle spasm.
Neurological	*	Motor - quadraparesis. Balance & gait - lurched forward. DTRs - symmetrically increased.
Neurological	Normal	Level of consciousness - Normal. Orientation - Normal. Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact. Sensory - Normal. Coordination - Normal. Fine motor skills - Normal. Hand dominance - Right-handed.

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Inflamed nerve root (729.2).
	Impression	Lumbar spine repeat esi and see response, continue with meds.

Medications *(Started, Stopped or Renewed this visit)*

Started	Medication	Directions	Instruction	Stopped

04/14/2015	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening	
04/14/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	
04/14/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	Do not fill until 5-13-15
04/14/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 6 hours as needed for pain	Do not fill until 6-12-15
04/25/2013	Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)	
02/18/2015	promethazine 25 mg tablet	take 1 tablet by oral route every 8 hours prn nausea	
01/13/2015	Valium 10 mg tablet	take 1 tablet by oral route every 8 hours	
04/22/2015	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day	

Provider: George M. Sandoz MD 05/15/2015 12:43 PM

Grand Strand Spine and Neuro
8170 Rourk Street
Myrtle Beach, SC 29572
Ph: (843) 449-2336
Fax: (843) 497-2505

Grand Strand
HEALTH SYSTEM
Spine & Neuro Center

May 20, 2015

To Whom It May Concern:

RE: Victor Benjamin
DOB: [redacted]
Char[redacted]

Dear Sir/Madam:

Mr. Benjamin is a patient of mine who was seen initially on 09/16/2011 after being involved in a work-related injury. If you refer to that initial visit, he had complained of neck pain and limb pain secondary to a work-related injury. Unfortunately, this is secondary to the lack of workmen's comp care of the patient's cervical issues that he has with his neck, we were never been able to pay attention to his back issues. At this time since we have controlled his symptomatology in his neck, it is necessary to pursue evaluation of his back and we need to go ahead and try to relieve the symptoms with an epidural steroid injection and MRI and nerve conduction study of the leg should be done. According to his findings, we will see if it is necessary to pursue with any further treatment or investigation. We will follow up with the patient on a outpatient basis.

Sincerely,

George Sandoz, MD

GS/kis

cc: Jeff Chandler

Electronically Signed on 06/02/2015 2:41 PM

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TELEPHONE: 843.449.2336 • FACSIMILE: 843.497.2505 • WWW.GRANDSTRANDSURGICAL.COM

Grand Strand HEALTH SYSTEM
Spine & Neuro Center

Neurology
Jeff Benjamin, DO
Kenneth McCarthy, MD
Barbara Berk, DO
Anil Yellapragada, MD

Neurology and Ophthalmology
George Sandor, MD

Neurosurgery
Joseph Chacko, MD
Eugene Gleiberman, MD
Dini Hinkley, PA-C
Kenny Smith, NP

Orthopaedic Surgery/Traumatology
Christopher Poletto, DO
Amanda Barker, PA-C

June 19, 2015

Mr. Jeff Chandler
Chandler Law Firm
PO Box 1889
Myrtle Beach, SC 29578-1889

RE: Victor Benjamin
DOB: [redacted]
Chart: [redacted]

SSN: [redacted]

To Whom It May Concern:

Mr. Benjamin is a patient of mine, who I saw for the first time on 09/16/2011 after being involved in a work-related injury on 06/15/2011. As a result of this injury, the patient has suffered cervical disc injury that has left him with myelomalacia and he has been undergoing care by Dr. Poletti. I agree with the impairment rating given from the spinal cord injury and from the spinal cord lesion that he has. From the neurological standpoint, the patient has also been complaining of a headache. This headache, after evaluation of the AMA Guidelines Sixth Edition, the patient has 4% impairment of the whole body. The patient has also has suffered a traumatic brain injury with late effect of this injury associated with the headaches, seizure, posttraumatic stress disorder, and lumbar pain. From the injury that the patient has suffered a traumatic brain injury, the patient suffers a 29% impairment of the whole body according to the AMA Guidelines Sixth Edition. From the seizure standpoint, the patient had like 34% impairment of the whole body. Utilizing a combined value chart, this translates to 54% impairment of the whole body. This does not include the injury that he has suffered from the lumbar standpoint secondary to the injury that he has suffered and has not been addressed here as per Workmen's Comp. At this moment, please do not hesitate to call me if you have any other further questions or indications.

Sincerely,

Grand Strand HEALTH SYSTEM

Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 07/16/2015 11:00 AM
VISIT TYPE: Office Visit
Historian: self

This 53 year old male presents for neck pain and back pain.

History of Present Illness:

1. neck pain
   Onset: sudden. The problem is severe. The problem has worsened. The frequency of pain is daily. Location of pain is bilateral posterior neck. There is radiation of pain to the bilateral upper arm. The patient describes the pain as aching and burning. The event(s) surrounding the occurrence of the symptom include injury. Aggravating factors include exertion, hyperextension, pushing, straining, walking and working. Relieving factors include ice, injection, massage, narcotic analgesics, NSAIDs, physical therapy and standing. Associated symptoms include bladder incontinence, decreased mobility, difficulty sleeping, incoordination, loss of balance, muscle atrophy, muscle spasm, numbness, sexual dysfunction, tenderness, tingling and weakness. Pertinent negatives include bladder dysfunction not spinal related, bladder retention, bowel dysfunction not spinal related, bowel incontinence, bowel retention, dermatomic rash, dysphagia, joint pain, rash, sexual dysfunction (not spinal related) and weight loss. Additional information: feels worse unable to ambulate forlon distance causing decrease on ADL's, in bed until 3 back in bed after few hours and no relief with hydrocodone.
2. back pain
   Onset: sudden with injury. Duration: year. The problem is worsening. It occurs persistently. Location of pain is lower back. Pain is radiated to the dermatome anteriorly.The patient describes the pain as an ache, burning and throbbing. Context: trauma. Symptoms are aggravated by daily activities. Symptoms are relieved by pain meds/drugs.

Medications (active prior to today)

Medication Name	Sig Desc	Start Date	Stop Date	Refilled	Elsewhere
Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)	04/25/2013			N
Valium 10 mg tablet	take 1 tablet by oral route every 8 hours	01/13/2015		01/13/2015	N
promethazine 25 mg tablet	take 1 tablet by oral route every 8 hours prn nausea	02/18/2015			N
hydrocodone 10	take 1 Tablet by oral route	04/14/2015		04/14/2015	N

mg-acetaminophen 325 mg tablet	every ours as needed for pain			
hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	04/14/2015	04/14/2015	N
hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 6 hours as needed for pain	04/14/2015	04/14/2015	N
clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening	04/14/2015	04/14/2015	N
Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day	04/22/2015	04/22/2015	N

Allergies:

Ingredient	Reaction	Medication Name	Comment
MEPERIDINE HCL		Demerol	

REVIEW OF SYSTEMS

System	Neg/Pos	Details
Constitutional	Negative	Weight loss.
ENMT	Negative	Dysphagia.
GI	Negative	Bowel dysfunction not spinal related, fecal incontinence and fecal retention.
GU	Positive	Urinary incontinence.
GU	Negative	Bladder dysfunction not spinal related, sexual dysfunction not spinal related and urinary retention.
Neuro	Positive	Incoordination, Loss of balance, Numbness, Tingling.
Psych	Positive	Difficulty sleeping.
Integumentary	Negative	Dermatomic rash and rash.
MS	Positive	Decreased mobility, Muscle spasms, Muscular atrophy, Musculoskeletal tenderness, Weakness.
MS	Negative	Joint pain.
Reproductive	Positive	Sexual dysfunction.

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress = moderate distress.
Constitutional	Normal	Well nourished. Well developed.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Extremities - No edema.
Musculoskeletal	*	Cervical spine - muscle spasm, Range of motion: severe pain w/ motion. Lumbar spine - muscle spasm, Range of motion: severely reduced ROM.
Neurological	*	Motor - spastic Quadriparesis. Balance & gait - spastic hemiparesis. DTRs - symmetrically increased.
Neurological	Comments	fluent speech
Neurological	Normal	Level of consciousness - Normal. Orientation - Normal. Memory - Normal. II. Optic - PERRL. III. Oculomotor - Grossly intact. IV. Trochlear - Grossly intact. V. Trigeminal - Grossly intact, Motor and reflexes: Grossly intact, Sensation: Grossly intact. VI. Abducens - Grossly intact. VII. Facial - Grossly intact. VIII. Acoustic - Grossly intact. IX. Glossopharyngeal - Grossly intact. X. Vagus - Grossly intact. XI. Spinal accessory - Grossly intact. XII. Hypoglossal - Grossly intact. Sensory - Normal. Coordination -.

Psychiatric		Normal. Fine motor skills - Normal. H[illegible]ominance - Right-handed.
Psychiatric	Normal	Anhedonia. Inappropriate mood and affect - severely depressed. Orientation - Oriented to time, place, person & situation. Normal insight. Normal judgment.

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Lumbago (724.2).
	Impression	Doing the same-still awaiting for w/u to be completed.
2.	Assessment	Late effect of intracranial injury without mention of skull fracture (907.0).
	Impression	Causing seizure and migraine controled with meds..
3.	Assessment	Chronic pain syndrome (338.4).
	Impression	not-controled mood-disorder decrease ambulation-sever restriction-on-ADL'S interpersonal relation suffering-due-to-poor mood control see response to-meds and better pain control using-oxycodone-or-hydromorphone.

Medications *(added, continued or stopped this visit)*:

Started	Medication	Directions	Instruction	Stopped
07/16/2015	Cialis 10 mg tablet	take 1 tablet by oral route every day as needed		
04/14/2015	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening		
04/14/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain		
04/14/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 12 hours as needed for pain	Do not fill until 5-13-15	
04/14/2015	hydrocodone 10 mg-acetaminophen 325 mg tablet	take 1 Tablet by oral route every 6 hours as needed for pain	Do not fill until 6-12-15	
07/16/2015	hydromorphone 4 mg tablet	take 1 tablet by oral route every 8 hours		
07/16/2015	Lexapro 10 mg tablet	take 1 tablet by oral route every day		
04/25/2013	Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)		
07/16/2015	oxycodone-acetaminophen 10 mg-325 mg tablet	take 1 tablet by oral route every 8 hours as needed		
02/18/2015	promethazine 25 mg tablet	take 1 tablet by oral route every 8 hours prn nausea		
01/13/2015	Valium 10 mg tablet	take 1 tablet by oral route every 8 hours		
04/22/2015	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day		

Provider: George M. Sandoz MD 07/16/2015 12:36 PM

Document generated by: Ge Sandoz 07/16/2015 12:36 PM

Grand Strand Spine and Neuro
8170 Rourk Street
Myrtle Beach, SC 29572
Ph: (843) 449-2836
Fax: (843) 497-2505

Grand Strand HEALTH SYSTEM

Spine & Neuro Center

PATIENT: Victor Benjamin
DATE OF BIRTH: [redacted]
DATE: 10/01/2015 9:00 AM
VISIT TYPE: Office Visit
Historian: self

This 53 year old male presents for neck pain.

History of Present Illness:

1. neck pain

Onset: sudden. The problem is severe. Duration: year. The problem has worsened. The frequency of pain is constant. Location of pain is bilateral posterior neck. There is radiation of pain to the bilateral head and bilateral upper arm. The patient describes the pain as aching and burning. The event(s) surrounding the occurrence of the symptom include injury. Aggravating factors include driving, flexion, pushing, straining, walking and working. Relieving factors include narcotic analgesics. Associated symptoms include decreased mobility, difficulty sleeping, numbness and weakness. Pertinent negatives include bladder dysfunction not spinal related, bladder incontinence, bladder retention, bowel dysfunction not spinal related, bowel incontinence, bowel retention, dermatomic rash, dysphagia, incoordination, joint pain, loss of balance, muscle atrophy, muscle spasm, rash, sexual dysfunction, sexual dysfunction (not spinal related), tenderness, tingling and weight loss.

Medications (active prior to today)

Medication Name	Sig Desc	Start Date	Stop Date	Refilled	Elsewhere
Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours.)	04/25/2013			N
promethazine 25 mg tablet	take 1 tablet by oral route every 8 hours prn nausea	02/18/2015			N
clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening	04/14/2015		04/14/2015	N
Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day	04/22/2015		04/22/2015	N
Lexapro 10 mg tablet	take 1 tablet by oral route every day	07/16/2015			N
oxycodone-acetaminophen 10 mg-325 mg tablet	take 1 tablet by oral route every 6 hours as needed	07/28/2015	10/01/2015	10/01/2015	N
Valium 10 mg tablet	take 1 tablet by oral route every 8 hours	07/28/2015		07/28/2015	N
Cialis 10 mg tablet	take 1 tablet by oral route	07/28/2015		07/28/2015	N

	every day as needed		
oxycodone-acetaminoph en 10 mg-325 mg tablet	take 1 tablet by oral route every 8 hours as needed	07/28/2015	N
oxycodone-acetaminoph en 10 mg-325 mg tablet	take 1 tablet by oral route every 6 hours as needed	07/28/2015	N

Medication Reconciliation

Medications reconciled today.

Allergies:

Ingredient	Reaction	Medication Name	Comment
MEPERIDINE HCL		Demerol	

REVIEW OF SYSTEMS

System	Neg/Pos	Details
Constitutional	Negative	Weight loss.
ENMT	Negative	Dysphagia.
GI	Negative	Bowel dysfunction not spinal related, fecal incontinence and fecal retention.
GU	Negative	Bladder dysfunction not spinal related, sexual dysfunction not spinal related, urinary incontinence and urinary retention.
Neuro	Positive	Numbness.
Neuro	Negative	Incoordination, loss of balance and tingling.
Psych	Positive	Difficulty sleeping.
Integumentary	Negative	Dermatomic rash and rash.
MS	Positive	Decreased mobility, Weakness.
MS	Negative	Joint pain, muscle spasms, muscular atrophy and musculoskeletal tenderness.
Reproductive	Negative	Sexual dysfunction.

VITAL SIGNS

Time	BP mm/Hg	Pulse /min	Resp /min	Temp F	Ht ft	Ht in	Ht cm	Wt lb	Wt kg	BMI kg/m2	BSA m2	O2 Sat%
9:17 AM	128/67	61		98.90	6.0	0.00	182.88	171.00	77.564	23.19		

MEASURED BY

Time	Measured by
9:17 AM	Heather Small

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress - moderate distress.
Constitutional	Normal	Well nourished. Well developed.
Eyes	Normal	General - Right: Normal, Left: Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Extremities - No edema.
Musculoskeletal	Normal	Cervical spine - Normal. Lumbar spine - Normal.
Neurological	*	VIII. Acoustic - Findings: Weber test abnormal, lateralizes to the right. Motor - spastic quadraparesis. DTRs - symmetrically increased.
Neurological	Comments	fluent speech
Neurological	Normal	Level of consciousness - Normal. Orientation - Normal. Memory - Normal. II. Optic - PERRL. III. Oculomotor - Grossly intact. IV. Trochlear - Grossly intact. V. Trigeminal - Grossly intact. Motor and reflexes: Grossly intact. Sensation: Grossly intact. VI. Abducens - Grossly intact. VII. Facial - Grossly intact. IX. Glossopharyngeal - Grossly intact. X. Vagus - Grossly intact. XI. Spinal accessory - Grossly intact. XII. Hypoglossal - Grossly intact. Sensory - Normal. Balance & gait - Normal. Coordination - Normal. Fine motor skills - Normal. Hand dominance - Right-handed.
Psychiatric	*	Inappropriate mood and affect - depressed.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Normal insight. Normal judgment.

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Cervical disc disorder with myelopathy of cervicothoracic region (M50.03).
	Impression	Continue with current meds and pain is worse stressed compliance xray flexion and extension made.
2.	Assessment	Intracranial injury w/o LOC, subsequent encounter (S06.9X0D).
	Impression	Causing dizziness seizure headache and TBI stressed compliance with meds and therapy.

Medications *(added, continued or stopped this visit)*:

Started	Medication	Directions	Instruction	Stopped
07/28/2015	Cialis 10 mg tablet	take 1 tablet by oral route every day as needed		
04/14/2015	clonazepam 2 mg tablet	take 1 tablet by oral route 2 times every evening		
07/16/2015	Lexapro 10 mg tablet	take 1 tablet by oral route every day		
04/25/2013	Lidoderm 5 % (700 mg/patch) Adhesive Patch	apply 1 patch by transdermal route every day (May wear up to 12hours)		
07/28/2015	oxycodone-acetaminophen 10 mg-325 mg tablet	take 1 tablet by oral route every 8 hours as needed	do not fill until 9-26-15	
07/28/2015	oxycodone-acetaminophen 10 mg-325 mg tablet	take 1 tablet by oral route every 8 hours as needed	Do not fill until 10-26-15	

	nophen 10 mg-325 mg tablet	every 6 hours as needed	8-27-15
10/01/2015	oxycodone-acetami nophen 10 mg-325 mg tablet	take 1 tablet by oral route every 6 hours as needed	
07/28/2015	oxycodone-acetami nophen 10 mg-325 mg tablet	take 1 tablet by oral route every 6 hours as needed	10/01/2015
02/18/2015	promethazine 25 mg tablet	take 1 tablet by oral route every 8 hours prn nausea	
07/28/2015	Valium 10 mg tablet	take 1 tablet by oral route every 8 hours	
04/22/2015	Vimpat 100 mg tablet	take 1 tablet (100MG) by oral route 2 times every day	

Provider: George M. Sandoz MD 10/02/2015 10:32 AM
Document generated by: George Sandoz 10/02/2015 10:32 AM

Grand Strand Spine and Neuro
9170 Resurk Street
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Grand Strand Spine & Neuro Care

www.spineandneurocenter.com

NEUROLOGY	NEUROSURGERY
☐BARBARA L. SARB, D.O.	☐EUGENE GIDDENS, M.S.
☐MICHAEL MCCAFFREY, M.D.	☐JOSEPH CHEATLE, M.D.
☐JEFF A. BENJAMIN, D.O.	☐ERIN FINLEY, P.A.-C
☐ANIL YALLAPRAGADA, M.D.	☐KEMP SMITH, A.N.P.
☐ROBERT CONI, M.D.	ORTHOPEDICS
☐RASESH SHETH, P.A.	☐CHRISTOPHER G. BOULLION, D.O.
NEUROLOGY & OPTHAMOLOGY	☐AMANDA BARBER, P.A.-C
☐GEORGE M. SANDOZ, M.D.	

☐8170 Rourk St., Myrtle Beach, SC 29572 • (843) 449-2336 ☐4367 Riverwood Dr., Suite 120, Murrells Inlet, SC 29576 • (843) 357-8008
☐2376 Cypress Cr., Suite 200, Conway, SC 29526 • (843) 234-1710

Date Ordered: 10/1/15

Authorizing Signature: Benjamin Vetter

Patient:

Phone #:

Date of Birth: [redacted]

Social Security #: [redacted]

Consult/Diagnosis Study (ies): Scooter

Diagnosis Code:

Diagnosis:

Clinical Information: Decubitus Ulcer

Insurance Company:

Patient Preparation/Information: 869x05

Appointment: _____ **Appointment Time:** _____ **Appointment Location:** _____

(182)

P227

Intake Note

Date:	10/18/2011
Admission Date:	10/18/2011
Service:	96116 x 4 Neurobehavioral Examination (Comprehensive)
Provider:	Leonard Goldschmidt
Session Length:	210 mins.
Session Time:	9:00 am - 12:30 pm
Type of Visit:	Scheduled
Program:	neuropsychological evaluation
Location:	GSPS, PA
Others Present:	Letia (consented by patient)
Legal Status:	Voluntary
Patient:	Benjamin, Victor G.
SSN:	
Date of Birth:	[redacted] Age: [redacted]
Sex:	Male

Identifying Information

The patient is a 49 year old male.

Chief Complaint/History of Present Illness

Reason for Testing:
Mr. Benjamin was referred by neurologist and neuro-ophthalmologist, George Sandoz, M.D., due to multiple complaints of sensorimotor, cognitive, and emotional difficulties, which reportedly were secondary to a work related injury of 6/15/2011. Neuropsychological evaluation was indicated for differential diagnostics, baseline measurement, and appropriate treatment planning.

Presenting Problems:
Mr. Benjamin was a 49 year old black male who initially presented accompanied by his wife (Letia Benjamin) with complaints of multiple cognitive, behavioral, somatic, sensorimotor, and emotional difficulties.

Mr. Benjamin reported that on 6/15/2011, while working as a heavy factory machine operator at Rexam Beverages, Inc., a large metal mash guard weighing roughly 30 lbs was ejected off the machine falling onto Mr. Benjamin. The guard struck him on the left fronto-temporal parietal area, right forearm, and left upper arm/shoulder area.

Regarding the left upper arm/shoulder area, he sustained a roughly 2 inch laceration requiring suture repair.

Regarding the right forearm, he reportedly sustained severe laceration perpendicular to the musculature causing damage to the underlying tendons and musculature, for which he has

undergone surgical repair, as well as outpatient physical therapy, which he was discharged from roughly 2 weeks prior to the current intake.

Regarding his head injury, he reportedly suffered laceration to the fronto-temporal-parietal scalp, requiring suture repair. He reportedly was later told by fellow employee witnesses that he had lost consciousness for roughly 8 minutes. Emergency medical services then transported Mr. Benjamin to McLeod Hospital Emergency Department where he was evaluated and treated. He reportedly was admitted to the hospital for 4 days and then was discharged home. Mr. Benjamin reported that the last thing that he remembered was getting ready for a coil change 5-10 minutes prior to the incident based on his knowledge of what he was doing, with his next memory being lying on the floor of the plant looking up at a fellow employee assuring him that he would "be OK". He did not remember EMS arriving or being placed on the stretcher, but remembered being placed in the ambulance. His memory was reportedly "in and out" with confusion which lasted roughly 2-3 weeks. He reportedly had diplopia for for roughly 1 week, which has resolved. He reportedly had continuing nausea for several weeks, which now occurs only when he is experiencing headaches or with motion sickness which has only occurred since his 6/2011 injury.

Furthermore, he reported chronic headaches beginning after his 6/2011 work-related injury with accompanying phonophobia and nausea, but no accompanying photophobia or vomiting, with these headaches occurring on a near daily basis "several" times per day, lasting from several minutes to half the day, and occur bilaterally in the eyes and down the back of his head into his neck.

Somatically, Mr. Benjamin reported multiple difficulties since his work-related injury of 6/2011, including but not limited to: 1) Numbness in the right hand which has been stable; 2) Skin tingling/feeling of "pins and needles" from his right shoulder blade down through his right arm, 3) Occasional ringing and decreased hearing in his ears bilaterally; 3) Occasional episodes of "squiggly lines" in his vision; 4) Neck pain bilaterally extending down through the right arm, which he described on the Visual Analog Scale as occurring at a maximum of 9/10, and at a minimum of 4/10 and as burning, throbbing, sharp and shooting; 5) Problems with balance, coordination, and dropping things; 6) Occasional dizziness; and stuttering, central dysarthria and hypokinetic dysarthria especially when fatigued.

Cognitively, Mr. Benjamin and his wife reported that since his 6/2011 injury he has been experiencing short-term memory problems, prospective memory issues, difficulty understanding others/following conversations, difficulty finding the right words when talking, difficulty thinking slower than in the past (e.g., bradyphrenia), and difficulty thinking clearly. Both Mr. Benjamin and his wife report that these deficits have remained relatively stable since his 6/2011 injury.

Emotionally, Mr. Benjamin reported that he has an increased sense of stress and tension, since coping with changes in his life since his 6/2011 work-related injury. Mr. Benjamin and his wife did report that since his 6/2011 work-related injury they have noted that he has become easily and increasingly more agitated than they have ever known him to be in the past. However, both Mr. Benjamin and his wife report a continuing positive marital relationship. He does

however report continuing problems with decreased libido, and erectile dysfunction. He does report that since his October 2008 work-related injury, he has for the first time in his life began having problems with middle and initial insomnia, which has been relatively stable since his injury. He reports an appropriate appetite and stated that he has gained approximately 10 pounds since his 6/2011 injury, which he believes is secondary to inactivity.

History and Developmental Milestones:
History was obtained from Mr. Benjamin and his wife. Medical records will be requested.

Mr. Benjamin reported that he was the product of a normal pregnancy with normal developmental milestones, and no unusual childhood diseases or injuries.

As previously noted, Mr. Benjamin was involved in a work-related accident on 6/15/2011 (see Presenting Problems for details). He was currently involved in a Workmen's Compensation claim, and his attorney is Jeff Chandler, J.D.

Head imaging and EEG have been performed, but records have yet to be furnished.

Other than as previously noted, Mr. Benjamin's medical history was significant for hypertension, hypercholesteremia and fracture of his left ankle several years ago. Surgical history was unremarkable other than as needed for his recent work-related injury.

Other than as previously reported, no significant motor vehicle accidents, head injuries, or other traumas or surgeries that would be significant to his neurobehavioral/cognitive functioning were reported.

Mr. Benjamin denied tobacco use. He denied any significant use of alcohol. He denied use of illicit substances. He denied any history of prescription medication abuse. Mr. Benjamin was arrested in New Jersey for possession of a firearm in 1990 with charges reduced to disorderly conduct for which he paid a fine and charges in 1999/2000 for possession of a stolen car with charges dropped; and otherwise denied any other history of criminal activity or arrest.

Mr. Benjamin stated he was currently taking multiple medications, but did not have a list to furnish.

Mr. Benjamin denied any history of significant mental health problem prior to his work-related injury of 6/2011. As previously noted, he has since had significant difficulties with increased stress/tension, as well as increased frequency and degree of agitation. He denied any history of psychiatric or psychological evaluation or treatment. He denied any history of psychiatric hospitalizations. He denied any history of self injurious behaviors. He denied any history of suicidal ideation, plans, or attempts. He denied any history of homicidal ideations, plans, or attempts. He does have hypnogogic/hypnopompic phenomena since his 6/2011 injury. Mr. Benjamin denied any history of psychotic processes such as hallucinations or delusions. He denied any history of violence.

Mr. Benjamin lives in Sumter, South Carolina with his only wife of 28 years and his 19 year-old

son; he has a 12 year old son who lives with his mother with which he has visitation every other weekend and holidays. Both of his children were reportedly healthy. He reported that he was the eldest of 7 siblings. He stated that his siblings are relatively healthy with the exception of a sister who dies in her late 20's from leukemia. He reported that his father suffered from hypertension and hypothyroidism. Otherwise, his family history was reportedly not significant for any major physical or mental illness that would be significant to his neurobehavioral/cognitive functioning.

Mr. Benjamin reported that he completed high school as an average student in mainstream classes. He stated that he has been working in factory work for 35 years with 29 of them with his current employer. He has been out of work on medical disability since his 6/2011 injury.

DSM-IV Diagnosis

Axis I: 294.11 Dementia Due to Closed Head Brain Injury, with Behavioral Disturbance
Rule-Out Post-Traumatic Stress Disorder
Axis II: 799.9 Diagnosis or Condition Deferred on Axis II
Axis III: Closed Head Brain Injury
Axis IV: Loss of active employment
Axis V: Current GAF 50

Mental Status

The patient appears stated age. He is well oriented in all spheres. Regarding level of consciousness, he appears alert. Affect is labile. Mood is irritable. He presented himself in a neatly dressed and well-groomed fashion. Eye contact can be described as good. His speech is characterized by loosening associations. Recent memory appears mildly impaired. Remote memory is not impaired. Psychomotor activity can be characterized by psychomotor agitation. There is a mild degree of conceptual disorganization evident. His thought content is characterized by preoccupation with illness. Regarding perceptual functioning, the patient denies hallucinations and none are evident. Attitude can be described as cooperative and interested. As far as insight is concerned, the patient verbalizes partial awareness of problems. Judgment is fair. Attention/Concentration is characterized by distractibility. Regarding impulse control the patient shows poor frustration tolerance.

Plan: Full formal neuropsychological evaluation for differential diagnostics, baseline measurement and treatment planning. Will refer to Odepapo Oduwale, MD for psychopharmacologic management; will refer to Jason Rosenberg, MD for interventional pain and headache management; continue with George Sandoz, MD; weekly psychotherapy with Dr Nick Spring under my supervision; and monthly 2x 96116 neurobehavioral examination and rehabilitation/remediation with myself.



Leonard Goldschmidt, Psy.D., J.D.
Clinical Neuropsychologist
Forensic psychologist
Licensed Clinical Psychologist
South Carolina License #: 845

Grand Strand Psychological Services, PA
Patient Testing Note

Date: 11 / 10 2011
Patient: Last Name: BENJAMIN ; First Name: VICTOR
SSN: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Sex: ____Female ✓ Male
Service:
____96100 Psychological Testing/Scoring/Analysis/Report
____96101 Psychological Testing/Scoring/Analysis/Report
____96102 Psychological Testing/Scoring/Analysis/Report
S 96117 Neuropsychological Testing/Scoring/Analysis/Report
____96118 Neuropsychological Testing/Scoring/Analysis/Report
____96119 Neuropsychological Testing/Scoring/Analysis/Report
Provider: Leonard Goldschmidt, Psy.D.
Examiner: Becky Owens, Psychometrician
Location: Grand Strand Psychological Services, PA
11943 Grandhaven Blvd, Suite B
Murrells Inlet, SC 29576
Scheduled Session Time: 9:00 AM to 12:00 PM
Type of Visit: Scheduled
Program: ✓ Neuropsychological Evaluation
____Psychological Evaluation

Content/Process
Descriptive: Patient administered psychological/neuropsychological tests (see Tests Administered for details) by psychometrician, Becky Owens, for purposes of determination of diagnosis, baseline measurement and treatment planning/recommendations.

Scoring and analysis pending. Neuropsychological/Psychological Evaluation Report pending.

Assessment: Differential diagnosis and treatment recommendations pending.

Intake Diagnosis Code/s: 294.11 ; _____ ; _____ ; _____

Tests Administered

___ 5-POINT
___ APHASIA
___ BAI
✓ BCT
___ BHS
___ BNT
✓ CCPT II
___ CLOCK
___ COWAT
___ CVLT II
___ GDS
___ GRIP
___ GROOVE
___ ILS
___ JOLO
___ MMPI II
___ NAART
✓ PASAT
___ RCFT
___ REY 15
___ RHYTHM
___ SIMS
___ SPE
___ SSPT
___ STROOP
___ TAP
___ TOMM
✓ TPT
___ TRAILS A&B
___ WAIS-III
✓ WCST-4
___ WMS-III
Other:

Rebecca Owens
Becky Owens, Psychometrician

Leonard Goldschmidt J.D., Psy.D.
Clinical Neuropsychologist
Forensic Psychologist
Licensed Clinical Psychologist
South Carolina License #: 845

Grand Strand Psychological Services, PA
Patient Testing Note

Date: 10 / 27 /2011
Patient: Last Name: BENJAMIN ; First Name: VICTOR
SSN: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Sex: ___ Female ✓ Male
Service:
___ 96100 Psychological Testing/Scoring/Analysis/Report
___ 96101 Psychological Testing/Scoring/Analysis/Report
___ 96102 Psychological Testing/Scoring/Analysis/Report
5 96117 Neuropsychological Testing/Scoring/Analysis/Report
___ 96118 Neuropsychological Testing/Scoring/Analysis/Report
___ 96119 Neuropsychological Testing/Scoring/Analysis/Report
Provider: Leonard Goldschmidt, Psy.D.
Examiner: Becky Owens, Psychometrician
Location: Grand Strand Psychological Services, PA
11943 Grandhaven Blvd, Suite B
Murrells Inlet, SC 29576
Scheduled Session Time: 9:00 am to 12:00 Pm
Type of Visit: Scheduled
Program: ✓ Neuropsychological Evaluation
___ Psychological Evaluation

Content/Process
Descriptive: Patient administered psychological/neuropsychological tests (see Tests Administered for details) by psychometrician, Becky Owens, for purposes of determination of diagnosis, baseline measurement and treatment planning/recommendations.

Scoring and analysis pending. Neuropsychological/Psychological Evaluation Report pending.

Assessment: Differential diagnosis and treatment recommendations pending.

Intake Diagnosis Code/s: 294.11 ; ___ ; ___ ; ___

Tests Administered

___ 5-POINT	/ ILS	___ TPT
___ APHASIA	___ JOLO	/ TRAILS A&B
___ BAI	___ MMPI II	___ WAIS-III
___ BCT	___ NAART	___ WCST-4
___ BHS	___ PASAT	___ WMS-III
/ BNT Full	/ RCFT	Other:
___ CCPT II	___ REY 15	
___ CLOCK	/ RHYTHM	
___ COWAT	___ SIMS	
/ CVLT II	/ SPE	
___ GDS	/ SSPT	
/ GRIP	/ STROOP	
___ GROOVE	/ TAP	
	/ TOMM	

Becky Owens, Psychometrician

Leonard Goldschmidt J.D., Psy.D.
Clinical Neuropsychologist
Forensic Psychologist
Licensed Clinical Psychologist
South Carolina License #: 845

Grand Strand Psychological Services, PA
Patient Testing Note

Date: 10/26/2011
Patient: Last Name: BENJAMIN ; First Name: VICTOR
SSN: [redacted]
Date of Birth: [redacted]
Age: _____
Sex: ____Female ✓ Male
Service:
____96100 Psychological Testing/Scoring/Analysis/Report
____96101 Psychological Testing/Scoring/Analysis/Report
____96102 Psychological Testing/Scoring/Analysis/Report
5 96117 Neuropsychological Testing/Scoring/Analysis/Report
____96118 Neuropsychological Testing/Scoring/Analysis/Report
____96119 Neuropsychological Testing/Scoring/Analysis/Report
Provider: Leonard Goldschmidt, Psy.D.
Examiner: Becky Owens, Psychometrician
Location: Grand Strand Psychological Services, PA
11943 Grandhaven Blvd, Suite B
Murrells Inlet, SC 29576
Scheduled Session Time: 9:00 AM to 12:00 PM
Type of Visit: Scheduled
Program: ✓ Neuropsychological Evaluation
____Psychological Evaluation

Content/Process
Descriptive: Patient administered psychological/neuropsychological tests (see Tests Administered for details) by psychometrician, Becky Owens, for purposes of determination of diagnosis, baseline measurement and treatment planning/recommendations.

Scoring and analysis pending. Neuropsychological/Psychological Evaluation Report pending.

Assessment: Differential diagnosis and treatment recommendations pending.

Intake Diagnosis Code/s: 294.11 ; _____ ; _____ ; _____

Tests Administered

___ 5-POINT
___ APHASIA
___ BAI
___ BCT
___ BHS
___ BNT
___ CCPT II
___ CLOCK
✓ COWAT
___ CVLT II
___ GDS
___ GRIP
✓ GROOVE
___ ILS
___ JOLO
___ MMPI II
___ NAART
___ PASAT
___ RCFT
___ RBY 15
✓ RHYTHM
✓ SIMS
___ SPE
___ SSPT
___ STROOP
___ TAP
___ TOMM
___ TPT
✓ TRAILS A&B
✓ WAIS-III
___ WCST-4
✓ WMS-III
Other:

Becky Owens, Psychometrician

Leonard Goldschmidt J.D., Psy.D.
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Forensic Psychologist
Licensed Clinical Psychologist
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Grand Strand Psychological Services, PA
Patient Testing Note

Date: 10/25/2011
Patient:
Last Name: BENJAMIN ; First Name: VICTOR
SSN: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Sex: ___Female ✓ Male
Service:
___96100 Psychological Testing/Scoring/Analysis/Report
___96101 Psychological Testing/Scoring/Analysis/Report
___96102 Psychological Testing/Scoring/Analysis/Report
5 96117 Neuropsychological Testing/Scoring/Analysis/Report
___96118 Neuropsychological Testing/Scoring/Analysis/Report
___96119 Neuropsychological Testing/Scoring/Analysis/Report
Provider: Leonard Goldschmidt, Psy.D.
Examiner: Becky Owens, Psychometrician
Location: Grand Strand Psychological Services, PA
11943 Grandhaven Blvd, Suite B
Murrells Inlet, SC 29576
Scheduled Session Time: 9:00 AM to 12:00 PM
Type of Visit: Scheduled
Program: ✓ Neuropsychological Evaluation
___Psychological Evaluation

Content/Process
Descriptive: Patient administered psychological/neuropsychological tests (see Tests Administered for details) by psychometrician, Becky Owens, for purposes of determination of diagnosis, baseline measurement and treatment planning/recommendations.

Scoring and analysis pending. Neuropsychological/Psychological Evaluation Report pending.

Assessment: Differential diagnosis and treatment recommendations pending.

Intake Diagnosis Code/s: 294.11 ; ____ ; ____ ; ____

Tests Administered

- ✓ 5-POINT
- ✓ APHASIA
- ___ BAI
- ___ BCT
- ___ BHS
- ___ BNT
- ___ CCPT II
- ___ CLOCK
- ___ COWAT
- ___ CVLT II
- ___ GDS
- ___ GRIP
- ___ GROOVE
- ✓ ILS
- ✓ JOLO
- ✓ MMPI II
- ✓ NAART
- ___ PASAT
- ___ RCFT
- ✓ REY 15
- ___ RHYTHM
- ___ SIMS
- ___ SPE
- ___ SSPT
- ___ STROOP
- ___ TAP
- ___ TOMM
- ___ TPT
- ___ TRAILS A&B
- ___ WAIS-III
- ___ WCST-4
- ___ WMS-III

Other: P3

Rebecca Owens

Becky Owens, Psychometrician

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REPORT OF NEUROPSYCHOLOGICAL EVALUATION

PLEASE NOTE: THE INFORMATION IN THIS REPORT HAS BEEN DISCLOSED TO YOU FROM RECORDS FOR WHICH CONFIDENTIALITY IS PROTECTED BY SOUTH CAROLINA STATE LAW. NO FURTHER DISCLOSURE OF THIS INFORMATION SHOULD BE MADE WITHOUT THE WRITTEN PERMISSION OF THE INDIVIDUAL TO WHOM IT PERTAINS.

Name: Benjamin, Victor
Date of Birth: [redacted]
Age: [redacted]
Date(s) of Evaluation: 10/18/2011, 10/25/2011, 10/26/2011, 10/27/2011 and 11/10/2011
Location of Evaluation: The Neurobehavioral Institute at GSPS, PA
Evaluator: Leonard Goldschmidt, Psy.D., J.D.
Handedness: Left
Education: 12 years
Living Situation: Presently living at home independently with his spouse.
Others Present During Intake: Spouse with patient consent (Letia Benjamin)
Legal Status: Voluntary
SSN: [redacted]
Sex: Male

Chief Complaint/History of Present Illness

Mr. Benjamin was a 49 year old black male who initially presented accompanied by his wife (Letia Benjamin) with complaints of multiple cognitive, behavioral, somatic, sensorimotor, and emotional difficulties.

Mr. Benjamin was referred by neurologist and neuro-ophthalmologist, George Sandoz, M.D., due to multiple complaints of sensorimotor, cognitive, and emotional difficulties, which reportedly were secondary to a work related injury of 6/15/2011. Neuropsychological evaluation was indicated for differential diagnostics, baseline measurement, and appropriate treatment planning.

Mr. Benjamin reported that on 6/15/2011, while working as a heavy factory machine operator at Rexam Beverages, Inc., a large metal mash guard weighing roughly 30 lbs. was ejected off the machine falling onto Mr. Benjamin. The guard struck him on the left fronto-temporal parietal area, right forearm, and left upper arm/shoulder area.

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Regarding the left upper arm/shoulder area, he sustained a roughly 2 inch laceration requiring suture repair.

Regarding the right forearm, he reportedly sustained severe laceration perpendicular to the musculature causing damage to the underlying tendons and musculature, for which he has undergone surgical repair, as well as outpatient physical therapy, which he was discharged from roughly 2 weeks prior to the current intake.

Regarding his head injury, he reportedly suffered laceration to the fronto-temporal-parietal scalp, requiring suture repair. He reportedly was later told by fellow employee witnesses that he had lost consciousness for roughly 8 minutes. Emergency medical services then transported Mr. Benjamin to McLeod Hospital Emergency Department where he was evaluated and treated. He reportedly was admitted to the hospital for 4 days and then was discharged home. Mr. Benjamin reported that the last thing that he remembered was getting ready for a coil change 5-10 minutes prior to the incident based on his knowledge of what he was doing, with his next memory being lying on the floor of the plant looking up at a fellow employee assuring him that he would "be OK". He did not remember EMS arriving or being placed on the stretcher, but remembered being placed in the ambulance. His memory was reportedly "in and out" with confusion which lasted roughly 2-3 weeks. He reportedly had diplopia for roughly 1 week, which has resolved. He reportedly had continuing nausea for several weeks, which now occurs only when he is experiencing headaches or with motion sickness which has only occurred since his 6/2011 injury.

Furthermore, he reported chronic headaches beginning after his 6/2011 work-related injury with accompanying phonophobia and nausea, but no accompanying photophobia or vomiting, with these headaches occurring on a near daily basis "several" times per day, lasting from several minutes to half the day, and occur bilaterally in the eyes and down the back of his head into his neck.

Somatically, Mr. Benjamin reported multiple difficulties since his work-related injury of 6/2011, including but not limited to: 1) Numbness in the right hand which has been stable; 2) Skin tingling/feeling of "pins and needles" from his right shoulder blade down through his right arm, 3) Occasional ringing and decreased hearing in his ears bilaterally; 3) Occasional episodes of "squiggly lines" in his vision; 4) Neck pain bilaterally extending down through the right arm, which he described on the Visual Analog Scale as occurring at a maximum of 9/10, and at a minimum of 4/10 and as burning, throbbing, sharp and shooting; 5) Problems with balance, coordination, and dropping things; 6) Occasional dizziness; and stuttering, central dysarthria and hypokinetic dysarthria especially when fatigued.

Cognitively, Mr. Benjamin and his wife reported that since his 6/2011 injury he has been experiencing short-term memory problems, prospective memory issues, difficulty understanding others/following conversations, difficulty finding the right words when talking, difficulty thinking slower than in the past (e.g., bradyphrenia), and difficulty thinking clearly. Both Mr. Benjamin and his wife report that these deficits have remained relatively stable since his 6/2011 injury.

Emotionally, Mr. Benjamin reported that he has an increased sense of stress and tension, since

coping with changes in his life since his 6/2011 work-related injury. Mr. Benjamin and his wife did report that since his 6/2011 work-related injury they have noted that he has become easily and increasingly more agitated than they have ever known him to be in the past. However, both Mr. Benjamin and his wife report a continuing positive marital relationship. He does however report continuing problems with decreased libido, and erectile dysfunction. He does report that since his work-related injury, he has for the first time in his life began having problems with middle and initial insomnia, which has been relatively stable since his injury. He reports an appropriate appetite and stated that he has gained approximately 10 pounds since his 6/2011 injury, which he believes is secondary to inactivity.

History and Developmental Milestones:

History was obtained from Mr. Benjamin and his wife. Medical records were requested on several occasions from both plaintiff's attorney and nurse case management, but were not as yet furnished at the time of the preparation of the current report.

Mr. Benjamin reported that he was the product of a normal pregnancy with normal developmental milestones, and no unusual childhood diseases or injuries.

As previously noted, Mr. Benjamin was involved in a work-related accident on 6/15/2011. He was currently involved in a Workmen's Compensation claim, and his attorney is Jeff Chandler, J.D.

Head imaging and EEG have been performed, but records have yet to be furnished.

Other than as previously noted, Mr. Benjamin's medical history was significant for hypertension, hypercholesteremia and fracture of his left ankle several years ago. Surgical history was unremarkable other than as needed for his recent work-related injury.

Other than as previously reported, no significant motor vehicle accidents, head injuries, or other traumas or surgeries that would be significant to his neurobehavioral/cognitive functioning were reported.

Mr. Benjamin denied tobacco use. He denied any significant use of alcohol. He denied use of illicit substances. He denied any history of prescription medication abuse. Mr. Benjamin was arrested in New Jersey for possession of a firearm in 1990 with charges reduced to disorderly conduct for which he paid a fine and charges in 1999/2000 for possession of a stolen car with charges dropped; and otherwise denied any other history of criminal activity or arrest.

Mr. Benjamin stated he was currently taking multiple medications, but did not have a list to furnish.

Mr. Benjamin denied any history of significant mental health problem prior to his work-related injury of 6/2011. As previously noted, he has since had significant difficulties with increased stress/tension, as well as increased frequency and degree of agitation. He denied any history of psychiatric or psychological evaluation or treatment. He denied any history of psychiatric

hospitalizations. He denied any history of self injurious behaviors. He denied any history of suicidal ideation, plans, or attempts. He denied any history of homicidal ideations, plans, or attempts. He does have hypnogogic/hypnopompic phenomena since his 6/2011 injury. Mr. Benjamin denied any history of psychotic processes such as hallucinations or delusions. He denied any history of violence.

Mr. Benjamin lives in Sumter, South Carolina with his only wife of 28 years and his 19 year-old son; he has a 12 year old son who lives with his mother with whom he has visitation every other weekend and holidays. Both of his children were reportedly healthy. He reported that he was the eldest of 7 siblings. He stated that his siblings are relatively healthy with the exception of a sister who dies in her late 20's from leukemia. He reported that his father suffered from hypertension and hypothyroidism. Otherwise, his family history was reportedly not significant for any major physical or mental illness that would be significant to his neurobehavioral/cognitive functioning.

Mr. Benjamin reported that he completed high school as an average student in mainstream classes. He stated that he has been working in factory work for 35 years with 29 of them with his current employer. He has been out of work on medical disability since his 6/2011 injury.

Mental Status:

The patient appeared his stated age. He was well oriented in all spheres. Regarding level of consciousness, he appeared alert. Affect was labile. Mood was irritable. He presented himself in a neatly dressed and well-groomed fashion. Eye contact could be described as good. His speech was characterized by loosening associations. Recent memory appeared mildly impaired. Remote memory was not impaired. Psychomotor activity could be characterized by psychomotor agitation. There was a mild degree of conceptual disorganization evident. His thought content was characterized by preoccupation with his illness. Regarding perceptual functioning, the patient denied hallucinations and none were evident. Attitude could be described as cooperative and interested. As far as insight was concerned, the patient verbalizes partial awareness of his problems. Judgment was fair. Attention/Concentration was characterized by distractibility. Regarding impulse control the patient showed poor frustration tolerance.

Evaluation Procedures:

Booklet Category Test (BCT)
Boston Naming Test (BNT)
California Verbal Learning Test – II (CVLT-II)
Clinical Interview
Conner's Continuous Performance Test - II (CCPT-II)
Controlled Oral Word Association Task (COWAT)
Five Point
Frontal Release Reflex Examination
Grip Test
Grooved Pegboard

Halstead-Reitan Aphasia Screening Test (HRB-AST)
Independent Living Skills (ILS)
Judgment of Line Orientation (JOLO)
Manual Finger Tapping Test
Minnesota Multiphasic Personality Inventory – 2 (MMPI-2)
North American Adult Reading Test (NAART)
Paced Auditory Serial Addition Test (PASAT)
Patient Neuropsychological Checklist
P-3
Rey Complex Figure Test (RCFT)
Rey-15 Item
Seashore Rhythm Test (Rhythm)
Sensory-Perceptual Examination (SPE)
Structured Inventory of Malingered Symptoms (SIMS)
Speech Sounds Perception Test (SSPT)
Stroop
Tactual Performance Test (TPT)
Test of Memory Malingering (TOMM)
Trail Making Test (Parts A & B)
Wechsler Adult Intelligence Scale-III (WAIS-III)
Wechsler Memory Scales - III (WMS-III)
Wisconsin Card Sorting Test- Computer Version 4 (WCST-CV4)

Behavioral Observations During Testing:

Mr. Benjamin was generally pleasant during the testing sessions. He was generally able to sit still, but did report headache and shoulder pain. He was generally able to stay on task even when the tasks were beyond his capacity, but did require some redirection to return to task. Mr. Benjamin was patient to answer questions. His answers were direct and elaborated.

Mr. Benjamin was generally cooperative. His speech was coherent, with minimal evidence of paraphasic errors or circumlocutions. His mood seemed to evidence a depressive and anxious outlook. He was seemingly aware of his poor performances.

Mr. Benjamin's neuropsychological profile was likely valid and interpretable.

FUNCTIONAL TESTING:

Memory Functions:
Memory functions were assessed generally and to the complex activities of memorization, recall and recognition. The patient generally does not evidence gross memory deficits with appropriate recall of personal information (e.g., his age, length of marriage, children's ages, etc.). Objective assessment of memory skills evidenced functioning generally within the mild level of deficit (10th percentile).

Composite memory scores evidenced functioning:

1. Within normal limits for auditory immediate memory (34th percentile);
2. Within the Below Average range for visual immediate memory (21st percentile);
3. Within the Below Average range for immediate memory (23rd percentile);
4. Within the Below Average range for auditory delayed memory (23rd percentile);
5. Within the mild level of deficit for visual delayed memory (10th percentile);
6. Within the mild level of deficit for auditory recognition delayed memory (9th percentile); and
7. Within the Below Average range for working memory (21st percentile). Working memory is a measure of complex or high level attentional tasks that stress the ability to attend to information, to hold and process that information in memory, and to formulate a response based on that information.

There was no difference between auditory immediate and visual immediate memory composites.

None of the memory composites were significantly different than predicted by the patient's full scale intellectual ability score (WAIS-III FSIQ = 80), suggesting a lack of acquired memory impairment.

Supraspan auditory word list learning evidenced functioning within the borderline level of deficit for single trial learning (16th percentile), but within normal limits by the end of five trials (50th percentile) with a positive learning slope within the Above Average range (84th percentile). There was no evidence of proactive interference. The patient evidenced functioning within normal limits for short delay free recall (69th percentile), short delay cued recall (31st percentile), long delay free recall (31st percentile) and long delay cued recall (50th percentile). Delayed "yes/no" recognition was within normal limits (50th percentile) with normal levels of false positives. Forced choice recognition evidenced moderate levels of deficit (5th percentile).

The patient's memory evidenced Below Average functioning for abstract visual recall during both a 3 minute recall task (21st percentile) and a 30 minute delayed recall task (21st percentile). Delayed visual abstract recognition scores were within the borderline level of deficit (16th percentile).

Attention / Concentration:
Basic attention was grossly intact. Simple auditory verbal attention span evidenced functioning within normal limits (63rd percentile). Simple auditory verbal concentration/discrimination evidenced functioning within the severe level of deficit (<1st percentile). Simple auditory attention for rhythm patterns was within normal limits (31st percentile). On a task that measures divided auditory attention, vigilance and complex conceptual tracking, results evidenced functioning within normal limits (34th percentile).

Simple visual spatial tracking and attention evidenced functioning within the borderline level of deficit (16th percentile), increasing to within the Above Average range (76th percentile) when simple visual conceptual tracking was introduced. On a more complicated measure of divided visual attention and complex conceptual tracking performance evidenced functioning within normal limits (50th percentile).

Simple speeded visual-perceptual processing evidenced functioning within normal limits (35th percentile). The ability to switch perceptual set to conform to changing demands and to suppress a habitual response in favor of an unusual one, evidenced results ranging from within the moderate to severe level of deficit (<1st percentile-2nd percentile).

On a sensitive test of visual inattention, vigilance and motor impulsivity there was no indication of any timing difficulties or patient noncompliance, suggesting that the results were valid. Overall scores indicated that there was a 47.7% chance that a clinical attention problem existed; and there was a 37.3% chance that a neurologically related attention problem existed.

Motor Functions:
Frontal release reflex examination was negative (e.g., palmomental, glabellar, rooting, grasp and snout). No cogwheeling or tremor was noted without paratonia/*gegenhalten*. Gait was normal.

There was no evidence of facial droop, and there was no significant asymmetry of upper or lower facial musculature.

Grip strength was within the severe level of deficit for the dominant left hand (1st percentile) and within the profoundly severe level of deficit for the nondominant right hand (<0.03rd percentile) with nondominant right hand performance being significantly weaker than dominant left hand performance regarding expected right-left differences.

Manual motor speed was within normal limits for the dominant left hand (66th percentile) and within the Above Average range for the nondominant right hand (76th percentile) with no significant right-left differences noted.

Fine motor coordination was within normal limits for the dominant left hand (58th percentile) and within the Below Average range for the nondominant right hand (27th percentile) with no significant right-left differences noted.

Sensory Functions:
Tactile sensory functions were examined in the areas of gross perception and capacity to meaningfully integrate tactile stimuli. Primary unilateral perception of simple pressure stimuli was intact bilaterally for the hands and the face. There was no evidence of bilateral cortical suppression for the hands or face with no significant right-left differences noted.

Assessment of gross auditory perception revealed no impairment during unilateral stimulation however, there was no evidence of auditory cortical suppression with no significant right-left differences noted.

Gross peripheral vision was full as assessed by confrontation with no evidence of visual cortical suppression with no significant right-left differences noted.

There was no impairment of tactile finger localization bilaterally with no significant right-left differences noted.

There was evidence of severe deficit on a measure of graphesthesia for the dominant left hand (<0.03rd percentile) and moderate deficit for the nondominant right hand (4th percentile); there were no significant right-left differences noted.

Assessment of stereognostic skills produced evidence of normal functioning of tactile integration skill bilaterally with no significant right-left differences noted.

On a test of tactile-spatial integration and recognition, functioning was within normal limits (58th percentile).

Visual-Spatial Functions:
The patient evidenced detailed and complex visual organization and planning to be within normal limits (>16th percentile).

Ability to estimate angular relationships between line segments evidenced functioning within the Below Average range (22nd percentile).

Language Functions:
The patient's speech was coherent. There was evidence of moderate anomia during a thorough test of confrontation naming (5th percentile). There was no evidence of deficit in receptive speech functions throughout the assessment with comprehension of simple sentence structure evident in the patient's understanding of instructions and requirements on most tasks presented. Speech seemed to have a normal quality with respect to prosody and meter with minimal evidence of circumlocution or paraphasic error. There was evidence of spelling dyspraxia, central dysarthria, dyslexia and dyscalculia during gross examination. There was no evidence of ideational dyspraxia, body dysgnosia or right-left confusion during gross examination.

There was evidence of borderline deficit (14th percentile) in word finding during an associative word finding task that required production of words with letter cueing, but functioning remained within normal limits (34th percentile) when production was based on categorical cueing.

Executive Functions:
As previously noted, the patient evidenced detailed and complex visual organization and planning to be within normal limits (16th percentile).

On a test of visuo-graphic production, the patient performed within normal limits for number of unique designs, but within the borderline level of deficit (15th percentile) for levels of perseveration.

On one test of visual abstract pattern recognition and problem-solving the patient evidenced functioning within the Below Average range (18th percentile).

On a second test of visual abstract pattern recognition and problem-solving, the patient performed within the Above Average range for total number of problem-solving errors made (81st percentile), percent of problem-solving errors made (82nd percentile), number of perseverative responses (86th percentile), percent of perseverative responses (88th percentile),

number of perseverative errors (86th percentile), percent of perseverative errors (87th percentile), number of nonperseverative errors (75th percentile) and percent of conceptual level responses (86th percentile). Otherwise, results evidenced functioning within normal limits for percent of nonperseverative errors (70th percentile), number of problem-solving categories completed (>16th percentile), trials for novel problem-solving (>16th percentile), failure to maintain problem-solving set (>16th percentile), recognition to learn from feedback (>16th percentile).

On a task which measures the ability to follow directions, clerical speed and accuracy, and psychomotor speed (WAIS-III Digit Symbol-Coding), Mr. Benjamin performed within the moderate level of deficit (2nd percentile). This subtest has been found to be the most sensitive of the WAIS-III subtests to the presence of cerebral pathology.

On a measure of mental flexibility, visual conceptualization, and pattern recognition (WAIS-III Matrix Reasoning), Mr. Benjamin performed within normal limits (50th percentile).

On a task which measures anticipation of consequences, temporal sequencing and time concepts (WAIS-III Picture Arrangement), Mr. Benjamin performed within the mild level of deficit (9th percentile).

On a task which measures the ability to analyze a whole into its component parts, nonverbal concept formation and spatial visualization (WAIS-III Block Design), Mr. Benjamin performed within the mild level of deficit (9th percentile).

Orientation:
There was full awareness of the time, day of the week, day of the month, month, year, current president, past president and estimate of the length of the initial assessment session.

Intellectual Functions:
The patient obtained a Full Scale IQ score of 80, 9th percentile (Low Average); a Verbal IQ score of 83, 13th percentile (Low Average); and a Performance IQ score of 80, 9th percentile (Low Average).

The 3-point discrepancy between Verbal and Performance IQ scores was not enough to indicate statistical significance, meaning that ability for verbal comprehension and ability to use verbal skills in reasoning is not significantly different than the capacity for perceptual organization and for nonverbal reasoning skills.

Inter-subtest analysis revealed significant scatter among the patient's subtest scores within the Verbal subtests. Verbal subtest scores fell within the Borderline to Average range. The patient performed significantly better, relative to himself, on a task which measures auditory attention span (Digit Span).

Inter-subtest analysis revealed significant scatter among the patient's subtest scores within the Performance subtests. Performance subtest scores fell within the Borderline to Average range. The patient performed significantly better, relative to himself, on a measure of mental flexibility, visual conceptualization, and pattern recognition (WAIS-III Matrix Reasoning). The patient

performed significantly worse, relative to himself, on a task which measures the ability to follow directions, clerical speed and accuracy, psychomotor speed, and short term visual memory (Digit Symbol-Coding).

The patient's profile evidenced a substantial degree of intrasubtest scatter. In other words, he had a tendency to answer questions or perform tasks inconsistently (e.g., frequently scoring wrongly on easier items, while scoring correctly on more difficult items) suggesting problems with attention, thereby artificially lowering his measured intellectual ability scores. This finding is consistent with other results which evidence a higher premorbid intellectual ability (e.g., NAART, WCST-CV4).

Estimated full scale intellectual ability was within the Low Average range (Estimated FSIQ = 89); estimated verbal scale intellectual ability was within the Low Average range (Estimated VIQ = 84); and estimated performance scale intellectual ability was within the Average range (Estimated VIQ = 98) (NAART).

Overall, there is significant ambiguity between the patient's scores on measures of current and predicted intellectual ability, suggesting the possibility of acquired cerebral pathology.

Emotional Functions:

MMPI-2:

The MMPI-2 was administered to Mr. Benjamin. The MMPI-2 profile suggests that he may have been somewhat denying, repressing, or defensive or that he may simply have poor insight/awareness into his psychological state; and that he was probably experiencing some specific difficulties from an emotional standpoint. He was able to maintain a healthy balance between positive self-evaluation and self-criticism in responding to the MMPI-2 items. Mr. Benjamin's profile was likely valid and interpretable, but may underestimate the degree of his psychopathology. Based on other measures of validity on this test, as well as his MMPI-2 subscale profile, exaggeration is unlikely; rather, he was likely experiencing a significant thought disorder commensurate with his reports of cognitive and behavioral difficulties since his 6/2011 head injury.

Mr. Benjamin's Basic Scales profile evidenced a profoundly elevated Scale 1 (t-score = 90). For persons with such a highly elevated scale 1, dramatic and sometimes bizarre somatic concerns should be suspected, and in conjunction with scores on Basic Scales 3 and 8, his profile suggests the possibility of somatic delusions.

Basic Scale 3 was severely elevated (t-score = 81). Elevations of this level are often suggestive of persons who have strong somatic/bodily reactions towards stress. A salient feature of such scorers is a marked lack of insight concerning the possible underlying causes of their symptoms, motives and feelings. People like this may often be described as being psychologically immature and childish at times. When others do not respond appropriately, people like this tend to become hostile and resentful, but are likely to denied their feelings.

Basic Scale 2 was severely elevated (t-score = 76). People who score like this often display severe depressive symptomatology. They frequently report feeling depressed, unhappy, and dysphoric. They tend to be pessimistic about the future in general and more specifically about the

likelihood of overcoming their problems and becoming a better adjusted. Behavioral manifestations may include agitation, lack of energy, crying, refusal to speak, and psychomotor retardation.

P3:
Although Mr. Benjamin's Anxiety score was in the average range compared to other pain patients, he reported a number of symptoms of anxiety, agitation, and cognitive distress. He may have trouble controlling his anger. He may report being irritated by situations and events that formally went relatively unnoticed. He was probably not comfortable in social situations and would prefer to avoid them. He reported feeling irritable, tense, worried, impatient, and upset, and he may find it difficult to relax and make decisions. Others may describe him as on edge, somewhat agitated, and distracted. These symptoms of anxiety may be beginning to strain his coping skills. Although his score on the Anxiety scale was not unusual for a pain patient, his score was high enough to suggest that anxiety may complicate his symptom perception and response to pain treatment.

Mr. Benjamin's Somatization score was close to the average for pain patient. His scores suggested that he was concerned about and attentive to his health-related problems and symptoms, but somatic issues do not appear to occupy an undue amount of his attention. Individuals with a clearly defined organic basis for pain often respond in this manner. In individuals such as himself for which pain is associated with a physical trauma, he may feel victimized and angry, and he may blame others. He was probably experiencing mounting frustration and periodic somatic distraction. Although he was cognitively and emotionally distressed by his physical pain, his scores suggested that he has the ability to actively participate in a treatment plan without major interference from excessive somatic thought. Even though this level of somatic complaints should not seriously interfere with his treatment program, his somatic symptoms may complicate his symptom perception and response to treatment.

Mr. Benjamin's Depression score suggested that he was more depressed than the average community subject. However, he has fewer symptoms of depression than the average pain patient. He is probably optimistic that his pain disorder will improve. He should demonstrate appropriate levels of physical and psychological energy as well as the motivation required to participate as an active partner in a treatment plan. At present, his pain disorder does not appear to be creating undue emotional distress.

Life Skills:
Evaluation of Mr. Benjamin's life skills evidenced that he was experiencing some difficulties with the skills needed for independent living including moderate levels for memory/orientation, managing home, managing transportation, problem-solving, health and safety. Otherwise, functioning was within the high levels for managing money, performance, information base, and social adjustment.

Overall, evaluation of Mr. Benjamin's life skills evidenced a moderate degree of functionality for independent living suggesting that he likely requires some support with his living skills and is unlikely to be able to live independently without such support.

Validity Assessment:
On the Structured Inventory of Malingered Symptoms (SIMS), results evidenced that Mr. Benjamin scored beyond cutoff on several scales and overall. These scores suggested the need to consider the possibility of exaggeration of deficits.

Mr. Benjamin was further administered multiple tasks to rule out any exaggeration of deficits or malingering. On the Rey-15-item, Mr. Benjamin scored perfectly (15/15), suggesting appropriate motivation and effort.

The patient was given the Test of Memory Malingering (TOMM); which is a test of effort and motivation on memory tasks. Results of these tasks evidenced performance above cutoff on both of the appropriate trials indicating that that the patient was likely motivated and giving full effort to his performances.

The generally normal scores throughout the actual memory testing were also supportive of appropriate levels of motivation, and effort.

Finally, the MMPI-2 validity profile was indicative of appropriate responding reflecting significant psychopathological difficulties.

Although there was some question of exaggeration of deficits during self-report questionnaire, this was likely the result of the rather profound psychiatric difficulties and cognitive deficits noted during the remainder of the evaluation. This is further supported by the consistency of documented deficits over time, and it is likely that the neuropsychological findings during current neuropsychological evaluation were valid.

Summary and Conclusions:
Mr. Benjamin was a 49 year old black male who presented accompanied by his wife for clinical interview.

Mr. Benjamin reported that on 6/15/2011, while working as a heavy factory machine operator at Rexam Beverages, Inc., a large metal mash guard weighing roughly 30 lbs. was ejected off the machine falling onto Mr. Benjamin. The guard struck him on the left fronto-temporal parietal area, right forearm, and left upper arm/shoulder area.

Mr. Benjamin was referred by neurologist and neuro-ophthalmologist, George Sandoz, M.D., due to multiple complaints of sensorimotor, cognitive, and emotional difficulties, which reportedly were secondary to his work related injury of 6/15/2011. Neuropsychological evaluation was indicated for differential diagnostics, baseline measurement, and appropriate treatment planning.

Results of objective testing including evaluation of effort and motivation, indicate that Mr. Benjamin's functional profile was likely valid and showed appropriate levels of effort.

Mr. Benjamin obtained a Full Scale IQ score of 80, 9th percentile (Low Average); a Verbal IQ score of 83, 13th percentile (Low Average); and a Performance IQ score of 80, 9th percentile (Low Average).

Test data suggested that Mr. Benjamin was experiencing several cognitive deficits and behavioral deficits that were consistent with his closed head traumatic brain injury; these deficits were primarily concerning memory, attention, and executive functioning (See Functional testing for details). Otherwise, he was generally functioning within normal limits of functioning, reaching to as high as in the Above Average range. Other than in the previously mentioned areas of functioning, Mr. Benjamin's functional status was largely commensurate with his intellectual ability.

In addition, Mr. Benjamin was likely evidencing significant levels of somatic concerns and chronic pain, which are not surprising considering the multiple injuries sustained during his 6/2011 at work-related accident. His emotional functioning is likely marked by a significant lack of awareness/insight, but he was likely experiencing significant levels of depressed mood.

In regards to the etiology of Mr. Benjamin's emotional/psychological difficulties, it is likely that they are partially the result of a closed head brain injury, as well as, a post-traumatic stress response. There is likely a reciprocally exacerbating effect between these two etiologies. However, a thorough review of the patient's medical, academic and employment records is highly recommended for improved differential diagnostic between pre-injury/pre-morbid disability and post-injury cognitive losses.

The nature of Mr. Benjamin's history and functional profile is consistent with a diagnosis of a Cognitive Disorder, Not Otherwise Specified (Likely Secondary to a Closed Head Traumatic Brain Injury).

Diagnostic Impressions:

Mr. Benjamin met the diagnostic criteria for ICD-9/DSM IV:

Axis I:	294.11	Cognitive Disorder, Not Otherwise Specified (Likely Secondary to a Closed Head Traumatic Brain Injury)
Axis II:	Deferred	
Axis III:		Closed head brain injury and chronic pain secondary to work-related accident of 6/2011
Axis IV:		Coping with decreased cognitive and behavioral functionality
Axis V:	GAF = 50	

Recommendations:

1. Due to the etiology and effect of Mr. Benjamin's cognitive, neurobehavioral, and emotional condition on his current and future well-being, psychotherapy is recommended to help him to cope with his situation. Psychotherapy should be both supportive and insight based and could include working on issues of depression, frustration control, pain management, and coping with the possible loss/curtailment of his independence. Psychotherapy can include both individual and group modalities.

2. Due to the nature of Mr. Benjamin's cognitive and neurobehavioral deficits it is recommended that he attend psychoeducational treatment to create an underlying understanding of his deficits and how they may affect his capacity to perform certain activities safely and effectively, both in the present and the future.

3. Psychiatric consultation for psychopharmocologic intervention of Mr. Benjamin's depression and cognitive/attention deficits is recommended.

4. Due to the possibility of functional changes surrounding brain injury and their importance for independence and quality of life issues, neuropsychological follow up is recommended in 12 months which should include reevaluation of areas of functional loss and continued treatment planning.

5. Due to the chronicity of Mr. Benjamin's pain/cephalgia, referral is made to Jason Rosenberg, M.D. for interventional pain management.

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cc: George Sandoz, M.D.
Odedapo Oduwole, M.D.
Jason Rosenberg, M.D.
Stephania Stokes, R.N.
Jeff Chandler, J.D.

Name: Benjamin, Victor Date: 12.7.2011

Patient Name:	
Grand Strand Psychological Services	
Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Lamictal RX Nucynta
Psychiatric Hospitalizations	None
Age	Date Of Birth: [redacted]
Gender	Male
Date of Session	12.7.2011
Start Time	10:30 am
End Time	11:45 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Mr. Benjamin was referred due to multiple complaints. Patient is a 49 year old black male who is experiencing sensorimotor and emotional difficulties, cognitive and emotional difficulties which were related to work injury of 6.15.2011. Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. Did not tell the patient what the symptoms related to as far as the symptoms relating to PTSD. The end result was the patient suffers with PTSD and it is chronic. In the next session we will put all the symptoms that apply to patient down in his notes. Today was a time to review with patient the history of the injury and what is going on in his life. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative

PAGE 15/17
12/22/2011 15:48 8436524683 (210) PS, PA
P255

Name: Benjamin, Victor Date: 12.7.2011

	Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

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Forensic Psychologist

PAGE 17/17
12/22/2011 16:48 8436524603 (211) BPS, PA
P256

Name: Benjamin, Victor Date: 12.14.2011

Patient Name:	
Grand Strand Psychological Services Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Lamictal RX Nucynta
Psychiatric Hospitalizations	None
Age	Date Of Birth: [redacted]
Gender	Male
Date of Session	12.14.2011
Start Time	8:15 am
End Time	9:30 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Mr. Benjamin was referred due to multiple complaints. Patient is a 49 year old black male who is experiencing sensorimotor and emotional difficulties, cognitive and emotional difficulties which were related to work injury of 6.15.2011. Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 6 of 10. Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. Did not tell the patient what the symptoms related to as far as the symptoms relating to PTSD. The end result was the patient suffers with PTSD and it is chronic. 1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him: A. The patient has been exposed to a traumatic event in which both the following were present: 1. The patient experienced an event that involved actual threat of

PAGE 10/17
(2 1 2) 5, PA
12/22/2011 15:48 8435524583
P257

death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.

2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.

3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient

was asked to cooperate. Explained to patient the progressive nature of the therapy.
4-Have been building rapport between patient and therapist.
5-Gave the patient an opportunity to talk about the accident and other issues.
Went over with the patient the following forms:
1-Handout describing the physiology and psychology of fear and anxiety.
Patient reported he read the material last night.
2-Introduction to Relaxation
Practice the relaxation techniques today.
3-Book "Triumph Over Fear" by Jerilyn Ross
Discussed with patient the homework:
1-Start reading the book "Triumph Over Fear."
2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or less.
4-Read all handouts.
Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.

Went over with the patient that there are nine major goals that we need to accomplish during the therapy:
1-To remember and accept the accident and injuries that occurred.
2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.
3-To get beliefs that had been disrupted and distorted back in balance.
4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:

PAGE 12/17
12/22/2011 15:48 8436524583 (2 1 4) PS, PA
P259

-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10. (12.14.2011)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 9.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 9.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 8.
Experiencing intense psychological distress. Patient rated this 9.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 9.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 9.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of :
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the

PAGE 13/17
12/22/2011 15:48 8436524683 PS, PA (215)
P260

Name: Benjamin, Victor Date: 12.14.2011

	feelings that are experienced in as much detail as possible. Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life. Help patient identify his anger and practice techniques that will help him manage them. Helped patient implement relaxation techniques to cope with his anxiety, stress and anger. Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams. Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed. We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts. Patient reported that he still has the ringing in his ears. Patient is distraught about his inability to make a living and support his family. Went over with the patient the Self Monitoring Scale and Breathing Exercise homework. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns.

Name: Benjamin, Victor Date: 12.14.2011

	Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

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12/22/2011 15:48 8436524503 (217) PS, PA PAGE 18/17

P262

Name: Benjamin, Victo. Date: 12.19.2011

Patient Name:	
Grand Strand Psychological Services Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Lamictal RX Neurontin
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	12.19.2011
Start Time	7:30 am
End Time	8:45 am
Visit Type	Scheduled

Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Mr. Benjamin was referred due to multiple complaints. Patient is a 49 year old black male who is experiencing sensorimotor and emotional difficulties, cognitive and emotional difficulties which were related to work injury of 6.15.2011. Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 8 of 10. Patient brought in his homework. Went over the homework and how to complete it properly. Patient did record his triggers but was unable to reduce his stress below 4. Went over the importance of working the program and reducing his stress. Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative. Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. Did not tell the patient what the symptoms related to as far as the symptoms relating to PTSD. The end result was the patient suffers with PTSD and it is chronic.

PAGE 04/17
12/22/2011 16:48 8435824603 (2 1 8) SPS, PA
P263

Name: Benjamin, Victor Date: 12.19.2011

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:
1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.
2. The patient's response involved intense fear and helplessness.
B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response
E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
F. The disturbance causes clinically significant distress or

PAGE 85/17
12/22/2011 18:48 8436524603 (219) ?S, PA
P264

impairment in social, occupational, or other important areas of functioning.
2-Gave the patient a framework for understanding why those symptoms developed and why they have not gone away.
3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.
4-Have been building rapport between patient and therapist.
5-Gave the patient an opportunity to talk about the accident and other issues.
Went over with the patient the following forms:
1-Handout describing the physiology and psychology of fear and anxiety.
Patient reported he read the material last night.
2-Introduction to Relaxation
Practice the relaxation techniques today.
3-Book "Triumph Over Fear" by Jerilyn Ross
Discussed with patient the homework:
1-Start reading the book "Triumph Over Fear."
2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or less.
4-Read all handouts.
Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.

Went over with the patient that there are nine major goals that we need to accomplish during the therapy:
1-To remember and accept the accident and injuries that occurred.
2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.
3-To get beliefs that had been disrupted and distorted back in balance.
4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life

PAGE 05/17
12/22/2011 15:48 8435524653 PA, PS (220)
P265

Name: Benjamin, Victor Date: 12.19.2011

2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10.
(12.19.2011)
Patient has been experiencing a lot of depression and mood swings.
Patient rated his depression 9.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness.
Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 9.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 8.
Experiencing intense psychological distress. Patient rated this 9.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 9.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 9.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of

PAGE 07/17
12/22/2011 15:48 8435524503 (221) 'S, PA
P266

	the traumatic event. The objectives for the patient have included: Having patient cooperate with psychological testing and evaluation. Having patient comply with medication recommendations by professional medical personnel. Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible. Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life. Help patient identify his anger and practice techniques that will help him manage them. Helped patient implement relaxation techniques to cope with his anxiety, stress and anger. Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams. Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed. We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts. Patient reported that he still has the ringing in his ears. Patient is distraught about his inability to make a living and support his family. Went over with the patient the Self Monitoring Scale and Breathing Exercise homework. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.

PAGE 08/17
12/22/2011 15:48 8436524603 (222) S, PA
P267

Name: Benjamin, Victor Date: 12.19.2011

Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

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Forensic Psychologist

12/22/2011 16:48 8435524603 PA (223) 3, PA PAGE 89/17

Name: Benjamin, Vic[illegible] Date: 1.4.2012

Patient Name: Grand Strand Psychological Services Progress Note	
Referral Source:	Dr. Sendoz
Physical Complaints	See Chart of physical complaints
Medications	Lamictal RX Nuvynta
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	1.4.2012
Start Time	2:00 pm
End Time	3:15 pm
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Mr. Benjamin was referred due to multiple complaints. Patient is a 49 year old black male who is experiencing sensorimotor and emotional difficulties, cognitive and emotional difficulties which were related to work injury of 6.15.2011. Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 8 of 10. The patient reported, "The pain is getting worse." Went over the homework between this session and the next session. Patient's wife came in with patient and agreed to help patient with his homework. Patient brought in his homework. Went over the homework and how to complete it properly. Patient did record his triggers but was unable to reduce his stress below 4. Went over the importance of working the program and reducing his stress. Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative. Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones

Name: Benjamin, Victor Date: 1.4.2012

applied to him. Did not tell the patient what the symptoms related to as far as the symptoms relating to PTSD. The end result was the patient suffers with PTSD and it is chronic.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:
1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.
2. The patient's response involved intense fear and helplessness.
B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence

Name: Benjamin, Victor Date: 1.4.2012

5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.

3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.

4-Have been building rapport between patient and therapist.

5-Gave the patient an opportunity to talk about the accident and other issues.

Went over with the patient the following forms:

1-Handout describing the physiology and psychology of fear and anxiety.

Patient reported he read the material last night.

2-Introduction to Relaxation

Practice the relaxation techniques today.

3-Book "Triumph Over Fear" by Jerilyn Ross

Discussed with patient the homework:

1-Start reading the book "Triumph Over Fear."

2-Do Breathing exercise (Set of 10; 10 times a day).

3-When triggered do the exercise until anxiety or fear level is a 3 or less.

4-Read all handouts.

Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.

Went over with the patient that there are nine major goals that we need to accomplish during the therapy:

1-To remember and accept the accident and injuries that occured.

2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.

3-To get beliefs that had been disrupted and distorted back in balance.

4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.

5-Help patient identify anger control problems and implement techniques to help manage them.

6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.

7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.

8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.

Name: Benjamin, Victor Date: 1.4.2012

9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the affects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10, (1.4.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 9.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 9.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 8.
Experiencing intense psychological distress. Patient rated this 9.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 9.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 9.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of :
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma

Name: Benjamin, Victor Date: 1.4.2012

	and resultant behavior. Reducing the destructive avoidant behavior that fosters fear of distress. Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event. The objectives for the patient have included: Having patient cooperate with psychological testing and evaluation. Having patient comply with medication recommendations by professional medical personnel. Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible. Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life. Help patient identify his anger and practice techniques that will help him manage them. Helped patient implement relaxation techniques to cope with his anxiety, stress and anger. Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams. Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed. We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts. Patient reported that he still has the ringing in his ears. Patient is distraught about his inability to make a living and support his family. Went over with the patient the Self Monitoring Scale and Breathing Exercise homework. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed.

Name: Benjamin, Victor Date: 1.4.2012

	Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ed.D.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Benjamin, Victor Date: 1.11.2012

Patient Name:	
Grand Strand Psychological Services Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Lamictal RX Nucynta
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	1.11.2012
Start Time	7:45 am
End Time	9:00 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Mr. Benjamin was referred due to multiple complaints. Patient is a 49 year old black male who is experiencing sensorimotor and emotional difficulties, cognitive and emotional difficulties which were related to work injury of 6.15.2011. Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 8 of 10. The patient reported, "The pain is getting worse." Patient reported, "I saw Dr. Sandoz last Wednesday and he changed my pain medication to Tramadol 50 mg every six hours. The reason for the change was that the other medication, Nucynta, was causing the patient to be nauseated. The patient reported the new pain medication is not reducing the pain. Patient reported, "I am having bad dreams 5 to 6 nights per week. I dream about death a lot. Some of the dreams are about people getting killed. I never had any dreams like this before the accident. I wake up some nights shaking." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."

Name: Benjamin, Victor Date: 1.11.2012

Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 8 of 10." Patient is not seeing a psychiatrist at this time. It patient was recommended to see someone for his depression and see if that doctor thinks he needs medication.
Patient reported, "Both of my ears are having ringing going on in them all the time."
Went over the homework between this session and the next session. Patient's wife came in with patient and agreed to help patient with his homework.
Patient brought in his homework. Went over the homework and how to complete it properly. Patient did record his triggers but was unable to reduce his stress below 4. Went over the importance of working the program and reducing his stress. Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.
Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:
1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.
2. The patient's response involved intense fear and helplessness.
B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

Name: Benjamin, Victor Date: 1.11.2012

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.
3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.
4-Have been building rapport between patient and therapist.
5-Gave the patient an opportunity to talk about the accident and other issuss.

Went over with the patient the following forms:
1-Handout describing the physiology and psychology of fear and anxiety.
Patient reported he read the material last night.
2-Introduction to Relaxation
Practice the relaxation techniques today.
3-Book "Triumph Over Fear" by Jerilyn Ross
Discussed with patient the homework:
1-Start reading the book "Triumph Over Fear."
2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or less.
4-Read all handouts.

Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.

Went over with the patient that there are nine major goals that we

Name: Benjamin, Victor Date: 1.11.2012

need to accomplish during the therapy:
1-To remember and accept the accident and injuries that occurred.
2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.
3-To get beliefs that had been disrupted and distorted back in balance.
4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10.
(1.11.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 8.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 9.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.

Name: Benjamin, Victor Date: 1.11.2012

Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 8.
Experiencing intense psychological distress. Patient rated this 9.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 9.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 9.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed.
We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts.
Patient reported that he still has the ringing in his ears.
Patient is distraught about his inability to make a living and support his family.
Went over with the patient the Self Monitoring Scale and Breathing Exercise homework.

Name: Benjamin, Victor Date: 1.11.2012

	Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ed.S.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Benjamin, Victor Date: 1.16.2012

Patient Name:	
Grand Strand Psychological Services	
Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Lamictal RX Nucynta
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	1.16.2012
Start Time	12:00 pm
End Time	1:15 pm
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Mr. Benjamin was referred due to multiple complaints. Patient is a 49 year old black male who is experiencing sensorimotor and emotional difficulties, cognitive and emotional difficulties which were related to work injury of 6.15.2011. Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 7 of 10. The patient reported, "The pain is getting worse at times. Last week the doctor gave me braces for my arm to sleep in. The braces were for both arms. Since then it seems some of my pain has decreased. When I first wake up the pain is less but as the day goes on the pain increases. I still am depressed. I had 5 major triggers since our last session. I was able to do my exercises you gave me and was able to reduce my stress/anger down to 3 of 8 three times and 4 of 8 the other two times. I am doing all my home work." Patient had all his home work and it shows the triggers and how he did the exercises to come down. Patient reported, "I saw Dr. Sandoz last Wednesday and he changed my pain medication to Tramadol 50 mg every six hours. The reason for the change was that the other medication, Nucynta, was causing

Name: Benjamin, Victor Date: 1.16.2012

the patient to be nauseated. The new medication, Tramadol, is making me nauseated also. It is hard to take the medication and then feel sick." The patient reported the new pain medication is not reducing the pain. Patient reported, "The new medication makes me feel exhausted."

Patient reported, "I am having bad dreams 5 to 6 nights per week. I dream about death a lot. My dreams are crazy. I dream of drowning, being shot or being beat up." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."

Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 7 of 10." Patient is not seeing a psychiatrist at this time. It patient was recommended to see someone for his depression and see if that doctor thinks he needs medication.

Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."

Went over the homework between this session and the next session. Patient's wife came in with patient and agreed to help patient with his homework.

Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.

Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:

1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.
2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Name: Benjamin, Victor Date: 1.16.2012

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.
3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.
4-Have been building rapport between patient and therapist.
5-Gave the patient an opportunity to talk about the accident and other issues.

Went over with the patient the following forms:
1-Handout describing the physiology and psychology of fear and anxiety.

Patient reported he read the material last night.

2-Introduction to Relaxation

Practice the relaxation techniques today.

3-Book "Triumph Over Fear" by Jerilyn Ross

Discussed with patient the homework:
1-Start reading the book "Triumph Over Fear."
2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or

Name: Benjamin, Victor Date: 1.16.2012

	less. 4-Read all handouts. Today went over with the patient the handouts and explained to the patient the importance of doing all his homework. Went over with the patient that there are nine major goals that we need to accomplish during the therapy: 1-To remember and accept the accident and injuries that occurred. 2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached. 3-To get beliefs that had been disrupted and distorted back in balance. 4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life. 5-Help patient identify anger control problems and implement techniques to help manage them. 6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger. 7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy. 8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered. 9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive. Gave patient the homework of writing about the following: 1-The accident and the after effects on patient's life 2-Asked patient to consider the effects the accident had on his: -beliefs about himself -beliefs about others -beliefs about the world 3-Asked the patient to consider the following topics while writing about his traumatic event: -safety, trust, power, esteem and security Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
	Patient is in pain and experiences anxiety and is stress. Patient was asked to rate the following on a scale of 0 to 10. (1.16.2012) Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 8. Patient reported that he doesn't have any friends. Patient rated it 7. Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8. Went over with the patient the problems he is experiencing. The patient is having: Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.

Name: Benjamin, Victor Date: 1.16.2012

Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 9.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 8.
Experiencing intense psychological distress. Patient rated this 9.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 9.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 9.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of :
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed.
We discussed how he needs to retrain his bad thoughts and feelings

Name: Benjamin, Victor Date: 1.16.2012

	and retrain is thoughts with positive thoughts. Patient reported that he still has the ringing in his ears. Patient is distraught about his inability to make a living and support his family. Went over with the patient the Self Monitoring Scale and Breathing Exercise homework. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

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Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Benjamin, Victor Date: 2.21.2012

Patient Name:	
Grand Strand Psychological Services Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Clonazepam Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	2.21.2012
Start Time	4:30 pm
End Time	5:45 pm
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 6 of 10. Patient reported, "My stress level is 10 of 10. I saw Dr. Sandoz and he told me I was having seizures. I had the test with the helmet on my head and I had a seizure during the test. I had to wear the cap for 24 hours. Dr. Sandoz told me that I cannot drive for the next 3 months. Dr. Sandoz said that the seizures are a result from the cage falling on my head. Dr. Sandoz wrote me a prescription for Keppra 500 mg twice per day. Dr. Sandoz stopped the Clonazpam." Patient had all his home work and it shows the triggers and how he did the exercises to come down. Patient reported, "I am having bad dreams 3 to 4 nights this past week. I dream about death a lot. My dreams are crazy. I am still shaking real bad while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. The other day I was in the bank and my heart started racing and I had a panic attack. I have no idea what the trigger was that brought on the panic attack. I knew everybody that was in the bank. The

only thing that I think triggered the panic attack was that one of the people I worked with on my job was in the bank and asked me how I was doing. That happened just as I was walking into the back. Right after that I had the panic attack." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."
Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 7 of 10. I think the increase today is due to the news that I have had seizures." Patient is not seeing a psychiatrist at this time. When patient saw Dr. Goldschmidt last week he called attorney and requested patient see psychiatrist. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.
Patient continues to be frustrated and reported in his homework that he is frustrated or angry 60 to 70 % of the day every day.
Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."
Went over the homework between this session and the next session.
Patient's wife came in with patient and agreed to help patient with his homework.
Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.
Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:
1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.
2. The patient's response involved intense fear and helplessness.
B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Name: Benjamin, Victor Date: 2.21.2012

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event:

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.

3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.

4-Have been building rapport between patient and therapist.

5-Gave the patient an opportunity to talk about the accident and other issues.

Went over with the patient the following forms:

1-Handout describing the physiology and psychology of fear and anxiety.

Patient reported he read the material last night.

2-Introduction to Relaxation

Practice the relaxation techniques today.

3-Book "Triumph Over Fear" by Jerilyn Ross

Discussed with patient the homework:

1-Start reading the book "Triumph Over Fear."

3

Name: Benjamin, Victor Date: 2.21.2012

2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or less.
4-Read all handouts.
Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.

Went over with the patient that there are nine major goals that we need to accomplish during the therapy:
1-To remember and accept the accident and injuries that occurred.
2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.
3-To get beliefs that had been disrupted and distorted back in balance.
4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10.
(2.21.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 7.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:

Page: 7/23
To:4388173
MAR-21-2012 12:43 From:
3 (245)
P290

Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 9.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 8.
Experiencing intense psychological distress. Patient rated this 9.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 9.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 9.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on remaining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and

Page:8/23 To:4388173 MAR-21-2012 12:44 From: (246)

	stressed. We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts. Patient reported that he still has the ringing in his ears. Patient is distraught about his inability to make a living and support his family. Went over with the patient the Self Monitoring Scale and Breathing Exercise homework. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations. No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

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Forensic Psychologist

Page: 9/23 To:4388173 3 (247) MAR-21-2012 12:44 From:

Name: Victor Benjamin Dates:

Weekly Anger and Frustration Report

Each evening before you go to bed, please make the following ratings, using the scale below:

1. Your average level of anger/frustration (taking all things into consideration)
2. Your maximum level of anger/frustration which you experienced that day.
3. Your average level of depression.
4. Your average level of pleasantness.
5. The percentage of the day that you felt angry/frustrated, using a 0-100% scale where 0 mean no anger/frustration at all and 100 means angry/frustrated all the waking day.

Level of Anxiety/Depression/Pleasantness feelings:

0 1 2 3 4 5 6 7 8

None Slight Moderate A Lot As much as you you can imagine

Date	Average Anger/Frustration	Maximum Anger/Frustration	Average Depression	Average Pleasantness	Percentage of day angry or frustrated
3-1-12	6	7	6	2	75%
3-2-12	6	7	6	2	75%
3-3-12	6	7	5	2	65
3-4-12	6	6	5	2	60
3-5-12	6	7	6	2	75
3-6-12	6	7	6	2	75

Name			Victor Benjamin				Dates:			
	Stress Level									
Date:		3-1		3-2		3-3		3-4		3-5
1st Set	7	7	7	7	7	7	6	6	7	7
2nd Set	7	6	7	6	7	6	6	6	7	6
3rd Set	6	6	6	5	6	6	6	5	6	6
4th Set	6	5	5	5	6	5	5	5	6	5
5th Set	5	4	5	4	5	5	5	4	5	5
6th Set					5	4			5	4
7th Set										
8th Set										
9th Set										
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17th Set										
18th Set										
19th Set										
20th Set										

3-6

7-7
7-6
6-6
6-5
5-4

Name: Victor Benjamin

Dates:

Cognitive Self-Monitoring Form

	Trigger or Event	Automatic Thought	Frustration/Anger Irritability/Stress Level (0 to 8)	Countering using Breathing Exercises & Affirmations	Frustration/Anger/ Irritability/Stress Level (0 to 8)
3-1	Unit Sleepgate Deposition	Frustrated-Tired-Stress	7		4
3-2	Fear-Stress Deposition	Frustrated-depressed	7		4
3-3	Health-Pain Controlled	Frustrated, helpless Angry	7		4
3-4	Finance-Family Health	hopeless-Unsecured depressed	6		4
3-5	Health-Tired. Waiting on driver	Stress-Frustrated depressed	7		4
3-6	Tired-Sluggish-Health-Finance	Angry-depressed Sleepy	7		4

Name: Benjamin, Victor Date: 3.1.2012

Patient Name:	
Grand Strand Psychological Services	
Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Keppra Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	3.1.2012
Start Time	3:00 pm
End Time	4:15 pm
Visit Type	Scheduled

Session Content

Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 5 of 10. Patient reported, "My stress level is 10 of 10. I saw Dr. Sandoz last week and he told me I was having seizures. I had the test with the helmet on my head and I had a seizure during the test. I had to wear the cap for 24 hours. Dr. Sandoz told me that I cannot drive for the next 3 months. Dr. Sandoz said that the seizures are a result from the cage falling on my head. Dr. Sandoz wrote me a prescription for Keppra 500 mg twice per day. Dr. Sandoz stopped the Clonazpam. I wasn't able to get my new prescription, Keppra, filled until Tuesday of this week. Workers Comp kept declining until they finally approved it. I took the first dosage Tuesday night and it knocked me out. I couldn't get out of bed the next day. I was in a daze all day. I am sleeping too much now. I don't know if that will continue or if the medication will level out and I want be in a daze all day." Patient had all his home work and it shows the triggers and how he did the exercises to come down. Patient reported, "I am having bad dreams 3 to 4 nights this past

Name: Benjamin, Victor Date: 3.1.2012

week. I dream about death a lot. My dreams are crazy. I am still shaking real bad while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I experienced a couple of panic attacks this past week. I can't drive so my son was driving me and when he would switch lanes he would almost clip another car and I became anxious and panicky. Other times I don't remember the trigger." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't." Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 8 of 10. I think the increase today is due to the news that I have had seizures and I can't drive." Patient is not seeing a psychiatrist at this time. When patient saw Dr. Goldschmidt last week he called attorney and requested patient see psychiatrist. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.
Patient continues to be frustrated and reported in his homework that he is frustrated or angry 60 to 70 % of the day every day.
Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."
Went over the homework between this session and the next session. Patient's wife came in with patient and agreed to help patient with his homework.
Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.
Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

I Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:

1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.

2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

2. Recurrent distressing dreams of the event.

3. Acting or feeling as if the traumatic event were recurring when

Name: Benjamin, Victor Date: 3.1.2012

the patient has flashbacks, relives the experience and has hallucinations about the event.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.

3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.

4. Markedly diminished interest or participation in significant activities.

5. Feeling of detachment or estrangement from others.

6. Restricted range of affect.

7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.

3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.

4-Have been building rapport between patient and therapist.

5-Gave the patient an opportunity to talk about the accident and other issues.

Went over with the patient the following forms:

1-Handout describing the physiology and psychology of fear and anxiety.

Patient reported he read the material last night.

2-Introduction to Relaxation

Name: Benjamin, Victor Date: 3.1.2012

Practice the relaxation techniques today.
3-Book "Triumph Over Fear" by Jerilyn Ross
Discussed with patient the homework:
1-Start reading the book "Triumph Over Fear."
2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or less.
4-Read all handouts.
Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\
Went over with the patient that there are nine major goals that we need to accomplish during the therapy:
1-To remember and accept the accident and injuries that occurred.
2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.
3-To get beliefs that had been disrupted and distorted back in balance.
4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10.
(3.1.2012)
Patient has been experiencing a lot of depression and mood swings.
Patient rated his depression 7.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness.

Name: Benjamin, Victor Date: 3.1.2012

Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 9.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 8.
Experiencing intense psychological distress. Patient rated this 9.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 9.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 9.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has

Name: Benjamin, Victor Date: 3.1.2012

	been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed. We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts. Patient reported that he still has the ringing in his ears. Patient is distraught about his inability to make a living and support his family. Went over with the patient the Self Monitoring Scale and Breathing Exercise homework. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

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Clinical Neuropsychologist
Forensic Psychologist

Name: Benjamin, Victor Date: 3.7.2012

Patient Name:	
Grand Strand Psychological Services	
Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Keppra Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	3.7.2012
Start Time	9:15 am
End Time	10:30 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF–40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 7 of 10. Patient reported, "My stress level is 8 of 10. Dr. Sandoz gave me the Keppra for my seizures. Dr. Sandoz told me that I cannot drive for the next 3 months. Dr. Sandoz said that the seizures are a result from the cage falling on my head. Dr. Sandoz wrote me a prescription for Keppra 500 mg twice per day. The Keppra is causing me to have mood swings and sleep issues. Some days I sleep all day and some days I can't sleep. My moods are up and down. I would rate my depression to 7 of 10." Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems. Patient had all his home work and it shows the triggers and how he

Name: Benjamin, Victor Date: 3.7.2012

did the exercises to come down.
Patient reported, "I am having bad dreams 4 to 5 nights this past week. I dream about death a lot. I am still shaking real badly while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. The other night she said I was riding a bike in my dreams. My legs were moving all over the place. I experienced a couple of panic attacks this past week. I can't drive so I have to have someone else drive me if I need to go somewhere. Other times I don't remember the trigger." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."
Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 7 of 10. I think the increase today is due to the news that I have had seizures and I can't drive." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.
Patient reported, "Last Friday I had the deposition and it lasted 1 ½ hours. By the time it was finished I was wore out."
Patient reported, "I have not been able to get an erection since the injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident."
Patient continues to be frustrated and reported in his homework that he is frustrated or angry 60 to 70 % of the day every day.
Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."
Went over the homework between this session and the next session.
Patient's wife came in with patient and agreed to help patient with his homework.
Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.
Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:
A. The patient has been exposed to a traumatic event in which both the following were present:

Name: Benjamin, Victor Date: 3.7.2012

1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.
2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.

3-Presented an overview of treatment to help patient understand why

Name: Benjamin, Victor Date: 3.7.2012

homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.
4-Have been building rapport between patient and therapist.
5-Gave the patient an opportunity to talk about the accident and other issues.
Went over with the patient the following forms:
1-Handout describing the physiology and psychology of fear and anxiety.
Patient reported he read the material last night.
2-Introduction to Relaxation
Practice the relaxation techniques today.
3-Book "Triumph Over Fear" by Jerilyn Ross
Discussed with patient the homework:
1-Start reading the book "Triumph Over Fear."
2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or less.
4-Read all handouts.
Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\
Went over with the patient that there are nine major goals that we need to accomplish during the therapy:
1-To remember and accept the accident and injuries that occurred.
2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.
3-To get beliefs that had been disrupted and distorted back in balance.
4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:

Name: Benjamin, Victor Date: 3.7.2012

-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10. (3.7.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 7.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 9.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 8.
Experiencing intense psychological distress. Patient rated this 9.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 9.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 9.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the

Name: Benjamin, Victor Date: 3.7.2012

	feelings that are experienced in as much detail as possible. Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life. Help patient identify his anger and practice techniques that will help him manage them. Helped patient implement relaxation techniques to cope with his anxiety, stress and anger. Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams. Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed. We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts. Patient reported that he still has the ringing in his ears. Patient is distraught about his inability to make a living and support his family. Went over with the patient the Self Monitoring Scale and Breathing Exercise homework. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns.

Name: Benjamin, Victor Date: 3.7.2012

	Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ed.D.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Victor Benjamin Dates:

Weekly Anger and Frustration Report

Each evening before you go to bed, please make the following ratings, using the scale below:

1. Your average level of anger/frustration (taking all things into consideration)
2. Your maximum level of anger/frustration which you experienced that day.
3. Your average level of depression.
4. Your average level of pleasantness.
5. The percentage of the day that you felt angry/frustrated, using a 0-100% scale where 0 mean no anger/frustration at all and 100 means angry/frustrated all the waking day.

Level of Anxiety/Depression/Pleasantness feelings:

0 1 2 3 4 5 6 7 8

None Slight Moderate A Lot As much as you you can imagine

Date	Average Anger/Frustration	Maximum Anger/Frustration	Average Depression	Average Pleasantness	Percentage of day angry or frustrated
3-28-12	6	6	6	2	70%
3-29-12	6	7	6	2	75%
3-30-12	6	7	6	2	75%
3-31-12	7	7	6	2	80%
4-1-12	6	6	5	2	70%
4-2-12	7	7	6	2	70%
4-3-12	6	7	6	2	70%

Name: Victor Benjamin | Dates:

Cognitive Self-Monitoring Form

	Trigger or Event	Automatic Thought	Frustration/Anger Irritability/Stress Level (0 to 8)	Countering using Breathing Exercises & Affirmations		Frustration/Anger/ Irritability/Stress Level (0 to 8)
3/28	pains sleepless Withdrawals	tired, Frustrated depressed	6			3
3/29	pains, Job, can't cut grass	Angry - stress helpless, depress	7			3
3/30	Finance - Bills sleepless	tired, depressed Frustrated	7			4
3/31	no Check Finance Car drive, - Job	Frustrated, tired - stress	7			4
4/1	Pains, Fell Sleepless dreams	Angry, stress Frustrated - tired	6			3
4/2	Job - Finance Jump in Sleep	Angry - tired - depressed	7			3
4/3	Pain - Finance bad dreams	tired, depressed Frustrated	7			3

Name			Victor Benjamin								
	Stress Level										
Date:		3-28		3-29		3-30		3-31		4-1	
1st Set	6	6	7	7	7	7	7	7	6	6	
2nd Set	6	6	7	6	7	6	7	6	6	6	
3rd Set	6	5	6	6	6	6	6	6	6	5	
4th Set	5	5	6	5	6	5	6	5	5	5	
5th Set	5	4	5	5	5	5	5	5	5	4	
6th Set	4	4	4	4	5	4	5	4	4	4	
7th Set	4	3	4	3					4	3	
8th Set											
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Name: Benjamin, Victor Date: 3.28.2012

Patient Name:	
Grand Strand Psychological Services	
Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Keppra Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	3.28.2012
Start Time	8:45 am
End Time	10:00 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 7 of 10. Patient reported, "My stress level is 7 of 10. Dr. Sandoz called in a prescription for Vimpat 50 mg to take the place of Keppra. I would rate my depression 8 of 10." During the session last week the patient called Dr. Sandoz office and tried to get an appointment with him that day. Patient did talk Dr. Sandoz and he told patient to stop taking the Keppra and see if that was causing patient to be irritable and upset. Then patient was told to stay off the medication until this past Sunday. If patient had not had the symptoms while off the medication and then after starting the medication again on Monday then he would stop the medication and start patient on something else. Patient was off the medication but was still experiencing the same problems of being irritable and angry. Dr. Sandoz was notified on Monday and Dr. Sandoz said that with the symptoms continuing while off the medication that patient was dealing with Posttraumatic Stress Disorder. Dr. Sandoz called the patient Monday afternoon after patient started taking the Keppra again. Patient became

Name: Benjamin, Victor Date: 3.28.2012

nauseated and was in bed after starting the Keppra again. Dr. Sandoz called and patient explained that he was nauseated after starting the Keppra. Dr. Sandoz told to stop the Keppra and he was to call in a prescription of another medication. The medication, Vimpat, was approved and patient is now taking the new medication. The new medication is causing patient to be tired but not nauseated.
Patient reported, "When I have sharp pain shooting through my head and I start to go to bed I wonder if I am going to wake or be dead. This is causing a lot of mental stress for me. There have been times were I am unable to speak and not know the reason. It could be the sharp pains that are causing the problem or possible something else. My concern is that I don't know what is happening. My wife will call be during the day while she is at work to check on me."
Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems.
Patient had all his home work and it shows the triggers and how he did the exercises to come down.
Patient reported, "I am having bad dreams 4 to 5 nights this past week. I dream about death a lot. I am still shaking real badly while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I experienced a couple of panic attacks this past week. I can't drive so I have to have someone else drive me if I need to go somewhere. Other times I don't remember the trigger." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."
Patient reported, "My right hand is shaking a more. The shaking started right after the accident but it is getting worse."
Patient had all his assignments completed. The homework showed that the patient is depressed and has experienced a lot anger and frustration. Patient homework showed that the patient is frustrated and angry over 80% of the time every day.
Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 10 of 10. I think the increase today is due to the news that I have had seizures and I can't drive." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.
Patient reported, "I have not been able to get an erection since the

Name: Benjamin, Victor Date: 3.28.2012

injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident."

Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."

Went over the homework between this session and the next session.

Patient's wife came in with patient and agreed to help patient with his homework.

Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.

Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:

1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.

2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

2. Recurrent distressing dreams of the event.

3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.

3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.

4. Markedly diminished interest or participation in significant

Name: Benjamin, Victor Date: 3.28.2012

activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.

3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.

4-Have been building rapport between patient and therapist.

5-Gave the patient an opportunity to talk about the accident and other issues.

Went over with the patient the following forms:

1-Handout describing the physiology and psychology of fear and anxiety.

Patient reported he read the material last night.

2-Introduction to Relaxation

Practice the relaxation techniques today.

3-Book "Triumph Over Fear" by Jerilyn Ross

Discussed with patient the homework:

1-Start reading the book "Triumph Over Fear."

2-Do Breathing exercise (Set of 10; 10 times a day).

3-When triggered do the exercise until anxiety or fear level is a 3 or less.

4-Read all handouts.

Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\

Went over with the patient that there are nine major goals that we need to accomplish during the therapy:

1-To remember and accept the accident and injuries that occurred.

2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.

3-To get beliefs that had been disrupted and distorted back in balance.

Name: Benjamin, Victor Date: 3.28.2012

4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10. (3.28.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 10.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 10.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 10.
Experiencing intense psychological distress. Patient rated this 10.

Name: Benjamin, Victor Date: 3.28.2012

Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 10.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 10.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed.
We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts.
Patient reported that he still has the ringing in his ears.
Patient is distraught about his inability to make a living and support his family.
Went over with the patient the Self Monitoring Scale and Breathing Exercise homework.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
The patient exhibited fair hygiene in his appearance.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
With the condition of the patient not improving in relationship to his

Name: Benjamin, Victor Date: 3.28.2012

	PTSD issues it is recommended that the patient be in intensive outpatient therapy three days per week with a minimum of two hours per day. Discussed this with the patient and his wife. The issues are so intense and the symptoms are so bad that if the patient does not receive this type of treatment the patient will continue to regress. The patient is willing to commit to this type of therapeutic approach and wants to improve. The PTSD issues are intensifying and medication without intensive therapy intervention will not work by itself. This was discussed with the patient and Dr. Goldschmidt at the very beginning of the patient' therapy. It now has gotten to the point that it is no longer an option but a necessity. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor (Even when patient sleeps he wakes tired and gets fatigued during the day) Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ph.D

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name	Victor Benjamin	Dates:

	Stress Level											
Date:	4	9	4	5	4	6	4	7	4	8		
1st Set	7	7	6	6	7	7	7	7	6	6		
2nd Set	7	6	6	6	7	6	7	6	6	6		
3rd Set	6	6	6	5	6	6	6	6	6	5		
4th Set	6	5	5	4	6	5	6	6	5	5		
5th Set	5	4	4	4	5	5	6	5	5	4		
6th Set	4	4	4	3	5	4	5	5	4	3		
7th Set					4	4	5	4				
8th Set					4	3	4	4				
9th Set												
10th Set												
11th Set												
12th Set												
13th Set												
14th Set												
15th Set												
16th Set												
17th Set												
18th Set												
19th Set												
20th Set												

4/9
7-7
7-6
6-6
6-5
5-5
5-4
4-4
4-3

Name: Benjamin, Victor Date: 4.4.2012

Patient Name:	
Grand Strand Psychological Services **Progress Note**	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Keppra Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	4.4.2012
Start Time	8:45 am
End Time	10:00 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF--40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 6 of 10. Patient reported, "My stress level is 7 of 10. Dr. Sandoz called in a prescription for Vimpat 50 mg to take the place of Keppra. I would rate my depression 7 of 10." Patient is still having irritable and periods of being very upset. Patient reported, "When I have sharp pain shooting through my head and I start to go to bed I wonder if I am going to wake or be dead. This is causing a lot of mental stress for me. There have been times were I am unable to speak and not know the reason. It could be the sharp pains that are causing the problem or possible something else. My concern is that I don't know what is happening. My wife will call be during the day while she is at work to check on me. I am having sharp pains shooting through my head on a daily basis. The pain is so bad that I have to close my eyes. This happens several times a day. I don't know exactly how many times but it is three or more per day. This past week I fell in my backyard. I got disoriented and dizzy and fell. I don't know what was happening. Right before

Name: Benjamin, Victor Date: 4.4.2012

that I was going down the steps and almost fell then."
Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems. Patient reported, "Last night it took me over an hour to fall asleep. It was about 11:30 pm when I fell asleep and then I woke up at 3 am and it took me until 4 am to fall back asleep."
Patient had all his home work and it shows the triggers and how he did the exercises to come down.
Patient reported, "I am having bad dreams 4 to 5 nights this past week. I dream about death a lot. I am still shaking real badly while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I experienced a couple of panic attacks this past week. This past week I had two terrible dreams that I remember in detail. One dream was about my mother dying and being in a casket in the church. The casket was being moved around to each pew for people to few her body. I thought this was odd because usually people walk up and few the body at the altar. While the casket was being moved around each pew I saw my mother moving in the casket. When I saw her moving in the casket I asked family members sitting by me what was going on and they said this was normal. I was numb. I couldn't figure out why I wasn't crying and upset. I couldn't believe what was happening. I wasn't experiencing any type of emotions. The second dream was very disturbing. I walked into the bank and was told not to say a word. I saw someone I knew and asked them how they were doing. When I said that a gun was put to my neck and I was told not to say a word. I closed my eyes. I could feel the barrel of the gun against the right side of my neck. I was shaking in the dream. When I woke up I was still shaking and it woke my wife up. It was so real that it took me over 1 ½ hours to calm down. The experience bothered me all day long. I couldn't get it out of my head what happened and how it affected me. There are times that I get upset and agitated but I can't identify the trigger. I think it is because I can't go anywhere without someone taking me. If I want to go somewhere I have to ask someone to take me and I don't want to impose on anybody. I'll sit there and get upset because my life is in the hands of everybody else. Just the simple fact of wanting to go to the store means I have to rely on someone to take me. My independence has been taken from me. With my son in college and my wife working means that I am home all day by myself. If I need to go somewhere or get something I can't because no one is around to help me. This causes me a lot of pain and depression." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."

Name: Benjamin, Victor Date: 4.4.2012

The patient has started not caring about his appearance and goes without shaving. Patient does bath daily but has changed in taking care of his appearance. Patient has always been a person who was very concerned about his appearance and was always clean shaven and nicely dressed. Patient's wife reported that patient has always been very concerned about his appearance, dress, and clean shaven and how he looks. Patient over the past several weeks has changed in how he takes care of himself. Patient began to change when he was told that he could not drive due to the seizures. Patient's depression has gotten worse due to his circumstances. Patient needs intensive therapy to help overcome the issues that he is dealing with.

Patient reported, "My right hand is shaking a more. The shaking started right after the accident but it is getting worse."

Patient had all his assignments completed. The homework showed that the patient is depressed and has experienced a lot anger and frustration. Patient homework showed that the patient is frustrated and angry over 70% of the time every day.

Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 7 of 10." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.

Patient reported, "I have not been able to get an erection since the injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident."

Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."

Went over the homework between this session and the next session. Patient's wife came in with patient and agreed to help patient with his homework.

Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.

Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

Discussed with the patient and his wife that due to the PTSD issues that it is recommended that patient be involved in intensive therapy at least three days per week for two hours per day. This will help the patient process the PTSD issue and help the patient move forward in

Name: Benjamin, Victor Date: 4.4.2012

desensitizing his bad thoughts and feelings associated with the trauma that he patient experienced.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:

1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.

2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

2. Recurrent distressing dreams of the event.

3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.

3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.

4. Markedly diminished interest or participation in significant activities.

5. Feeling of detachment or estrangement from others.

6. Restricted range of affect.

7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and

Name: Benjamin, Victor Date: 4.4.2012

D) is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.
3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.
4-Have been building rapport between patient and therapist.
5-Gave the patient an opportunity to talk about the accident and other issues.
Went over with the patient the following forms:
1-Handout describing the physiology and psychology of fear and anxiety.
Patient reported he read the material last night.
2-Introduction to Relaxation
Practice the relaxation techniques today.
3-Book "Triumph Over Fear" by Jerilyn Ross
Discussed with patient the homework:
1-Start reading the book "Triumph Over Fear."
2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or less.
4-Read all handouts.
Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\
Went over with the patient that there are nine major goals that we need to accomplish during the therapy:
1-To remember and accept the accident and injuries that occurred.
2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.
3-To get beliefs that had been disrupted and distorted back in balance.
4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:

Name: Benjamin, Victor Date: 4.4.2012

1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10. (4.4.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 7.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 10.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 10.
Experiencing intense psychological distress. Patient rated this 10.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 10.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 10.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of

Name: Benjamin, Victor Date: 4.4.2012

distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed.
We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts.
Patient reported that he still has the ringing in his ears.
Patient is distraught about his inability to make a living and support his family.
Went over with the patient the Self Monitoring Scale and Breathing Exercise homework.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
The patient exhibited fair hygiene in his appearance.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
With the condition of the patient not improving in relationship to his PTSD issues it is recommended that the patient be in intensive outpatient therapy three days per week with a minimum of two hours per day. Discussed this with the patient and his wife. The issues are so intense and the symptoms are so bad that if the patient does not receive this type of treatment the patient will continue to regress. The patient is willing to commit to this type of therapeutic approach and wants to improve. The PTSD issues are intensifying and medication without intensive therapy intervention will not work by itself. This was discussed with the patient and Dr. Goldschmidt at the very beginning of the patient' therapy. It now has gotten to the point that it is no longer an option but a necessity.
The patient exhibited good hygiene in his appearance.
The mood of patient was depressed, anxious and worried
Appearance: Clean

Name: Benjamin, Victor Date: 4.4.2012

	Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor (Even when patient sleeps he wakes tired and gets fatigued during the day) Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ed.D

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Benjamin, Victor Date: 4.10.2012

Patient Name:	
Grand Strand Psychological Services **Progress Note**	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Keppra Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	4.10.2012
Start Time	8:45 am
End Time	10:00 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported that his pain level was 8 of 10. Patient reported, "My stress level is 7 of 10. Dr. Sandoz called in a prescription for Vimpat 50 mg to take the place of Keppra. I would rate my depression 7 of 10." Patient is still having irritable and periods of being very upset. Patient reported, "When I have sharp pain shooting through my head and I start to go to bed I wonder if I am going to wake or be dead. This is causing a lot of mental stress for me. There have been times were I am unable to speak and not know the reason. It could be the sharp pains that are causing the problem or possible something else. My concern is that I don't know what is happening. My wife will call be during the day while she is at work to check on me. I am having sharp pains shooting through my head on a daily basis. The pain is so bad that I have to close my eyes. This happens several times a day. I don't know exactly how many times but it is three or more per day. I got disoriented and dizzy and I think that is due to the headaches. I have been having sharp pains running down my

Name: Benjamin, Victor Date: 4.10.2012

right side of my head and behind my right eye. The pain is very sharp and this is happening several times per day. I don't know what is happening."

Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems. Patient reported, "Last night I didn't sleep at all. My wife said that I was throwing the covers off the bed. I was turning from side to side and jerking all during the night. I don't remember sleeping at all. It was a miserable night." Patient had all his home work and it shows the triggers and how he did the exercises to come down.

Patient reported, "I am having bad dreams 4 to 5 nights this past week. I dream about death a lot. I am still shaking real badly while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I experienced a couple of panic attacks this past week. This past week I had terrible dreams. There are times that I get upset and agitated but I can't identify the trigger. I think it is because I can't go anywhere without someone taking me. If I want to go somewhere I have to ask someone to take me and I don't want to impose on anybody. I'll sit there and get upset because my life is in the hands of everybody else. Just the simple fact of wanting to go to the store means I have to rely on someone to take me. My independence has been taken from me. With my son in college and my wife working means that I am home all day by myself. If I need to go somewhere or get something I can't because no one is around to help me. This causes me a lot of pain and depression." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."

The patient has started not caring about his appearance and goes without shaving. Patient does bath daily but has changed in taking care of his appearance. Patient has always been a person who was very concerned about his appearance and was always clean shaven and nicely dressed. Patient's wife reported that patient has always been very concerned about his appearance, dress, and clean shaven and how he looks. Patient over the past several weeks has changed in how he takes care of himself. Patient began to change when he was told that he could not drive due to the seizures. Patient's depression has gotten worse due to his circumstances. Patient needs intensive therapy to help overcome the issues that he is dealing with.

Patient reported, "My right hand is shaking a more. The shaking started right after the accident but it is getting worse."

Patient had all his assignments completed. The homework showed that the patient is depressed and has experienced a lot anger and frustration. Patient homework showed that the patient is frustrated and angry over 70% of the time every day.

Name: Benjamin, Victor Date: 4.10.2012

Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 7 of 10." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.

Patient reported, "I have not been able to get an erection since the injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident."

Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."

Went over the homework between this session and the next session.

Patient's wife came in with patient and agreed to help patient with his homework.

Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.

Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

Discussed with the patient and his wife that due to the PTSD issues that it is recommended that patient be involved in intensive therapy at least three days per week for two hours per day. This will help the patient process the PTSD issue and help the patient move forward in desensitizing his bad thoughts and feelings associated with the trauma that he patient experienced.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:

1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.

2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

2. Recurrent distressing dreams of the event.

Name: Benjamin, Victor Date: 4.10.2012

3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.
3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.
4-Have been building rapport between patient and therapist.
5-Gave the patient an opportunity to talk about the accident and other issues.
Went over with the patient the following forms:
1-Handout describing the physiology and psychology of fear and anxiety.

Patient reported he read the material last night.

Name: Benjamin, Victor Date: 4.10.2012

2-Introduction to Relaxation
Practice the relaxation techniques today.
3-Book "Triumph Over Fear" by Jerilyn Ross
Discussed with patient the homework:
1-Start reading the book "Triumph Over Fear."
2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or less.
4-Read all handouts.
Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\
Went over with the patient that there are nine major goals that we need to accomplish during the therapy:
1-To remember and accept the accident and injuries that occurred.
2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.
3-To get beliefs that had been disrupted and distorted back in balance.
4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10. (4.0.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 7.
Patient reported that he doesn't have any friends. Patient rated it 7.

Name: Benjamin, Victor Date: 4.10.2012

Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 10.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 10.
Experiencing intense psychological distress. Patient rated this 10.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 10.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 10.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining

Name: Benjamin, Victor Date: 4.10.2012

	his bad thoughts when he has the severe dreams. Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed. We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts. Patient reported that he still has the ringing in his ears. Patient is distraught about his inability to make a living and support his family. Went over with the patient the Self Monitoring Scale and Breathing Exercise homework. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. With the condition of the patient not improving in relationship to his PTSD issues it is recommended that the patient be in intensive outpatient therapy three days per week with a minimum of two hours per day. Discussed this with the patient and his wife. The issues are so intense and the symptoms are so bad that if the patient does not receive this type of treatment the patient will continue to regress. The patient is willing to commit to this type of therapeutic approach and wants to improve. The PTSD issues are intensifying and medication without intensive therapy intervention will not work by itself. This was discussed with the patient and Dr. Goldschmidt at the very beginning of the patient' therapy. It now has gotten to the point that it is no longer an option but a necessity. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor (Even when patient sleeps he wakes tired and gets fatigued during the day) Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life.

Name: Benjamin, Victor Date: 4.10.2012

	Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, M.D.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Victor Benjamin Dates:

Cognitive Self-Monitoring Form

	Trigger or Event	Automatic Thought	Frustration/Anger Irritability/Stress Level (0 to 8)	Countering using Breathing Exercises & Affirmations	Frustration/Anger/ Irritability/Stress Level (0 to 8)
4/4	Job Sleepless dreams-	tired, depressed Frustrated depressed	7		4
4/5	Security- Job- Finance	Sad, helpless Angry	6		3
4/6	no check, Finance depressed- Security, Pain) Angry		7		3
4/7	no Check, Pain, Fear- Job	Frustrated depressed	7		4
4/8	Can't work, Pain Finish Hire Plan	sad, upset, Helpless-depressed	6		3
4/9	Sleepless night Dreams- Pain	tired, Stressed Ill, Frustrated	7		3

Been having Sharp Pains run down right side of head and right eye, very sharp & painful several times during the day.

Name: Victor Benjamin Dates:

Weekly Anger and Frustration Report

Each evening before you go to bed, please make the following ratings, using the scale below:

1. Your average level of anger/frustration (taking all things into consideration)
2. Your maximum level of anger/frustration which you experienced that day.
3. Your average level of depression.
4. Your average level of pleasantness.
5. The percentage of the day that you felt angry/frustrated, using a 0-100% scale where 0 mean no anger/frustration at all and 100 means angry/frustrated all the waking day.

Level of Anxiety/Depression/Pleasantness feelings:

0 1 2 3 4 5 6 7 8

None Slight Moderate A Lot As much as you you can imagine

Date	Average Anger/Frustration	Maximum Anger/Frustration	Average Depression	Average Pleasantness	Percentage of day angry or frustrated
4-4	6	7	6	2	75%
4-5	6	6	6	2	70%
4-6	6	7	7	2	75%
4-7	7	7	6	2	80%
4-8	7	6	6	2	75%
4-9	7	7	6	2	80%

Name: Victor Benjamin Dates:

Weekly Anger and Frustration Report

Each evening before you go to bed, please make the following ratings, using the scale below:

1. Your average level of anger/frustration (taking all things into consideration)
2. Your maximum level of anger/frustration which you experienced that day.
3. Your average level of depression.
4. Your average level of pleasantness.
5. The percentage of the day that you felt angry/frustrated, using a 0-100% scale where 0 mean no anger/frustration at all and 100 means angry/frustrated all the waking day.

Level of Anxiety/Depression/Pleasantness feelings:

0 1 2 3 4 5 6 7 8

None Slight Moderate A Lot As much as you you can imagine

Date	Average Anger/Frustration	Maximum Anger/Frustration	Average Depression	Average Pleasantness	Percentage of day angry or frustrated
4-26-12	6	7	7	2	75%
4-26-12	6	7	7	2	75%
4-27-12	7	7	7	2	80 %
4-28-12	7	7	7	2	80%
4-29-12	6	6	7	2	70%
4-30-12	6	7	7	2	75%
5-01-12	6	6	7	2	70%

Name: Victor Benjamin

Dates:

Cognitive Self-Monitoring Form

	Trigger or Event	Automatic Thought	Frustration/Anger Irritability/Stress Level (0 to 8)	Countering using Breathing Exercises & Affirmations	Frustration/Anger/ Irritability/Stress Level (0 to 8)
4-26	Sleepless night Panic Attacks	Tired, Scared depressed	7		4
4-27	Finance-pains Job-headache	Frustrated - helpless - Sad	7		3
4-28	neck, Pains Sleepless-dreams	angry-depressed Frustrated-tired	7		4
4-29	Panic Attack Pain - Finance	Scared - ill, tired helpless - depressed	7		3
4-30	Sad dreams Job - nerves	depressed, tired Sad - lonely	6		4
5-1	Arm + Headache hand cold - pains	Alone - tired - Frustrated	7		3
	Jerk in Sleep- sweating a lot	tired - Sad - worried depressed - Angry	6		3

Name	Victor Benjamin	Date: wk-4-25 -5-01-12

	Stress Level									
Date:		4-25		4-26		4-27		4-28		4-29
1st Set	7	7	7	7	7	7	7	7	6	6
2nd Set	7	7	7	6	7	7	7	6	6	6
3rd Set	7	6	6	6	7	6	6	6	6	5
4th Set	6	6	6	5	6	6	6	5	5	5
5th Set	6	5	5	4	6	5	5	5	5	4
6th Set	5	4	4	4	5	4	5	4	4	4
7th Set	4	4	4	3	4	4	4	4		
8th Set							4	3		
9th Set										
10th Set										
11th Set										
12th Set										
13th Set										
14th Set										
15th Set										
16th Set										
17th Set										
18th Set										
19th Set										
20th Set										

4-30

7 7
7 6
6 6
6 5
5 4
4 4
4 3

5-1

6 6
6 5
5 5
5 4
4 4
4 3

Grand Strand Psychological Services
Patient Evaluation/Treatment Progress Note

Progress Note

Date:	4/18/2012
Service:	96116 x 2 Neurobehavioral Status Exam/Feedback
Provider:	Leonard Goldschmidt
Session Length:	90 mins.
Type of Visit:	Scheduled
Program:	neuropsychological evaluation
Location:	GSPS, PA
Others Present:	Nurse case manager, Stefanie Stokes, RN and spouse, Letia Benjamin, with patient consent
Patient:	Benjamin, Victor G. [redacted]
Sex:	Male

Content/Process

Themes Discussed

[ ] Relationship/Family	[ ] School Problems	[X] Medical Problems
[X] Identity/Role	[ ] Substance Abuse	[ ] Parenting Issues
[X] Work Problems	[ ] Childhood/Family of Origin	[ ] Sexual Issues

Session Content: Mr. Benjamin Retuened accompanied with consent by his wife and nurse case manager, Stefania Stokes, RN. The initial portion of the session was involved with communicating the patient's current status and further evaluation and treatment reccomendations, including continued seizure management, headachmanagement and pain management with George Sandoz, MD; interventional pain management with Jason Rosenberg, MD; psychopharmacologic management with Odedapo Oduwole, MD; outpatient intensive psychotherapy with Dr. Nick Spring under my supervision; and continued monthly neurobehavioral examination, rehabilitation and remediation training. The remeinder of the session was involved in discussing these issues in detail with the patient and his wife after Ms. Stokes left the session.

Session Characteristics

Motivation: good
Resistance: mild
Cognitive Focus: difficulty focusing on one topic
Cognitive Flexibility: rigidity in thinking
Affect Expression: excessive emotional constraint
Activity Level: active and verbal in sessions
Use of Session: makes constructive use of sessions
Treatment Compliance: high degree of compliance with treatment

Plan

Continue Current Treatment Plan [X] Yes [ ] No

Continue Current Medications [ ] Yes [ ] No [X] NA

Referrals or Consultations Needed: Continued seizure management, headachmanagement and pain management with George Sandoz, MD; interventional pain management with Jason Rosenberg, MD; psychopharmacologic management with Odedapo Oduwole, MD

Suicide Risk: Not Evident

Physical Violence Risk: Not Evident

Benjamin, Victor G.

Interventions

1) psychoeducation of deficits/issues
2) cognitive rehabilitative/remediative techniques

DSM-IV Diagnosis

Axis I: 294.11 Dementia Due to Closed Head Brain Injury, with Behavioral Disturbance (Principal)
309.81 Post-Traumatic Stress Disorder
Axis II: 799.9 Diagnosis or Condition Deferred on Axis II
Axis III: Closed Head Brain Injury
Axis IV: Loss of active employment
Axis V: Current GAF 41
Highest Past Year

Symptoms/Impairments

The patient is experiencing angry outbursts (3-Moderate), anxiety (4-Severe), anxiety upon exposure to stimuli symbolizing trauma (3-Moderate), avoidance of situations which elicit memories of trauma (4-Severe), depressed mood (4-Severe), distressing and intrusive memories of trauma (3-Moderate), exaggerated startle response (3-Moderate), feelings of detachment from others (3-Moderate), hypervigilance (3-Moderate), impaired abstracting ability (3-Moderate), impaired concentration (3-Moderate), impaired judgment and impulsivity (3-Moderate), irritable mood (4-Severe), motor restlessness (4-Severe), narrowed range of affect responsiveness (3-Moderate), panic attacks (4-Severe) and short-term memory impairment (2-Mild).

Mental Status

The patient appears stated age. He is well oriented in all spheres. Regarding level of consciousness, he appears alert. Affect is restricted in range. Mood is anxious. He presented himself in a neatly dressed and well-groomed fashion. Eye contact can be described as fair. His speech is halting. Recent memory appears mildly impaired. Remote memory is not impaired. Psychomotor activity can be characterized by psychomotor agitation. There is a mild degree of conceptual disorganization evident. His thought content is characterized by preoccupation with illness. Regarding perceptual functioning, the patient denies hallucinations and none are evident. Attitude can be described as cooperative and interested. As far as insight is concerned, the patient verbalizes partial awareness of problems. Judgment is fair. Attention/Concentration is characterized by distractibility. Regarding impulse control the patient shows poor frustration tolerance.

Risks/Strengths

Suicide: Not Evident

Physical Violence: Not Evident

Substance Abuse: Not Evident

Psychosis: Not Evident

Treatment Planning

Primary Treatment/Recommendation: Neuropsychological Evaluation

Primary Treatment/Recommendation: Neurobehavioral Examination

Primary Treatment/Recommendation: Individual Therapy

Primary Treatment/Recommendation: Referred for psychiatric management (psychopharmacologic)

Primary Treatment/Recommendation: Referred for interventional pain management

Benjamin, Victor G.

Goals

Treatment Goal #1: Ability to face and assumption of different perspective of traumatic event

Treatment Goal #2: Assist patient in grieving and accepting disability

Treatment Goal #3: Control generalizations from traumatic event

Treatment Goal #4: Control physiological reactions to associated events

Treatment Goal #5: Decreased intrusive recollections of trauma

Treatment Goal #6: Diminished intensity of startle responses

Treatment Goal #7: Diminished psychomotor agitation

Treatment Goal #8: Educate family members about the patient's disorder and techniques for dealing with problem behavior

Treatment Goal #9: Enlist family and social supports

Treatment Goal #10: Improved behavioral control

Treatment Goal #11: Increased ability to organize and express trauma experience

Treatment Goal #12: Increased ability to tolerate ideation and emotion associated with trauma

Treatment Goal #13: Increased social activity

Treatment Goal #14: Maintain appropriate level of environmental stimulation

Treatment Goal #15: Maximize remaining abilities and strengths

Treatment Goal #16: Reduce depression and depressive symptoms

Treatment Goal #17: Reduce anxiety level

Provider: Leonard Goldschmidt
11943 Grandhaven Blvd Ste B
Murrells Inlet, SC 29576
Title: Clinical Neuropsychologist
South Carolina 845

Provider Signature Date

Name: Benjamin, Victor Date: 4.25.2012

Patient Name:	
Grand Strand Psychological Services Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Vimpat Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	4.25.2012
Start Time	10:00 am
End Time	11:15 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported, "Last Wednesday I met with Dr. Goldschmidt and my case manager from WMC. Dr. Goldschmidt explained to the case manager that I needed intensive therapy to deal with the issues of PTSD and that I was getting worse. He also requested that I see Dr. Oduwole and Dr. Rosenberg. The case manager said she would work on getting the approvals dealing with his request." Patient reported that his pain level was 7.5 of 10. Patient reported, "My stress level is 7 of 10. I would rate my depression 7 of 10." Patient is still having periods of being very upset. Patient reported, "Last week on the way to your office I had a panic attack in the car. Today on the way here I had a panic attack. I was sitting in the front set and my wife was driving and the cars in the front of us had stopped. I didn't think she was changing lanes and I thought we were going to hit the back end of the cars in front of us. She did change lanes but I had a panic attack. I am having panic attacks 4 to 6 times per week." Patient reported, "This morning when I woke up I still had the sharp

Name: Benjamin, Victor Date: 4.25.2012

pain in my head. I am having sharp pains in my head all day and night. It never is gone more than 30 minutes to an hour and then it returns. The pain is shooting through my head and I start to go to bed I wonder if I am going to wake or be dead. This is causing a lot of mental stress for me. There have been times were I am unable to speak and not know the reason. It could be the sharp pains that are causing the problem or possible something else. My concern is that I don't know what is happening. My wife will call me during the day while she is at work to check on me. I am having sharp pains shooting through my head on a daily basis. The pain is so bad that I have to close my eyes. This happens several times a day. I don't know exactly how many times but it is three or more per day. I got disoriented and dizzy and I think that is due to the headaches. I have been having sharp pains running down my right side of my head and behind my right eye. The pain is very sharp and this is happening several times per day. I don't know what is happening." Patient reported, "I saw Dr. Sandoz and he increased the dosage of Vimpat. Dr. Goldschmidt had notified Dr. Sandoz about the pain in my head and Dr. Sandoz decided to increase the Vimpat. I have been on other medications but had reactions to them. I have not had a reaction to the Vimpat but even with the increase from 50 mg to 100 mg my pain in my head has not stopped. On the way down I had a sharp pain in the right side of my head that went down into my jaw. The pain never stays in one place. One time it may be in the right side of my head then it will be on the left side of my head. Other times may be in the middle of my head or in the front of my head."

Patient reported, "I see Dr. Sandoz today. My right wrist and hand stays cold all the time. When I see Dr. Sandoz I am going to remind him about this. I told him before but I want to let him know that it is constantly this way. My whole right side from my shoulder blade down to the end of my fingers is cold and numb. I am going to bring all of this back up this morning with Dr. Sandoz."

Patient reported, "From day one after the accident I have had constant pain in right shoulder blade and right arm. The pain never goes away. I would rate the pain 6 to 7 on a constant basis every hour of the day."

Patient reported that he will see Dr. Goldschmidt and case manager this morning after our session.

Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems. Patient reported, "I have had sleepless nights, horrible dreams, constant pain in my head, money concerns and have been depressed and frustrated."

Patient reported, "I am having bad dreams 4 to 5 nights this past week. I dream about death a lot. I am still shaking real badly while I

Name: Benjamin, Victor Date: 4.25.2012

am asleep. In my dream last night I was dreaming of a fire in my back yard and in the dream I started walking into the flames. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I experienced a couple of panic attacks this past week. This morning on the way here I had a panic attack in the car. This past week I had terrible dreams. There are times that I get upset and agitated but I can't identify the trigger. I think it is because I can't go anywhere without someone taking me. If I want to go somewhere I have to ask someone to take me and I don't want to impose on anybody. I'll sit there and get upset because my life is in the hands of everybody else. Just the simple fact of wanting to go to the store means I have to rely on someone to take me. My independence has been taken from me. With my son in college and my wife working means that I am home all day by myself. If I need to go somewhere or get something I can't because no one is around to help me. This causes me a lot of pain and depression." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."

Patient's depression has gotten worse due to his circumstances. Patient needs intensive therapy to help overcome the issues that he is dealing with.

Patient reported, "My right hand is shaking a more. The shaking started right after the accident but it is getting worse."

Patient had all his assignments completed. The homework showed that the patient is depressed and has experienced a lot anger and frustration. Patient homework showed that the patient is frustrated and angry over 80% of the time every day.

Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 7 of 10." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.

Patient reported, "I have not been able to get an erection since the injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident."

Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."

Went over the homework between this session and the next session. Patient's wife came in with patient and agreed to help patient with his

Name: Benjamin, Victor Date: 4.25.2012

homework.
Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.
Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

Discussed with the patient and his wife that due to the PTSD issues that it is recommended that patient be involved in intensive therapy at least three days per week for two hours per day. This will help the patient process the PTSD issue and help the patient move forward in desensitizing his bad thoughts and feelings associated with the trauma that he patient experienced.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:
A. The patient has been exposed to a traumatic event in which both the following were present:
1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (oage) fell from about 25 feet on patients head on 6.15.2011.
2. The patient's response involved intense fear and helplessness.
B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.

Name: Benjamin, Victor Date: 4.25.2012

	7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.) D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5): 1. Difficulty falling or staying asleep. 2. Irritability or outbursts of anger. 3. Difficulty concentrating. 4. Hypervigilence 5. Exaggerated startle response E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month. F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. 2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away. 3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy. 4-Have been building rapport between patient and therapist. 5-Gave the patient an opportunity to talk about the accident and other issues. Went over with the patient the following forms: 1-Handout describing the physiology and psychology of fear and anxiety. Patient reported he read the material last night. 2-Introduction to Relaxation Practice the relaxation techniques today. 3-Book "Triumph Over Fear" by Jerilyn Ross Discussed with patient the homework: 1-Start reading the book "Triumph Over Fear." 2-Do Breathing exercise (Set of 10; 10 times a day). 3-When triggered do the exercise until anxiety or fear level is a 3 or less. 4-Read all handouts.
	Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\ Went over with the patient that there are nine major goals that we need to accomplish during the therapy: 1-To remember and accept the accident and injuries that occurred. 2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached. 3-To get beliefs that had been disrupted and distorted back in balance. 4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life. 5-Help patient identify anger control problems and implement

Name: Benjamin, Victor Date: 4.25.2012

techniques to help manage them.
6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.
7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.
8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10. (4.25.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 7.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 10.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 10.
Experiencing intense psychological distress. Patient rated this 10.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 10.

Name: Benjamin, Victor Date: 4.25.2012

Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 10.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed.
We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts.
Patient reported that he still has the ringing in his ears.
Patient is distraught about his inability to make a living and support his family.
Went over with the patient the Self Monitoring Scale and Breathing Exercise homework.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
The patient exhibited fair hygiene in his appearance.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
With the condition of the patient not improving in relationship to his PTSD issues it is recommended that the patient be in intensive outpatient therapy three days per week with a minimum of two hours per day. Discussed this with the patient and his wife. The issues are

Name: Benjamin, Victor Date: 4.25.2012

	so intense and the symptoms are so bad that if the patient does not receive this type of treatment the patient will continue to regress. The patient is willing to commit to this type of therapeutic approach and wants to improve. The PTSD issues are intensifying and medication without intensive therapy intervention will not work by itself. This was discussed with the patient and Dr. Goldschmidt at the very beginning of the patient' therapy. It now has gotten to the point that it is no longer an option but a necessity. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor (Even when patient sleeps he wakes tired and gets fatigued during the day) Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ed D.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Victor Benjamin Dates:

Weekly Anger and Frustration Report

Each evening before you go to bed, please make the following ratings, using the scale below:

1. Your average level of anger/frustration (taking all things into consideration)
2. Your maximum level of anger/frustration which you experienced that day.
3. Your average level of depression.
4. Your average level of pleasantness.
5. The percentage of the day that you felt angry/frustrated, using a 0-100% scale where 0 mean no anger/frustration at all and 100 means angry/frustrated all the waking day.

Level of Anxiety/Depression/Pleasantness feelings:

0 1 2 3 4 5 6 7 8

None Slight Moderate A Lot As much as you you can imagine

Date	Average Anger/Frustration	Maximum Anger/Frustration	Average Depression	Average Pleasantness	Percentage of day angry or frustrated
5-2-12	6	7	7	2	75%
5-3-12	7	7	7	2	80%
5-4-12	7	7	7	2	80%
5-5-12	7	7	7	2	80%
5-6-12	6	7	7	2	75%
5-7-12	6	7	7	2	75%
5-8-12	6	7	7	2	75%

Name	Victor Benjamin							Date: weekend 5-8-12			
	Stress Level										
Date:		5-2		5-3		5-4		5-5		5-6	
1st Set	7	7	7	7	7	7	7	7	7	7	
2nd Set	7	6	7	7	7	6	7	7	7	7	
3rd Set	6	6	7	6	6	6	7	6	7	6	
4th Set	6	5	6	6	6	5	6	6	6	6	
5th Set	5	5	6	5	5	5	6	5	6	5	
6th Set	5	4	5	5	5	4	5	5	5	5	
7th Set	4	4	5	4	4	3	5	4	5	4	
8th Set							4	4			
9th Set											
10th Set											
11th Set											
12th Set											
13th Set											
14th Set											
15th Set											
16th Set											
17th Set											
18th Set											
19th Set											
20th Set											

5-7

7 7
7 6
6 6
6 5
5 5
5 4

5-8

7 7
7 7
7 6
6 6
6 5
5 5
5 4

Name: Victor Benjamin

Dates:

Cognitive Self-Monitoring Form

	Trigger or Event	Automatic Thought	Frustration/Anger Irritability/Stress Level (0 to 8)	Countering using Breathing Exercises & Affirmations	Frustration/Anger/ Irritability/Stress Level (0 to 8)
52	pains – Jerks Sleepless nights	tired, ill feeling – depressed – Sad	7		4
53	Finance – Job Health – panic	Scared – Frustrated	7		4
54	T.D. Clx – Pains Bad dreams-hard	tired – Sad – helpless depressed – Frustrated	7		3
55	Can't help wife in Yard – Sleepless	helpless – Sad – Angry – Frustrated	7		4
56	Bad dreams – Jerk – Pains	tired, Frustrated Sad	7		4
57	Pains – head – Arm – Sleepless – Job	Angry – tired Frustrated depressed	7		4
58	Finance – helpless – handicapped	depressed – Scared Frustrated – lonely	7		4

Name: Benjamin, Victor Date: 5.2.2012

Patient Name:	
Grand Strand Psychological Services	
Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Vimpat Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	5.2.2012
Start Time	8:45 am
End Time	9:00 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported, "Last Wednesday I met with Dr. Goldschmidt and my case manager from WMC. Dr. Goldschmidt explained to the case manager that I needed intensive therapy to deal with the issues of PTSD and that I was getting worse. He also requested that I see Dr. Oduwole and Dr. Rosenberg. The case manager said she would work on getting the approvals dealing with his request. I am still waiting on the approval." Patient reported that his pain level was 7.5 of 10. Patient reported, "My stress level is 10 of 10. I would rate my depression 10 of 10." Patient is still having periods of being very upset. Patient's pain level and depression level has increased. Patient needs approval to see psychiatrist and Dr. Rosenberg to deal with these issues. Patient reported, "Dr. Sandoz informed me last week that I can't drive until August. He said that the law of the land says that a person can't drive for six months when they experience what I am going through. It was upsetting to my wife and me. I will be at home from 7 am until almost 5 pm with no one at home. My son starts working

Name: Benjamin, Victor Date: 5.2.2012

next week from 7 to 7 and my wife works from 7 to 4:30."
Patient reported, "Dr. Sandoz increased the Vimpat from 50 mg to 100 mg. Dr. Sandoz also stated that he would be giving me 25 shots of Botox in my head to deal with the headaches. The sharp pain in my head is not as bad but it is still there. The pain is more frequent but not as severe. There have been times were I am unable to speak and not know the reason. It could be the sharp pains that are causing the problem or possible something else. My concern is that I don't know what is happening. My wife will call me during the day while she is at work to check on me. I am having sharp pains shooting through my head on a daily basis. The pain is so bad that I have to close my eyes. This happens several times a day. I don't know exactly how many times but it is three or more per day. I got disoriented and dizzy and I think that is due to the headaches. I have been having sharp pains running down my right side of my head and behind my right eye. The pain is very sharp and this is happening several times per day. I don't know what is happening. I have not had a reaction to the Vimpat but even with the increase from 50 mg to 100 mg my pain in my head has not stopped. On the way down I had a sharp pain in the right side of my head that went down into my jaw. The pain never stays in one place. One time it may be in the right side of my head then it will be on the left side of my head. Other times may be in the middle of my head or in the front of my head."
Patient reported, "I saw Dr. Sandoz and told him about my right wrist and hand staying cold all the time. Dr. Sandoz said that he needed to talk with Dr. Welsch about this. My whole right side from my shoulder blade down to the end of my fingers is cold and numb. I am having more pain in my right arm and right hand."
Patient reported, "From day one after the accident I have had constant pain in right shoulder blade and right arm. The pain never goes away. I would rate the pain 6 to 7 on a constant basis every hour of the day."
Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems. Patient reported, "I have had sleepless nights, horrible dreams, constant pain in my head, money concerns and have been depressed and frustrated."
Patient reported, "I am having bad dreams 4 to 5 nights this past week. I dream about death a lot. I am still shaking real badly while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I am waking up during the bad dreams and I will be sweating and the pillow will be wet from it. I experienced a couple of panic attacks this past week. This past week I had terrible dreams. In one of my dreams I dreamed

Name: Benjamin, Victor Date: 5.2.2012

that someone stole my tow truck. I got it back in my dream but I wanted to kill the guy who stole my tow truck. It was all a dream but I woke up with tears running down my eyes. I had to go outside to see if my truck was there. I can't drive it or use it but I had to be sure it was there. It was. It was just a dream. There are times that I get upset and agitated but I can't identify the trigger. I think it is because I can't go anywhere without someone taking me. If I want to go somewhere I have to ask someone to take me and I don't want to impose on anybody. I'll sit there and get upset because my life is in the hands of everybody else. Just the simple fact of wanting to go to the store means I have to rely on someone to take me. My independence has been taken from me. With my son in college and my wife working means that I am home all day by myself. If I need to go somewhere or get something I can't because no one is around to help me. This causes me a lot of pain and depression." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."

Patient's depression has gotten worse due to his circumstances. Patient needs intensive therapy to help overcome the issues that he is dealing with.

Patient reported, "My right hand is shaking a more. The shaking started right after the accident but it is getting worse."

Patient had all his assignments completed. The homework showed that the patient is depressed and has experienced a lot anger and frustration. Patient homework showed that the patient is frustrated and angry over 80% of the time every day.

Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 10 of 10." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.

Patient reported, "I have not been able to get an erection since the injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident."

Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."

Went over the homework between this session and the next session.

Patient's wife came in with patient and agreed to help patient with his homework.

Name: Benjamin, Victor Date: 5.2.2012

Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.
Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

Discussed with the patient and his wife that due to the PTSD issues that it is recommended that patient be involved in intensive therapy at least three days per week for two hours per day. This will help the patient process the PTSD issue and help the patient move forward in desensitizing his bad thoughts and feelings associated with the trauma that he patient experienced.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:
A. The patient has been exposed to a traumatic event in which both the following were present:
1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.
2. The patient's response involved intense fear and helplessness.
B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
C. Persistent avoidance of stimuli associated with the trauma and ~~numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the~~ patient experiences the following 7 of the 7):
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a

Name: Benjamin, Victor Date: 5.2.2012

normal life span or cancer.)
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):
1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response
E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.
3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.
4-Have been building rapport between patient and therapist.
5-Gave the patient an opportunity to talk about the accident and other issues.
Went over with the patient the following forms:
1-Handout describing the physiology and psychology of fear and anxiety.
Patient reported he read the material last night.
2-Introduction to Relaxation
Practice the relaxation techniques today.
3-Book "Triumph Over Fear" by Jerilyn Ross
Discussed with patient the homework:
1-Start reading the book "Triumph Over Fear."
2-Do Breathing exercise (Set of 10; 10 times a day).
3-When triggered do the exercise until anxiety or fear level is a 3 or less.
4-Read all handouts.
Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\
Went over with the patient that there are nine major goals that we need to accomplish during the therapy:
1-To remember and accept the accident and injuries that occurred.
2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.
3-To get beliefs that had been disrupted and distorted back in balance.
4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.
5-Help patient identify anger control problems and implement techniques to help manage them.

Name: Benjamin, Victor Date: 5.2.2012

	6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger. 7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy. 8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered. 9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive. Gave patient the homework of writing about the following: 1-The accident and the after effects on patient's life 2-Asked patient to consider the effects the accident had on his: -beliefs about himself -beliefs about others -beliefs about the world 3-Asked the patient to consider the following topics while writing about his traumatic event: -safety, trust, power, esteem and security Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered. Patient is in pain and experiences anxiety and is stress. Patient was asked to rate the following on a scale of 0 to 10. (5.2.2012) Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 10. Patient reported that he doesn't have any friends. Patient rated it 7. Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 8. Went over with the patient the problems he is experiencing. The patient is having: Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10. Reliving the event as though he is experiencing the event at that moment. Patient rated this 10. Experiencing a marked reduction and inability to feel emotions. Patient rated this 10. Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9. Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8. Has a diminished response to external world. Patient rated this 9. Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10. Feeling detached from other people. Patient rated this 10. Experiencing intense psychological distress. Patient rated this 10. Experiencing a sense of foreshortened future. Patient rated this 10. Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 10. Experiencing irritability and outburst of anger. Patient rated this 10.

Name: Benjamin, Victor Date: 5.2.2012

Has trouble concentrating and completing tasks. Patient rated this 10.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed.
We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts.
Patient reported that he still has the ringing in his ears.
Patient is distraught about his inability to make a living and support his family.
Went over with the patient the Self Monitoring Scale and Breathing Exercise homework.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
The patient exhibited fair hygiene in his appearance.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
With the condition of the patient not improving in relationship to his PTSD issues it is recommended that the patient be in intensive outpatient therapy three days per week with a minimum of two hours per day. Discussed this with the patient and his wife. The issues are so intense and the symptoms are so bad that if the patient does not

Name: Benjamin, Victor Date: 5.2.2012

	receive this type of treatment the patient will continue to regress. The patient is willing to commit to this type of therapeutic approach and wants to improve. The PTSD issues are intensifying and medication without intensive therapy intervention will not work by itself. This was discussed with the patient and Dr. Goldschmidt at the very beginning of the patient' therapy. It now has gotten to the point that it is no longer an option but a necessity. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor (Even when patient sleeps he wakes tired and gets fatigued during the day) Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ed.D.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Victor Benjamin Dates:

Weekly Anger and Frustration Report

Each evening before you go to bed, please make the following ratings, using the scale below:

1. Your average level of anger/frustration (taking all things into consideration)
2. Your maximum level of anger/frustration which you experienced that day.
3. Your average level of depression.
4. Your average level of pleasantness.
5. The percentage of the day that you felt angry/frustrated, using a 0-100% scale where 0 mean no anger/frustration at all and 100 means angry/frustrated all the waking day.

Level of Anxiety/Depression/Pleasantness feelings:

0 1 2 3 4 5 6 7 8

None Slight Moderate A Lot As much as you you can imagine

Date	Average Anger/Frustration	Maximum Anger/Frustration	Average Depression	Average Pleasantness	Percentage of day angry or frustrated
5-9-12	7	7	7	1	90%
5-10-12	6.5	7	7	2	85%
5-11-12	7	7	7	2	85%
5-12-12	6	7	7	2	80%
5-13-12	6	7	7	2	80%
5-14-12	6	7	7	2	80%
5-15-12	6	7	7	2	80%

Wk of 5-9-12

Name: Victor Benjamin Dates:

Cognitive Self-Monitoring Form

	Trigger or Event	Automatic Thought	Frustration/Anger Irritability/Stress Level (0 to 8)	Countering using Breathing Exercises & Affirmations		Frustration/Anger/ Irritability/Stress Level (0 to 8)
5/9	Pains-Shots Family, nerve Cortisone	depressed-Angry Frustrated	☐			4
5/10	didn't see Parent	Frustrated	☐			4
5/11	Pain, health health-pain	Sad-helpless tired, depressed	☐			4
5/12	Neck-sleepless dreams-didn't	Sad-lonely tired-Frustrated	☐			4
5/13	Pain neck- Pain-health-tired-	depressed Sad	☐			4
5/14	Sleepless dreams Can't go anywhere	depressed Angry-helpless	☐			4
5/15	Can't ride bike Jerks, Can't go	Frustrated tired, no energy-	☐			4
	Anywhere-health	Sleepy, Frustrated				

Wk of 5-9-12

Name	Victor Benjamin									Date:	
	Stress Level										
Date:		5-9		5-10		5-11		5-12		5-13
1st Set	7	7	7	7	7	7	7	7	7	7
2nd Set	7	7	7	7	7	7	7	7	7	7
3rd Set	7	7	7	6	7	7	7	6	7	6
4th Set	7	6	6	6	7	6	6	6	6	6
5th Set	6	6	6	5	6	6	6	6	6	5
6th Set	6	5	5	5	6	6	6	5	5	5
7th Set	5	5	5	4	6	5	5	5	5	4
8th Set	5	4	4	4	5	5	5	4	4	4
9th Set					5	5	4	4		
10th Set					5	4				
11th Set					4	4				
12th Set										
13th Set										
14th Set										
15th Set										
16th Set										
17th Set										
18th Set										
19th Set										
20th Set										

5-14	5-15
7 7	7 7
7 7	7 7
7 6	7 6
6 6	6 6
6 5	6 5
5 5	5 5
5 4	5 4
4 4	4 4

Name: Benjamin, Victor Date: 5.9.2012

Patient Name:	
Grand Strand Psychological Services **Progress Note**	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Vimpat Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	5.9.2012
Start Time	10:00 am
End Time	11:15 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported, "I have all my homework. I am getting depressed over my circumstances. My pain in my head is so bad that I have a hard time sleeping. When I do sleep I jerk and wake up sweating. Sometimes my wife has to change the sheets on the bed. My wife tells me that I was jerking in my sleep. When I first try to go to sleep I find sometimes I am jerking before I fall asleep. I worry a lot over my financial situation. I have been a good provider for my family and it is frustrating for me not to be able to do the things I used to do. I can't even help around the house. I am still having panic attacks. My head is still hurting even on the new medication. My right arm from the shoulder down to the tips of my fingers hurts and gets numb. My anxiety level is high. My depression is getting worse. I am sleeping less than before. I am having racing thoughts and it is causing me to be depressed and have panic attacks. Today I see Dr. Sandoz and he is going to give me 25 or more injections in my head. I am real nervous about having that done. I don't like shots. Last night I had a bad dream about having staples being put in my head. It

Name: Benjamin, Victor Date: 5.9.2012

was the doctor that told me nothing was wrong with me. In my dream I had to go back to him and I didn't want to deal with him. He was telling me nothing was wrong with me. It was a miserable night. I couldn't rest and the dream was upsetting to me. I am nervous enough about having the injections in my head today. I am having a lot of pain on the right side of the back of my neck. When I had the shot in my neck in November of 2011 it didn't help me at all. Then in December of 2011 the doctor gave me another shot and the pain in my neck stopped. The pain in my neck started coming back last week. At first the pain was moderate and stopped for a few days. Then the pain in my neck started coming back and now it is there all the time. The pain level in my neck is 8 of 10."

Patient reported that his pain level was 10 of 10. Patient reported, "My stress level is 10 of 10. I would rate my depression 10 of 10." Patient is still having periods of being very upset. Patient's pain level and depression level has increased. Patient needs approval to see psychiatrist and Dr. Rosenberg to deal with these issues.

Patient reported, "Dr. Sandoz informed me last week that I can't drive until August. He said that the law of the land says that a person can't drive for six months when they experience what I am going through. It was upsetting to my wife and me. I will be at home from 7 am until almost 5 pm with no one at home. My son starts working next week from 7 to 7 and my wife works from 7 to 4:30."

Patient reported, "Dr. Sandoz increased the Vimpat from 50 mg to 100 mg. Dr. Sandoz also stated that he would be giving me 25 shots of Botox in my head to deal with the headaches. The sharp pain in my head is not as bad but it is still there. The pain is more frequent but not as severe. There have been times were I am unable to speak and not know the reason. It could be the sharp pains that are causing the problem or possible something else. My concern is that I don't know what is happening. My wife will call me during the day while she is at work to check on me. I am having sharp pains shooting through my head on a daily basis. The pain is so bad that I have to close my eyes. This happens several times a day. I don't know exactly how many times but it is three or more per day. I got disoriented and dizzy and I think that is due to the headaches. I have been having sharp pains running down my right side of my head and behind my right eye. The pain is very sharp and this is happening several times per day. I don't know what is happening. I have not had a reaction to the Vimpat but even with the increase from 50 mg to 100 mg my pain in my head has not stopped. On the way down I had a sharp pain in the right side of my head that went down into my jaw. The pain never stays in one place. One time it may be in the right side of my head then it will be on the left side of my head. Other times may be in the middle of my head or in the front of my head."

Patient reported, "I saw Dr. Sandoz and told him about my right wrist and hand staying cold all the time. Dr. Sandoz said that he needed to talk with Dr. Welsch about this. My whole right side from my shoulder blade down to the end of my fingers is cold and numb. I am

Name: Benjamin, Victor Date: 5.9.2012

	having more pain in my right arm and right hand." Patient reported, "From day one after the accident I have had constant pain in right shoulder blade and right arm. The pain never goes away. I would rate the pain 6 to 7 on a constant basis every hour of the day." Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems. Patient reported, "I have had sleepless nights, horrible dreams, constant pain in my head, money concerns and have been depressed and frustrated." Patient reported, "I am having bad dreams 4 to 5 nights this past week. I dream about death a lot. I am still shaking real badly while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I am waking up during the bad dreams and I will be sweating and the pillow will be wet from it. I experienced a couple of panic attacks this past week. This past week I had terrible dreams. In one of my dreams I dreamed that someone stole my tow truck. I got it back in my dream but I wanted to kill the guy who stole my tow truck. It was all a dream but I woke up with tears running down my eyes. I had to go outside to see if my truck was there. I can't drive it or use it but I had to be sure it was there. It was. It was just a dream. There are times that I get upset and agitated but I can't identify the trigger. I think it is because I can't go anywhere without someone taking me. If I want to go somewhere I have to ask someone to take me and I don't want to impose on anybody. I'll sit there and get upset because my life is in the hands of everybody else. Just the simple fact of wanting to go to the store means I have to rely on someone to take me. My independence has been taken from me. With my son in college and my wife working means that I am home all day by myself. If I need to go somewhere or get something I can't because no one is around to help me. This causes me a lot of pain and depression." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't." Patient's depression has gotten worse due to his circumstances. Patient needs intensive therapy to help overcome the issues that he is dealing with. Patient reported, "My right hand is shaking a more. The shaking started right after the accident but it is getting worse." Patient had all his assignments completed. The homework showed that the patient is depressed and has experienced a lot anger and frustration. Patient homework showed that the patient is frustrated and angry over 80% of the time every day. Patient reported, "People want to talk to me about the accident and I

Name: Benjamin, Victor Date: 5.9.2012

don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 10 of 10." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.

Patient reported, "I have not been able to get an erection since the injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident."

Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."

Went over the homework between this session and the next session.

Patient's wife came in with patient and agreed to help patient with his homework.

Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.

Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

Discussed with the patient and his wife that due to the PTSD issues that it is recommended that patient be involved in intensive therapy at least three days per week for two hours per day. This will help the patient process the PTSD issue and help the patient move forward in desensitizing his bad thoughts and feelings associated with the trauma that he patient experienced.

1.Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:

1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.

2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

2. Recurrent distressing dreams of the event.

3. Acting or feeling as if the traumatic event were recurring when

Name: Benjamin, Victor Date: 5.9.2012

	the patient has flashbacks, relives the experience and has hallucinations about the event. 4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. 5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7): 1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma. 2. Efforts to avoid activities, places, or people that arouse recollections of the trauma. 3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection. 4. Markedly diminished interest or participation in significant activities. 5. Feeling of detachment or estrangement from others. 6. Restricted range of affect. 7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.) D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5): 1. Difficulty falling or staying asleep. 2. Irritability or outbursts of anger. 3. Difficulty concentrating. 4. Hypervigilence 5. Exaggerated startle response E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month. F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
	2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away. 3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy. 4-Have been building rapport between patient and therapist. 5-Gave the patient an opportunity to talk about the accident and other issues. Went over with the patient the following forms: 1-Handout describing the physiology and psychology of fear and anxiety. Patient reported he read the material last night. 2-Introduction to Relaxation

Name: Benjamin, Victor Date: 5.9.2012

	Practice the relaxation techniques today. 3-Book "Triumph Over Fear" by Jerilyn Ross Discussed with patient the homework: 1-Start reading the book "Triumph Over Fear." 2-Do Breathing exercise (Set of 10; 10 times a day). 3-When triggered do the exercise until anxiety or fear level is a 3 or less. 4-Read all handouts. Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\ Went over with the patient that there are nine major goals that we need to accomplish during the therapy: 1-To remember and accept the accident and injuries that occurred. 2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached. 3-To get beliefs that had been disrupted and distorted back in balance. 4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life. 5-Help patient identify anger control problems and implement techniques to help manage them. 6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger. 7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy. 8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered. 9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive. Gave patient the homework of writing about the following: 1-The accident and the after effects on patient's life 2-Asked patient to consider the effects the accident had on his: -beliefs about himself -beliefs about others -beliefs about the world
	3-Asked the patient to consider the following topics while writing about his traumatic event: -safety, trust, power, esteem and security Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered. Patient is in pain and experiences anxiety and is stress. Patient was asked to rate the following on a scale of 0 to 10. (5.9.2012) Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 10. Patient reported that he doesn't have any friends. Patient rated it 7. Patient is distraught and has thoughts and feelings of hopelessness.

Name: Benjamin, Victor Date: 5.9.2012

Patient rated this 8.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 10.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 10.
Experiencing intense psychological distress. Patient rated this 10.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 10.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 10.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.

Name: Benjamin, Victor Date: 5.9.2012

	Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed. We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts. Patient reported that he still has the ringing in his ears. Patient is distraught about his inability to make a living and support his family. Went over with the patient the Self Monitoring Scale and Breathing Exercise homework. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. The patient exhibited fair hygiene in his appearance. Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event. With the condition of the patient not improving in relationship to his PTSD issues it is recommended that the patient be in intensive outpatient therapy three days per week with a minimum of two hours per day. Discussed this with the patient and his wife. The issues are so intense and the symptoms are so bad that if the patient does not receive this type of treatment the patient will continue to regress. The patient is willing to commit to this type of therapeutic approach and wants to improve. The PTSD issues are intensifying and medication without intensive therapy intervention will not work by itself. This was discussed with the patient and Dr. Goldschmidt at the very beginning of the patient' therapy. It now has gotten to the point that it is no longer an option but a necessity. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Oriented: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor (Even when patient sleeps he wakes tired and gets fatigued during the day) Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to

Name: Benjamin, Victor Date: 5.9.2012

	decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ed.D.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Benjamin, Victor Date: 5.16.2012

Patient Name:	
Grand Strand Psychological Services **Progress Note**	
Referral Source:	Dr. Sandoz)
Physical Complaints	See Chart of physical complaints
Medications	Vimpat Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	5.16.2012
Start Time	8:45 am
End Time	10:00 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported, "I have all my homework. I am getting depressed over my circumstances. I had 20 to 25 shots in my head last week by Dr. Sandoz. When he started giving me shots in the back of my head the area he was dealing with started hurting worse. I thought that after a day or two the pain would decrease. However, the pain has increased since I got the shots. It was bad enough before the shots but now is worse. I was having severe pain in my head that would be in one place one day and another place the next day. After the shots in my head I now have pain not only all over my head but in my neck. When I leave here I am going to call Dr. Sandoz and see what he says. My pain in my head is so bad that I have a hard time sleeping. When I do sleep I jerk and wake up sweating. Sometimes my wife has to change the sheets on the bed. My wife tells me that I was jerking in my sleep. When I first try to go to sleep I find sometimes I am jerking before I fall asleep. I worry a lot over my financial situation. I have been a good provider for my family and it is frustrating for me not to be able to do the things I used to do. I

Name: Benjamin, Victor Date: 5.16.2012

can't even help around the house. I am still having panic attacks. My head is still hurting even on the new medication. My right arm from the shoulder down to the tips of my fingers hurts and gets numb. My anxiety level is high. My depression is getting worse. I am sleeping less than before. I am having racing thoughts and it is causing me to be depressed and have panic attacks. The bad dreams that I had this past week caused me to be jerking and sweating but when I woke up I couldn't remember the dream. I am having a lot of pain on the right side of the back of my neck. When I had the shot in my neck in November of 2011 it didn't help me at all. Then in December of 2011 the doctor gave me another shot and the pain in my neck stopped. The pain in my neck did not get better after the shots last week but got worse. The pain level in my neck is 10 of 10. I have been irritable and depressed more this past week because I got no relief from my pain in my head or neck. This was the first week that I have been alone at home. My depression is worse. I can't go anywhere or do anything and no one is around to take me anywhere. I feel helpless and hopeless. My life is in turmoil and it upsets me that I am unable to function like I used to."

Patient reported that his pain level was 10 of 10. Patient reported, "My stress level is 10 of 10. My stress level is getting worse. This past week it was so bad that I was angry and short tempered with my wife. I would rate my depression 10 of 10." Patient is still having periods of being very upset. Patient's pain level and depression level has increased. Patient needs approval to see psychiatrist and Dr. Rosenberg to deal with these issues.

Patient reported, "Dr. Sandoz informed me last week that I can't drive until August. He said that the law of the land says that a person can't drive for six months when they experience what I am going through. It was upsetting to my wife and me. I will be at home from 7 am until almost 5 pm with no one at home. My son started working from 7 to 7 and my wife works from 7 to 4:30."

Patient reported, "Dr. Sandoz increased the Vimpat from 50 mg to 100 mg. Dr. Sandoz gave me 20 to 25 shots of Botox in my head to deal with the headaches. The sharp pain in my head before the shots were frequent and but not real severe. After the shots my pain has not gotten better but has become more severe. There have been times were I am unable to speak and not know the reason. It could be the sharp pains that are causing the problem or possible something else. My concern is that I don't know what is happening. My wife will call me during the day while she is at work to check on me. I am having sharp pains shooting through my head on a daily basis. The pain is so bad that I have to close my eyes. This happens several times a day. I don't know exactly how many times but it is three or more per day. I got disoriented and dizzy and I think that is due to the headaches. I have been having sharp pains running down my right side of my head and behind my right eye. The pain is very sharp and this is happening several times per day. I don't know what is happening. I have not had a reaction to the Vimpat but even with the increase from 50 mg to 100 mg my pain in my head has not

Name: Benjamin, Victor Date: 5.16.2012

stopped. On the way down I had a sharp pain in the right side of my head that went down into my jaw. The pain never stays in one place. One time it may be in the right side of my head then it will be on the left side of my head. Other times may be in the middle of my head or in the front of my head."

Patient reported, "I saw Dr. Sandoz and told him about my right wrist and hand staying cold all the time. Dr. Sandoz said that he needed to talk with Dr. Welsch about this. He told me last week that he and Dr. Welsch are playing phone tag but that he would talk with Dr. Welsch about what was going on. My whole right side from my shoulder blade down to the end of my fingers is cold and numb. I am having more pain in my right arm and right hand."

Patient reported, "From day one after the accident I have had constant pain in right shoulder blade and right arm. The pain never goes away. I would rate the pain 6 to 7 on a constant basis every hour of the day."

Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems. Patient reported, "I have had sleepless nights, horrible dreams, constant pain in my head, money concerns and have been depressed and frustrated."

Patient reported, "I am having bad dreams 4 to 5 nights this past week. I dream about death a lot. Sometimes the dreams are about my former job and wanting to fight. I am still shaking real badly while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I am waking up during the bad dreams and I will be sweating and the pillow will be wet from it. I experienced a couple of panic attacks this past week. This past week I had terrible dreams. There are times that I get upset and agitated but I can't identify the trigger. I think it is because I can't go anywhere without someone taking me. If I want to go somewhere I have to ask someone to take me and I don't want to impose on anybody. I'll sit there and get upset because my life is in the hands of everybody else. Just the simple fact of wanting to go to the store means I have to rely on someone to take me. My independence has been taken from me. With my son in college and my wife working means that I am home all day by myself. If I need to go somewhere or get something I can't because no one is around to help me. This causes me a lot of pain and depression." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."

Patient's depression has gotten worse due to his circumstances. Patient needs intensive therapy to help overcome the issues that he is dealing with.

Name: Benjamin, Victor Date: 5.16.2012

Patient reported, "My right hand is shaking a more. The shaking started right after the accident but it is getting worse."
Patient had all his assignments completed. The homework showed that the patient is depressed and has experienced a lot anger and frustration. Patient homework showed that the patient is frustrated and angry over 80% of the time every day.
Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day. If I was rating my depression on a scale of 0 to 10 I would say that mine is 10 of 10." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.
Patient reported, "I have not been able to get an erection since the injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident."
Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."
Went over the homework between this session and the next session.
Patient's wife came in with patient and agreed to help patient with his homework.
Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.
Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

Discussed with the patient and his wife that due to the PTSD issues that it is recommended that patient be involved in intensive therapy at least three days per week for two hours per day. This will help the patient process the PTSD issue and help the patient move forward in desensitizing his bad thoughts and feelings associated with the trauma that he patient experienced.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:
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1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.
2. The patient's response involved intense fear and helplessness.

Name: Benjamin, Victor Date: 5.16.2012

B. The traumatic event is persistently re-experienced in one or more of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.

3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.

4-Have been building rapport between patient and therapist.

Name: Benjamin, Victor Date: 5.16.2012

	5-Gave the patient an opportunity to talk about the accident and other issues. Went over with the patient the following forms: 1-Handout describing the physiology and psychology of fear and anxiety. Patient reported he read the material last night. 2-Introduction to Relaxation Practice the relaxation techniques today. 3-Book "Triumph Over Fear" by Jerilyn Ross Discussed with patient the homework: 1-Start reading the book "Triumph Over Fear." 2-Do Breathing exercise (Set of 10; 10 times a day). 3-When triggered do the exercise until anxiety or fear level is a 3 or less. 4-Read all handouts. Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\ Went over with the patient that there are nine major goals that we need to accomplish during the therapy: 1-To remember and accept the accident and injuries that occurred. 2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached. 3-To get beliefs that had been disrupted and distorted back in balance. 4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life. 5-Help patient identify anger control problems and implement techniques to help manage them. 6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger. 7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy. 8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered. 9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive. Gave patient the homework of writing about the following: 1-The accident and the after effects on patient's life 2-Asked patient to consider the effects the accident had on his: -beliefs about himself -beliefs about others -beliefs about the world 3-Asked the patient to consider the following topics while writing about his traumatic event: -safety, trust, power, esteem and security Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.

Name: Benjamin, Victor Date: 5.16.2012

Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10. (5.16.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 10.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 9.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 10.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 10.
Experiencing intense psychological distress. Patient rated this 10.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 10.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 10.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.

Name: Benjamin, Victor Date: 5.16.2012

	Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ed.D.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Victor Benjamin Dates: Week of 6-13-12

Weekly Anger and Frustration Report

Each evening before you go to bed, please make the following ratings, using the scale below:

1. Your average level of anger/frustration (taking all things into consideration)
2. Your maximum level of anger/frustration which you experienced that day.
3. Your average level of depression.
4. Your average level of pleasantness.
5. The percentage of the day that you felt angry/frustrated, using a 0-100% scale where 0 mean no anger/frustration at all and 100 means angry/frustrated all the waking day.

Level of Anxiety/Depression/Pleasantness feelings:

0 1 2 3 4 5 6 7 8

None Slight Moderate A Lot As much as you you can imagine

Date	Average Anger/Frustration	Maximum Anger/Frustration	Average Depression	Average Pleasantness	Percentage of day angry or frustrated
6-7-12	6	7	7	2	75%
6-8-12	6	7	7	2	75%
6-9-12	7	7	7	2	80%
6-10-12	7	7	7	2	80%
6-11-12	6	7	7	2	75%
6-12-12	6	7	7	2	75%
6-13-12	6	7	7	2	75%

Name	Victor Bryant	Date: Weekend 6-13

	Stress Level									
Date:	6-7		6-8		6-9		6-10		6-11	
1st Set	7	7	7	7	7	7	7	7	7	7
2nd Set	7	7	7	6	7	7	7	7	7	7
3rd Set	7	6	6	6	7	6	7	6	7	6
4th Set	6	6	6	5	6	6	6	6	6	6
5th Set	6	5	5	4	6	5	6	6	6	5
6th Set	5	5	4	4	5	4	6	5	5	5
7th Set	5	4			4	4	5	5	5	4
8th Set	4	4					5	4	4	4
9th Set	4	4								
10th Set										
11th Set										
12th Set										
13th Set										
14th Set										
15th Set										
16th Set										
17th Set										
18th Set										
19th Set										
	6-12		6-13							
1st Set	7	7	7	7						
2nd Set	7	7	7	7						
3rd Set	7	6	7	6						
4th Set	6	6	6	6						
5th Set	6	5	6	5						
6th Set	5	4	5	5						
7th Set	4	4	5	4						
8th Set	4	4	4	4						
9th Set										
10th Set										
11th Set										
12th Set										
13th Set										
14th Set										
15th Set										
16th Set										
17th Set										
18th Set										
19th Set										
20th Set										

Name: Victor Benjamin Dates: Week of 6-6-12

Weekly Anger and Frustration Report

Each evening before you go to bed, please make the following ratings, using the scale below:

1. Your average level of anger/frustration (taking all things into consideration)
2. Your maximum level of anger/frustration which you experienced that day.
3. Your average level of depression.
4. Your average level of pleasantness.
5. The percentage of the day that you felt angry/frustrated, using a 0-100% scale where 0 mean no anger/frustration at all and 100 means angry/frustrated all the waking day.

Level of Anxiety/Depression/Pleasantness feelings:

0 1 2 3 4 5 6 7 8

None Slight Moderate A Lot As much as you you can imagine

Date	Average Anger/Frustration	Maximum Anger/Frustration	Average Depression	Average Pleasantness	Percentage of day angry or frustrated
5-31-12	7	7	6	2	75%
6-1-12	7	7	6	2	75%
6-2-12	7	7	7	2	80%
6-3-12	6	7	7	2	75%
6-4-12	6	7	7	2	75%
6-5-12	7	7	7	2	80%
6-6-12	6	7	7	2	75%

Wk of 6-6-12

Name: Victor Benjamin Dates: Week of 6-6-12

Cognitive Self-Monitoring Form

	Trigger or Event	Automatic Thought	Frustration/Anger Irritability/Stress Level (0 to 8)	Countering using Breathing Exercises & Affirmations	Frustration/Anger/ Irritability/Stress Level (0 to 8)
5/31	Sleepless, dreams Job, Health	Angry-Sad-Tired depressed-Stress	7		4
6/1	no CK - Pains, head-arm, dreams	Frustrated, Sad depressed-Stress	7		4
6/2	Panic Attack, Health Finance	depressed - lonesome tired - helpless	7		4
6/3	Pains, Job, Health Car drive	Weak on Stomach - dizzy - tired - Sad	7		4
6/4	Can't go nowhere Sleepless - Panic Attack	upset - Angry Frustrated	7		4
6/5	Feel sick, disoriented Sleepless	depressed tired - helpless	7		4
6/6	Arm hurts, head aches - Health	Sad, depressed - ill stress	7		4

Week of 6-6-2012

Name	Victor Benjamin								Date: Wk end	6-6
	Stress Level									
Date:	5-31		6-1		6-2		6-3		6-4	
1st Set	7	7	7	7	7	7	7	7	7	7
2nd Set	7	7	7	7	7	6	7	6	7	7
3rd Set	7	6	7	7	6	6	6	6	7	6
4th Set	6	6	7	6	6	5	6	5	6	6
5th Set	6	5	6	6	5	5	5	5	6	5
6th Set	5	4	6	5	5	4	5	4	5	5
7th Set	4	4	5	5	4	4	4	4	5	4
8th Set			5	5					4	4
9th Set			5	4						
10th Set			4	4						
11th Set										
12th Set										
13th Set										
14th Set										
15th Set										
16th Set										
17th Set										
18th Set										
19th Set										
	6-5		6-6							
1st Set	7	7	7	7						
2nd Set	7	7	7	7						
3rd Set	7	6	7	6						
4th Set	6	6	6	6						
5th Set	6	5	6	5						
6th Set	5	5	5	5						
7th Set	5	4	5	4						
8th Set	4	4	4	4						
9th Set										
10th Set										
11th Set										
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18th Set										
19th Set										
20th Set										

Name: Benjamin, Victor Date: 5.30.2012

Patient Name:	
Grand Strand Psychological Services	
Progress Note	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Vimpat Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	5.30.2012
Start Time	8:45 am
End Time	10:00 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF=40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported, "I have been very agitated and angry lately. I have a short fuse and verbally express my agitation." Patient reported, "I have all my homework. I am getting depressed over my circumstances. I had 20 to 25 shots in my head three weeks ago by Dr. Sandoz. When he started giving me shots in the back of my head the area he was dealing with started hurting worse. I thought that after a day or two the pain would decrease. However, the pain has increased since I got the shots. It was bad enough before the shots but now is worse. I was having severe pain in my head that would be in one place one day and another place the next day. After the shots in my head I now have pain not only all over my head but in my neck. Since the shots in my head my pain isn't as severe but the pain is more frequent. I called Dr. Sandoz and he called a prescription of pain medication in. When I started taking the medication I immediately started having severe pain in my right foot. The name of the medication was Butalbital/Acetaminophen Tabs. Dr. Sandoz changed back to Tramadol. Since I started taking

Name: Benjamin, Victor Date: 5.30.2012

Tramadol last Thursday. Since I started taking Tramadol I have been real tired in the morning and have to make myself get up and move around. I feel like just staying in bed. The pain in my right foot each time would be so severe that I couldn't stand it. My pain in my head is so bad that I have a hard time sleeping. When I do sleep I jerk and wake up sweating. Sometimes my wife has to change the sheets on the bed. My wife tells me that I was jerking in my sleep. When I first try to go to sleep I find sometimes I am jerking before I fall asleep. I am not sleeping as well as I used to. When I wake up I am tired. I have no energy. My right wrist has started hurting. On a scale of 0 to 10 my pain in my wrist is 7 of 10. When the pain shoots through my head it is 7 of 10. This happens many times each hour of the day. There is no way I can keep count due to the frequency of the pain shooting through my head. After the shots the pain is occurring more frequent than before but the pain is a little less but not much. I will never take 25 shots in my head again. When he Dr. Sandoz did the shots in my head he also gave me shots in the neck where my neck pain is. The pain in my neck was bad before the shots in my head but now is worse. It isn't as bad as last week but still is very painful."

Patient reported, "I worry a lot over my financial situation. I have been a good provider for my family and it is frustrating for me not to be able to do the things I used to do. I can't even help around the house. I am still having panic attacks. My head is still hurting even on the new medication. My right arm from the shoulder down to the tips of my fingers hurts and gets numb. My anxiety level is high. My depression is getting worse. I am sleeping less than before. I am having racing thoughts and it is causing me to be depressed and have panic attacks. The bad dreams that I had this past week caused me to be jerking and sweating but when I woke up I couldn't remember the dream. I am having a lot of pain on the right side of the back of my neck. When I had the shot in my neck in November of 2011 it didn't help me at all. Then in December of 2011 the doctor gave me another shot and the pain in my neck stopped. The pain in my neck did not get better after the shots last week but got worse. The pain ~~level in my neck is 8 of 10 today. I have been irritable and depressed more this past week because I got no relief from my pain in my head~~ or neck. My depression is worse. I can't go anywhere or do anything and no one is around to take me anywhere. I feel helpless and hopeless. My life is in turmoil and it upsets me that I am unable to function like I used to."

Patient reported that his pain level was 8 of 10. Patient reported, "My stress level is 9 of 10. My stress level is getting worse. This past week it was so bad that I was angry and short tempered with my wife. I would rate my depression 9 of 10." Patient is still having periods of being very upset. Patient's pain level and depression level has increased. Patient needs approval to see psychiatrist and Dr. Rosenberg to deal with these issues.

Patient reported, "When Dr. Sandoz informed me three weeks ago that I can't drive until August it was very upsetting to me and my

Name: Benjamin, Victor Date: 5.30.2012

wife. He said that the law of the land says that a person can't drive for six months when they experience what I am going through. I will be at home from 7 am until almost 5 pm with no one at home.
Patient reported, "My concern is that I don't know what is happening. My wife will call me during the day while she is at work to check on me. I am having sharp pains shooting through my head on a daily basis. The pain is so bad that I have to close my eyes. I get disoriented and dizzy and I think that is due to the headaches. I have been having sharp pains running down my right side of my head and behind my right eye. I noticed that when I walk that I start moving to the right and I can't control it. I don't know what is happening. I have not had a reaction to the Vimpat but even with the increase from 50 mg to 100 mg my pain in my head has not stopped. I did talk with Dr. Sandoz about the walking and going to my right and I can't stop it and he said it was coming from my inner ear."
Patient reported, "I saw Dr. Sandoz and told him about my right wrist and hand staying cold all the time. Dr. Sandoz said that he needed to talk with Dr. Welsch about this. He told me last week that he and Dr. Welsch are playing phone tag but that he would talk with Dr. Welsch about what was going on. My whole right side from my shoulder blade down to the end of my fingers is cold and numb. I am having more pain in my right arm and right hand."
Patient reported, "From day one after the accident I have had constant pain in right shoulder blade and right arm. The pain never goes away. I would rate the pain 6 to 7 on a constant basis every hour of the day."
Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems. Patient reported, "I have had sleepless nights, horrible dreams, constant pain in my head, money concerns and have been depressed and frustrated."
Patient reported, "I am having bad dreams 4 to 5 nights every week. I dream about death a lot. Sometimes the dreams are about my former job and wanting to fight. I am still shaking real badly while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I am waking up during the bad dreams and I will be sweating and the pillow will be wet from it. I experienced a couple of panic attacks this past week. This past week I had terrible dreams. There are times that I get upset and agitated but I can't identify the trigger. I think it is because I can't go anywhere without someone taking me. If I want to go somewhere I have to ask someone to take me and I don't want to impose on anybody. I'll sit there and get upset because my life is in the hands of everybody else. Just the simple fact of wanting to go to the store means I have to rely on someone to take me. My

Name: Benjamin, Victor Date: 5.30.2012

	independence has been taken from me. With my son in college and my wife working means that I am home all day by myself. If I need to go somewhere or get something I can't because no one is around to help me. This causes me a lot of pain and depression." Patient's wife was with the patient and reported, "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't." Patient's depression has gotten worse due to his circumstances. Patient needs intensive therapy to help overcome the issues that he is dealing with. Patient reported, "My right hand is shaking a more. The shaking started right after the accident but it is getting worse." Patient reported, "My wife tells me that I keep repeating myself and I don't realize it." Patient had all his assignments completed. The homework showed that the patient is depressed and has experienced a lot anger and frustration. Patient homework showed that the patient is frustrated and angry over 75% of the time every day. Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist. Patient reported, "I have not been able to get an erection since the injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident." Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away." Went over the homework between this session and the next session. Patient's wife came in with patient and agreed to help patient with his homework. Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative. Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic. Discussed with the patient and his wife that due to the PTSD issues that it is recommended that patient be involved in intensive therapy at least three days per week for two hours per day. This will help the patient process the PTSD issue and help the patient move forward in desensitizing his bad thoughts and feelings associated with the

Name: Benjamin, Victor Date: 5.30.2012

trauma that he patient experienced.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:

1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.

2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one or more of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

2. Recurrent distressing dreams of the event.

3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.

3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.

4. Markedly diminished interest or participation in significant activities.

5. Feeling of detachment or estrangement from others.

6. Restricted range of affect.

7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Difficulty falling or staying asleep.

2. Irritability or outbursts of anger.

3. Difficulty concentrating.

4. Hypervigilence

5. Exaggerated startle response .

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

Name: Benjamin, Victor Date: 5.30.2012

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.

3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.

4-Have been building rapport between patient and therapist.

5-Gave the patient an opportunity to talk about the accident and other issues.

Went over with the patient the following forms:

1-Handout describing the physiology and psychology of fear and anxiety.

Patient reported he read the material last night.

2-Introduction to Relaxation

Practice the relaxation techniques today.

3-Book "Triumph Over Fear" by Jerilyn Ross

Discussed with patient the homework:

1-Start reading the book "Triumph Over Fear."

2-Do Breathing exercise (Set of 10; 10 times a day).

3-When triggered do the exercise until anxiety or fear level is a 3 or less.

4-Read all handouts.

Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\

Went over with the patient that there are nine major goals that we need to accomplish during the therapy:

1-To remember and accept the accident and injuries that occurred.

2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.

3-To get beliefs that had been disrupted and distorted back in balance.

~~4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.~~

5-Help patient identify anger control problems and implement techniques to help manage them.

6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.

7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.

8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.

9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.

Gave patient the homework of writing about the following:

1-The accident and the after effects on patient's life

Name: Benjamin, Victor Date: 5.30.2012

2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10. (5.30.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 9.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 9.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 10.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 10.
Experiencing intense psychological distress. Patient rated this 10.
~~Experiencing a sense of foreshortened future. Patient rated this 10.~~
~~Experiencing anxiety and increased trouble falling asleep and~~ staying asleep. Patient rated this 10.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 10.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.
The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.

Name: Benjamin, Victor Date: 5.30.2012

Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed.
We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts.
Patient reported that he still has the ringing in his ears.
Patient is distraught about his inability to make a living and support his family.
Went over with the patient the Self Monitoring Scale and Breathing Exercise homework.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
The patient exhibited fair hygiene in his appearance.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
With the condition of the patient not improving in relationship to his PTSD issues it is recommended that the patient be in intensive outpatient therapy three days per week with a minimum of two hours per day. Discussed this with the patient and his wife. The issues are so intense and the symptoms are so bad that if the patient does not receive this type of treatment the patient will continue to regress. The patient is willing to commit to this type of therapeutic approach and wants to improve. The PTSD issues are intensifying and medication without intensive therapy intervention will not work by itself. This was discussed with the patient and Dr. Goldschmidt at the very beginning of the patient' therapy. It now has gotten to the point that it is no longer an option but a necessity.
The patient exhibited good hygiene in his appearance.
The mood of patient was depressed, anxious and worried
Appearance: Clean
Attitude: Open and Cooperative

Name: Benjamin, Victor Date: 5.30.2012

	Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor (Even when patient sleeps he wakes tired and gets fatigued during the day) Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ph.D.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Name: Benjamin, Victor Date: 6.7.2012

Patient Name:	
Grand Strand Psychological Services **Progress Note**	
Referral Source:	Dr. Sandoz
Physical Complaints	See Chart of physical complaints
Medications	Vimpat Hydrocodone
Psychiatric Hospitalizations	None
Age	[redacted]
Gender	Male
Date of Session	6.7.2012
Start Time	10:00 am
End Time	11:15 am
Visit Type	Scheduled
Session Content	
Diagnosis	DSM-IV Diagnosis Axis I: 294.11 Dementia due to Remote Closed TBI with Behavioral Disturbance 309.81 Posttraumatic Stress Disorder, Chronic Axis II: Deferred Axis III: Deferred Axis IV: Deferred Axis V: Current GAF–40
Suicide Risk	None
Descriptive:	Patient has increased sense of stress and tension due to the changes in his life since his 6.15.2011 injury. Patient reported, "I have been very agitated and angry lately. I have a short fuse and verbally express my agitation." Patient reported, "I have all my homework. I am getting depressed over my circumstances. I had 20 to 25 shots in my head four weeks ago by Dr. Sandoz. When he started giving me shots in the back of my head the area he was dealing with started hurting worse. I thought that after a day or two the pain would decrease. However, the pain has increased since I got the shots. It was bad enough before the shots but now is worse. I was having severe pain in my head that would be in one place one day and another place the next day. After the shots in my head I now have pain not only all over my head but in my neck. Since the shots in my head my pain isn't as severe but the pain is more frequent. I saw Dr. Sandoz this morning. He gave me a new medication that is supposed to help my muscles relax. He thinks it may help me with my pain in my neck, head and arms. Dr. Sandoz told me that the pain in my head due to the injury is never going to improve. He said I will live with the pain in my head the rest of my

Name: Benjamin, Victor Date: 6.7.2012

life. Dr. Sandoz said some of the medicine he gives me may help with the pain but it will not stop the pain. Since I started taking Tramadol I have been real tired in the morning and have to make myself get up and move around. When I told Dr. Sandoz about his he said to change the way I am taking the medication. Instead of two times a day he wants me to break it up into four times a day and see if that will help me. My follow up visit with him is on the 20th of this month. I feel like just staying in bed. The pain in my right foot each time would be so severe that I couldn't stand it. My pain in my head is so bad that I have a hard time sleeping. When I do sleep I jerk and wake up sweating. Sometimes my wife has to change the sheets on the bed. My wife tells me that I was jerking in my sleep. When I first try to go to sleep I find sometimes I am jerking before I fall asleep. I am not sleeping as well as I used to. When I wake up I am tired. I have no energy. My right wrist has started hurting. On a scale of 0 to 10 my pain in my wrist is 7 of 10. When the pain shoots through my head it is 7 of 10. This happens many times each hour of the day. There is no way I can keep count due to the frequency of the pain shooting through my head. After the shots the pain is occurring more frequent than before but the pain is a little less but not much. I will never take 25 shots in my head again. When he Dr. Sandoz did the shots in my head he also gave me shots in the neck where my neck pain is. The pain in my neck was bad before the shots in my head but now is worse. It isn't as bad as last week but still is very painful."

Patient reported, "I worry a lot over my financial situation. I have been a good provider for my family and it is frustrating for me not to be able to do the things I used to do. I can't even help around the house. I am still having panic attacks. My head is still hurting even on the new medication. My right arm from the shoulder down to the tips of my fingers hurts and gets numb. My anxiety level is high. My depression is getting worse. I am sleeping less than before. I am having racing thoughts and it is causing me to be depressed and have panic attacks. The bad dreams that I had this past week caused me to be jerking and sweating but when I woke up I couldn't remember the dream. I am having a lot of pain on the right side of the back of my neck. When I had the shot in my neck in November of 2011 it didn't help me at all. Then in December of 2011 the doctor gave me another shot and the pain in my neck stopped. The pain in my neck did not get better after the shots last week but got worse. The pain level in my neck is 8 of 10 today. I have been irritable and depressed more this past week because I got no relief from my pain in my head or neck. My depression is worse. I can't go anywhere or do anything and no one is around to take me anywhere. I feel helpless and hopeless. My life is in turmoil and it upsets me that I am unable to function like I used to."

Patient reported that his pain level was 8 of 10. Patient reported, "My stress level is 10 of 10. My stress level is getting worse. This past week it was so bad that I was angry and short tempered with my wife. I would rate my depression 9 of 10." Patient is still having

Name: Benjamin, Victor Date: 6.7.2012

periods of being very upset. Patient's pain level and depression level has increased. Patient needs approval to see psychiatrist and Dr. Rosenberg to deal with these issues.

Patient reported, "When Dr. Sandoz informed me three weeks ago that I can't drive until August it was very upsetting to me and my wife. He said that the law of the land says that a person can't drive for six months when they experience what I am going through. I will be at home from 7 am until almost 5 pm with no one at home.

Patient reported, "My concern is that I don't know what is happening. My wife will call me during the day while she is at work to check on me. I am having sharp pains shooting through my head on a daily basis. The pain is so bad that I have to close my eyes. I get disoriented and dizzy and I think that is due to the headaches. I have been having sharp pains running down my right side of my head and behind my right eye. I noticed that when I walk that I start moving to the right and I can't control it. I don't know what is happening. I have not had a reaction to the Vimpat but even with the increase from 50 mg to 100 mg my pain in my head has not stopped. I did talk with Dr. Sandoz about the walking and going to my right and I can't stop it and he said it was coming from my inner ear."

Patient reported, "I saw Dr. Sandoz and told him about my right wrist and hand staying cold all the time. Dr. Sandoz said that he needed to talk with Dr. Welsch about this. He told me last week that he and Dr. Welsch are playing phone tag but that he would talk with Dr. Welsch about what was going on. My whole right side from my shoulder blade down to the end of my fingers is cold and numb. I am having more pain in my right arm and right hand."

Patient reported, "From day one after the accident I have had constant pain in right shoulder blade and right arm. The pain never goes away. I would rate the pain 6 to 7 on a constant basis every hour of the day."

Patient's depression is evident and patient needs to see psychiatrist to be evaluated and treated medically for his depression. The patient is experiencing mood swings and reported that he may sleep 8 to 10 hours and wake up with no energy. Other night's patient may not sleep at all. The sleep patterns of patient are erratic. Patient is getting fatigued during the day. Patient is having problems concentrating and experiences short term memory problems. Patient reported, "I have had sleepless nights, horrible dreams, constant pain in my head, money concerns and have been depressed and frustrated."

Patient reported that last night he didn't sleep more than two hours. Patient reported, "I am having bad dreams 4 to 5 nights every week. I dream about death a lot. Sometimes the dreams are about my former job and wanting to fight. I am still shaking real badly while I am asleep. My wife tells me that when I am sleeping I will be jerking and moving around and she has to wake me up. I am waking up during the bad dreams and I will be sweating and the pillow will be wet from it. I experienced a couple of panic attacks this past week. This past week I had terrible dreams. There are times that I get upset

Name: Benjamin, Victor Date: 6.7.2012

and agitated but I can't identify the trigger. I think it is because I can't go anywhere without someone taking me. If I want to go somewhere I have to ask someone to take me and I don't want to impose on anybody. I'll sit there and get upset because my life is in the hands of everybody else. Just the simple fact of wanting to go to the store means I have to rely on someone to take me. My independence has been taken from me. With my son in college and my wife working means that I am home all day by myself. If I need to go somewhere or get something I can't because no one is around to help me. This causes me a lot of pain and depression." Patient's wife was with the patient and reported. "Almost ever night my husband is shaking in his sleep. Some nights he wakes up and other nights he doesn't."

Patient's depression has gotten worse due to his circumstances. Patient needs intensive therapy to help overcome the issues that he is dealing with.

Patient reported, "My right hand is shaking a more. The shaking started right after the accident but it is getting worse."

Patient reported, "My wife tells me that I keep repeating myself and I don't realize it."

Patient had all his assignments completed. The homework showed that the patient is depressed and has experienced a lot anger and frustration. Patient homework showed that the patient is frustrated and angry over 75% of the time every day.

Patient reported, "People want to talk to me about the accident and I don't want to talk about it. I haven't been around people this week since I can't drive so I didn't get triggered by people asking me how I was or what happened. I avoid going toward the place where I work because it triggers me and I get very depressed. My depression is every day." Patient is not seeing a psychiatrist at this time. The attorney is working on the appointment through Workers Comp. This still is in the process of being done. As of today the patient has not been approved by Workers Comp to see the psychiatrist.

Patient reported, "I have not been able to get an erection since the injury. I have told Dr. Sandoz and Dr. Goldschmidt about this. Dr. Sandoz wrote me a prescription to see if that would help but Workers Comp has not approved it. I brought this out in the deposition and they asked me how long I have been experiencing this and I told them it started when I got hurt. I never had the problem prior to the accident."

Patient reported, "Both of my ears are having ringing going on in them all the time. It is a constant ringing that never goes away."

Went over the homework between this session and the next session.

Patient's wife came in with patient and agreed to help patient with his homework.

Worked with patient on his breathing exercise to be sure he was doing it right. Patient was cooperative.

Went over with the patient all the symptoms of PTSD and as we went through the symptoms the patient would respond to which ones applied to him. The patient suffers with PTSD and it is chronic.

Name: Benjamin, Victor Date: 6.7.2012

Discussed with the patient and his wife that due to the PTSD issues that it is recommended that patient be involved in intensive therapy at least three days per week for two hours per day. This will help the patient process the PTSD issue and help the patient move forward in desensitizing his bad thoughts and feelings associated with the trauma that he patient experienced.

1-Described the symptoms of PTSD and discussed with patient which symptoms apply to him:

A. The patient has been exposed to a traumatic event in which both the following were present:

1. The patient experienced an event that involved actual threat of death and injury when a 30 pound guard (cage) fell from about 25 feet on patients head on 6.15.2011.

2. The patient's response involved intense fear and helplessness.

B. The traumatic event is persistently re-experienced in one or more of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

2. Recurrent distressing dreams of the event.

3. Acting or feeling as if the traumatic event were recurring when the patient has flashbacks, relives the experience and has hallucinations about the event.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following: (Out of the 7 the patient experiences the following 7 of the 7):

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.

3. Inability to recall an important aspect of the trauma. Patient was unconscious for approximately five minutes to the best of his recollection.

4. Markedly diminished interest or participation in significant activities.

5. Feeling of detachment or estrangement from others.

6. Restricted range of affect.

7. Sense of foreshortened future (Patient does not expect to have a normal life span or career.)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following. (Out of the 5 the patient experiences the following 5 of the 5):

1. Difficulty falling or staying asleep.

Name: Benjamin, Victor Date: 6.7.2012

2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence
5. Exaggerated startle response

E. The duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2-Gave the patient a framework for understanding why these symptoms developed and why they have not gone away.

3-Presented an overview of treatment to help patient understand why homework completion and therapy attendance are important. Patient was asked to cooperate. Explained to patient the progressive nature of the therapy.

4-Have been building rapport between patient and therapist.

5-Gave the patient an opportunity to talk about the accident and other issues.

Went over with the patient the following forms:

1-Handout describing the physiology and psychology of fear and anxiety.

Patient reported he read the material last night.

2-Introduction to Relaxation

Practice the relaxation techniques today.

3-Book "Triumph Over Fear" by Jerilyn Ross

Discussed with patient the homework:

1-Start reading the book "Triumph Over Fear."

2-Do Breathing exercise (Set of 10; 10 times a day).

3-When triggered do the exercise until anxiety or fear level is a 3 or less.

4-Read all handouts.

Today went over with the patient the handouts and explained to the patient the importance of doing all his homework.\

Went over with the patient that there are nine major goals that we need to accomplish during the therapy:

1-To remember and accept the accident and injuries that occurred.

2-To help patient to feel his emotions and let them run their course (extinguish) so the memory can be put away without such strong feelings still attached.

3-To get beliefs that had been disrupted and distorted back in balance.

4-To help patient develop insight into how the accident has affected his functioning in social, occupational and personal life.

5-Help patient identify anger control problems and implement techniques to help manage them.

6-Practice with patient and implement relaxation techniques to cope with her anxiety, panic, stress and anger.

7-Help patient to understand how having restful sleep without distressing dreams will help patient be more relaxed and have more energy.

Name: Benjamin, Victor Date: 6.7.2012

8-Patient to learn systematic desensitization to retrain his bad thoughts and feelings when triggered.
9-Patient to learn to verbalize positive, healthy and rational self-talk that reduces fear and allows patient to be more positive.
Gave patient the homework of writing about the following:
1-The accident and the after effects on patient's life
2-Asked patient to consider the effects the accident had on his:
-beliefs about himself
-beliefs about others
-beliefs about the world
3-Asked the patient to consider the following topics while writing about his traumatic event:
-safety, trust, power, esteem and security
Patient did his breathing exercise and discussed his thoughts. We worked on patient retraining his bad thoughts and feelings when triggered.
Patient is in pain and experiences anxiety and is stress.
Patient was asked to rate the following on a scale of 0 to 10. (6.7.2012)
Patient has been experiencing a lot of depression and mood swings. Patient rated his depression 9.
Patient reported that he doesn't have any friends. Patient rated it 7.
Patient is distraught and has thoughts and feelings of hopelessness. Patient rated this 9.
Went over with the patient the problems he is experiencing. The patient is having:
Intense thoughts of helplessness in response to the traumatic event. Patient rated this 10.
Reliving the event as though he is experiencing the event at that moment. Patient rated this 10.
Experiencing a marked reduction and inability to feel emotions. Patient rated this 10.
Avoid thoughts, feelings or conversations about the trauma. Patient rated this 9.
Avoids activities, situations and people who arouse recollection of the trauma. Patient rated this 8.
Has a diminished response to external world. Patient rated this 9.
Intrusive recollection of the event and recurring distressing dreams about the event. Patient rated this 10.
Feeling detached from other people. Patient rated this 10.
Experiencing intense psychological distress. Patient rated this 10.
Experiencing a sense of foreshortened future. Patient rated this 10.
Experiencing anxiety and increased trouble falling asleep and staying asleep. Patient rated this 10.
Experiencing irritability and outburst of anger. Patient rated this 10.
Has trouble concentrating and completing tasks. Patient rated this 10.
Working with patient to desensitize his emotional triggers about the incident. Patient is still highly sensitive to trauma and has anxiety attacks at least two to three times per week.

Name: Benjamin, Victor Date: 6.7.2012

The patient continues to work on the goals of:
Rebuilding his sense of self worth and identity.
Reducing his sense of fear and sadness associated with the trauma and resultant behavior.
Reducing the destructive avoidant behavior that fosters fear of distress.
Reducing his nightmares, flashbacks and intrusive recollections of the traumatic event.
The objectives for the patient have included:
Having patient cooperate with psychological testing and evaluation.
Having patient comply with medication recommendations by professional medical personnel.
Having patient describe the traumatic event and deal with the feelings that are experienced in as much detail as possible.
Helping the patient develop insight into how his injury has affected his ability to function in his social and personal life.
Help patient identify his anger and practice techniques that will help him manage them.
Helped patient implement relaxation techniques to cope with his anxiety, stress and anger.
Helping patient work on desensitizing his thoughts and feelings associated with the traumatic event. Patient is working on retraining his bad thoughts when he has the severe dreams.
Patient reported that he has not used any illegal drugs. Patient has been forthcoming about his past history and has shown no signs of any relapse. Patient continues to have dreams dealing with the accident and the dreams cause the patient to become agitated and stressed.
We discussed how he needs to retrain his bad thoughts and feelings and retrain is thoughts with positive thoughts.
Patient reported that he still has the ringing in his ears.
Patient is distraught about his inability to make a living and support his family.
Went over with the patient the Self Monitoring Scale and Breathing Exercise homework.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
The patient exhibited fair hygiene in his appearance.
Patient continues to experience increased emotional dysfunctional behavior and gets angry and impatient at the least little event.
With the condition of the patient not improving in relationship to his PTSD issues it is recommended that the patient be in intensive outpatient therapy three days per week with a minimum of two hours per day. Discussed this with the patient and his wife. The issues are so intense and the symptoms are so bad that if the patient does not receive this type of treatment the patient will continue to regress. The patient is willing to commit to this type of therapeutic approach and wants to improve. The PTSD issues are intensifying and medication without intensive therapy intervention will not work by itself. This was discussed with the patient and Dr. Goldschmidt at the

Name: Benjamin, Victor Date: 6.7.2012

	very beginning of the patient' therapy. It now has gotten to the point that it is no longer an option but a necessity. The patient exhibited good hygiene in his appearance. The mood of patient was depressed, anxious and worried Appearance: Clean Attitude: Open and Cooperative Affect: fair Speech: clear Thought Process: fair Orientated: orientated in all spheres Memory: Short term memory poor Judgment: Fair Sleep: Poor (Even when patient sleeps he wakes tired and gets fatigued during the day) Cognitive: Serious Difficulties with short term memory
Assessment	Patient reports that he is depressed. Patient reported that he has no visual or verbal hallucinations No homicidal or suicidal ideation was present. The attitude of patient is cooperative. The interaction of patient was cooperative.
Plan	Assist Patient in developing effective coping strategies in dealing with problems encountered in everyday life. Patient to continue individual psychotherapy one time per week to decrease his depression, anxiety and to improve his mood. Assist Patient in developing and rehearsing problem-solving skills Assist Patient in retraining his negative thought patterns. Assist Patient in identifying and labeling emotions. Assist Patient in developing strategies to deal with his anger in a healthier manner. Assist Patient in rebuilding his sense of self worth and identity.

Nick Spring, Ed.D.

Leonard Goldschmidt, Psy.D., J.D.
Licensed Clinical Psychologist
Clinical Neuropsychologist
Forensic Psychologist

Post Trauma Resources
1709 Laurel Street
Columbia, South Carolina 29201
803.765.0700

Progress Note

Date:	6/6/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor
Sex:	Male

Content/Process

Session Content: Mr. Benjamin was referred to Post Trauma Resources for "necessary evaluation and treatment" by Mr. Jason Lockhart, Attorney at Law. Medical records were provided for review. Before the initial interview, the purpose and process of our meeting was described. Mr. Benjamin presented as cooperative and concerned about his transfer of treatment here.

Provided medical records were reviewed. Mr. Benjamin was initially seen by Dr. Leonard Goldschmidt, psychologist, on 10/18/11 and participated in five evaluation sessions. Dr. Goldschmidt noted no history of psychological or cognitive problems before Mr. Benjamin was injured. The report offers the opinion that Mr. Benjamin was honest and exerted appropriate effort during the evaluation. Diagnostic impressions included Cognitive Disorder NOS and recommended treatment including psychotropic medication and psychotherapy. Mr. Benjamin was continued to be seen after the evaluation and the last note was dated 3/21/12. The noted was signed by Dr. Goldschmidt and Dr. Nick Spring who was apparently treating Mr. Benjamin. The note indicated diagnoses of Dementia Due to Remote Closed TBI with Behavioral Disturbance and PTSD. Continued cognitive symptoms and depressed mood was noted as well as continued pain, sleep disruption, panic, avoidance, and erectile dysfunction. Treatment techniques included information given, support, use of written materials, and breathing exercises.

Other reviewed records included those from Dr. George Sandoz, Florence MRI, Dr. Matthew Welsch, Dr. William Naso, and McLeod Regional Medical Center.

During the clinical interview, Mr. Benjamin reported that he was not aware of the purpose of the visit nor his transfer of care. I provided him information on the care that we provide here and noted that he would be seeing both Dr. Deal and I in a coordinated fashion. I encouraged him to clarify any concerns that he might have with his attorney. Although clearly concerned, Mr. Benjamin remained cooperative throughout.

Mr. Benjamin reported on the details of the incident and explained that he does not remember much of what happened. He reported his physical injuries as a blow to the head with unconsciousness, hand and arm injuries. In addition, he reported that he has developed seizures secondary to his head injury and is unable to drive at this time. Mr. Benjamin reported that he is being treated by Dr. Sandoz for pain and seizures and

is also being treated for elevated cholesterol and blood pressure.

Mr. Benjamin reported that he is seeing Dr. Springs about one time per week and is somewhat improved. He explained that he continues to experience irritability and anger, cognitive symptoms, sleep difficulties with nightmares, and depressed mood related to pain and physical limitations. He has not been prescribed psychotropic medication. His cognitive symptoms include headaches, lack of balance, and ringing in his ears.

During the initial session, I described the treatment process here and the role of medication. He was also scheduled to see Dr. Deal and did so.

We rescheduled Mr. Benjamin for June 21, 2012.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) review relationship between pain and psychological factors
4) ventilation related to details of current stressors
5) normalization of trauma related symptoms
6) reviewed treatment progress to date and began to set treatment goals

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 6/19/2012 1:53:47 PM

Post Trauma Resources
1709 Laurel Street
Columbia, South Carolina 29201
803.765.0700

Progress Note

Date:	7/19/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported no improvment in sleep or mood, continues to report headaches, frustration with his life and changes in his life since he was hurt, depressed mood withdrawal

Session Content: Continues in a very difficult way and presents as frustrated and angry. Worked during the first part of the session to build rapport and then moved to an explanation of the connection between thoughts and feelings. This seemed somewhat frustrating for him and it was apparent that it was not working, then pulled back for more rapport building. Pt stated that he desired a higher level of treatment and we agreed to to meet two times per week for the next six weeks or so to see how that will work for him.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) cognitive modification -- development of more appropriate self-talk

Response to Interventions: too much too soon

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 7/22/2012 9:48:32 PM

Progress Note

Date:	7/24/2012
Provider:	Lawrence Bergmann, Ph.D.

Session Length: 45 mins.
Type of Visit: Scheduled

Patient: Benjamin, Victor
[redacted]
Sex: Male

Content/Process

Other themes: presented today as more calm, open, similar complaints of pain without warning, frustration with wc, his employer who he blames for his injury, irritability, multiple losses, presentation much different

Session Content: Noted his condition as above and I was somewhat concerned after meeting with him last session but the process went totally different, pulled back, only gave just a bit of information with little teaching, continued to ask questions that might lead to pattern id but that is not going to be easy for him. Tempo and tone much different today. Will see in two days.

Interventions

1) active listening, provision of support for recovery
2) behavioral techniques – teach and/or practice techniques that prevent/delay impulsivity
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to interventions:-good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 7/24/2012 10:27:27 AM

Progress Note

Date: 7/26/2012
Provider: Lawrence Bergmann, Ph.D.
Session Length: 45 mins.
Type of Visit: Scheduled

Patient: Benjamin, Victor
[redacted]
Sex: Male

Content/Process

Other themes: reported that he has a headache this morning and is not feeling well, reported that he is not aware of any triggers, noted considerable hypervigilance with an exaggerated startle response, anxiety, multiple fears

Session Content: Discussed his status and activities, continue to build rapport via open ended questions and active listening. Seems to be improving his comfort level. Discussed headaches and explored possible triggers and patterns without success. Moved on and discussed the impact of his head injury on his feelings of safety and security. Provided information and examples and introduced concept of exposure, all went well today.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 7/26/2012 12:00:57 PM

Progress Note

Date:	7/31/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	46 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: we had a miscommunication on times today and we started a bit late, noted that he had a bad weekend with increased pain and anger, continues to present the losses that he has experienced, reported and discussed his goals today, a first

Session Content: Reported that he had a difficult time this weekend and we spent the first part of the session discussing this and how he managed himself and his family, this is when he reports significant withdrawal from his family. Also verbalized additional losses associated with his injury. These were acknowledged and normalized. Went on to discuss his goals of security for his family and increased coping skills. Remains difficult to get any sort of working contract with patient, maybe the relationship and talk is treatment.

Interventions

1) active listening, provision of support for recovery
2) behavioral techniques -- teach and/or practice techniques that prevent/delay impulsivity
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
6) review relationship between pain and psychological factors

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 7/31/2012 2:22:46 PM

Progress Note

Date:	8/2/2012
Provider:	Lawrence Bergmann, Ph.D.

Benjamin, Victor

Session Length: 45 mins.
Type of Visit: Scheduled

Patient: Benjamin, Victor
[redacted]
Sex: Male

Content/Process

Other themes: noted continued pain, frustration, much discomfort, depressed

Session Content: Reported on his status, followed up from last session where we discussed the significant losses that he has experienced. Discussed the nature of injury as a loss and continue to gently push in the direction of adjustment and change. Very difficult going. Left quite a bit of time for ventilation as he seems most comfortable with that at this point. Reviewed meds and md appointments.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: ok

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 9/18/2012 10:07:57 AM

Progress Note

Date: 8/6/2012
Provider: Lawrence Bergmann, Ph.D.
Session Length: 45 mins.
Type of Visit: Scheduled

Patient: Benjamin, Victor
[redacted]
Sex: Male

Content/Process

Other themes: reported continued pain, anxiety, irritability and depressed mood, isolated during periods of increased pain, issues with change in providers continue

Session Content: Began session with check in, no new issues. Had received email from pt attorney expressing concerns about a scheduling error and a wait from a previous session. I expressed my concern about him not addressing me directly especially since we had discussed what had happened last week at some length at that time. He stated that being here is not like the treatment he received, that it is a different kind of experience. I acknowledged that treatment is and will be different and that neither of us is controlling where he goes and we need to have as a joint goal his recovery. Then moved to make the expression of anger a therapeutic issue, we discussed the typical response to anger that he now makes given his head injury. I taught him assertive expression of anger techniques. All in all went very well.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) behavioral techniques – rehearse coping skills
4) taught assertive communication
5) discuss treatment options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/6/2012 7:36:42 AM

Progress Note

Date:	8/9/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported increased pain in his right hand, one period of time when he was more depressed without any specific identifiable triggers, continued reports of hypervigilance

Session Content: Session began usual with check in and discussion of specific symptoms. Continues to have little awareness of triggers or changes but they are certainly there as he has no history of mood disorder. I provided that information to him and we discussed a cognitive model of depression via the cognitive triad of depression. Also provided him with written materials regardinging cogn distortions associated with chronic pain. Noted that he was afraid of sleeping and we discussed the role of fear on pain as well as the the sources of fear. He will talk with Dr. Deal about his fear of dying in his sleep.

Interventions

1) active listening, provision of support for recovery
2) behavioral techniques -- teach and/or practice techniques that prevent/delay impulsivity
3) cognitive modification – reviewed relationship between thoughts and feelings
4) cognitive modification -- development of more appropriate self-talk

Response to Interventions: cbm is still the way to go

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/9/2012 12:24:04 PM

Progress Note

Date:	8/14/2012
Provider:	Lawrence Bergmann, Ph.D.

Session Length: 45 mins.
Type of Visit: Scheduled

Patient: Benjamin, Victor
[redacted]
Sex: Male

Content/Process

Other themes: had made an emergency call yesterday to change appointments so he can attend to his pain, noted continued feelings of being out of control related to the pain and inability to make predictions about any patterns

Session Content: Discussed status and reviewed call from yesterday, it was appropriate. Spent a good bit of the session today discussing the frustration he is experiencing with pain, had not brought materials I gave him last session and has been in quite a bit of pain do did not feel like I could push any specific agenda today. Noted that he is irritable and does not easily take feedback and this was another indication to me that we need to move very deliberately. We rescheduled his appointment, and discussed when to call.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) review relationship between pain and psychological factors

Response to Interventions: ok

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/14/2012 12:00:56 PM

Patient Cancellation Note

Patient: Benjamin, Victor
[redacted]
Sex: Male

Date: 8/16/2012
Provider: Lawrence Bergmann, Ph.D.
Type: Patient Cancellation

Reason: c/r

Provider: Lawrence Bergmann, Ph.D.
Post Trauma Resources
1811 Bull Street
Columbia, SC 29201

Provider Signature _____ Date _____

Progress Note

Date:	8/21/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: noted some improvement in pain after last Tuesday when he had injections, noted increased pain after multiple stressors, illness of mother and financial issue when check did not come, first time he was able to see the connection

Session Content: I was very focused on this connection because from the first, pt has found it difficult to make this connection and it really allows him to focus more on what we are doing here. Used a variety of metaphors and humor to make this point today. Not sure he is comfortable with the implications and we dealt with that as well. Noted importance of not being surprised by pain. Has some new meds and I asked him to be sure that he discusses this with Dr. Deal (Cymbalta).

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) cognitive modification -- correction of errors
6) cognitive modification -- development of more appropriate self-talk
7) review relationship between pain and psychological factors

Response to interventions: good, hope this will take

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/21/2012 10:51:13 AM

Progress Note

Date:	8/23/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: noted early significant side effects from Cymbalta, will consult with Dr. Deal, reported continued pain and physical limitations, reported distressing nightmares with theme of danger and hypervigilance

Session Content: During the first part of the session, he reported his problems with newly prescribed Cymbalta, he is seeing Dr. Deal today and he will discuss that. Naturally led into a conversation about the use and limits of medication. He is not so positive about medication given the problems that he has been having withthem. Described to him the process of getting medications right especially the importance of sleep. Discussed the specifics of his dreams, identified theme of danger and connected to his injury. Suggested that proper meds will likely result in him not having and or remembering the dreams. Looked at our schedules and will go to once a week, that is good, will also fit in with his pt schedule. Checked in on treatment, no issues verbalized todsy.

Interventions

1) active listening, provision of support for recovery
2) behavioral techniques – teach and/or practice techniques that prevent/delay impulsivity
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) problem solving – assist pt in generating options

Response to interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/23/2012 9:14:42 AM

Progress Note

Date:	8/30/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported increased sleep with medication, reported that pain is somewhat improved, is going to pt now with no improvement yet from there reported, frustrated with family stressors

Session Content: Discussed status and activities, spent a good bit of the first part of the session discussed medication, sleep, dreams and dream management. Is getting about six hours of sleep and we reviewed Dr. Deal's recommendations. Also problem solving and discussion using cogn mod and reframing concerning family stressors. Worked to slow down thinking to reduce stress.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors

...ion of trauma related symptoms
...solving -- assist pt in generating options
...nse to interventions: good

Benjamin, Victor

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/30/2012 9:00:07 AM

Progress Note

Date: 9/6/2012
Provider: Lawrence Bergmann, Ph.D.
Session Length: 45 mins.
Type of Visit: Scheduled

Patient: [redacted] Benjamin, Victor
Sex: Male

Content/Process

Other themes: reported continued irritability and anger today focused on family issues, reported increased pain after a visit to pt yesterday, continues to report cognitive changes, frustration and depressed mood

Session Content: Discussed status and activities, reported on the conflict that he is experiencing and used problem solving to assist mgt. Continue to normalize irritability as a component of head injury and to emphasize need for careful management. Also discussed his physical status and injury at pt, completed some forms for him as well this week.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 9/6/2012 10:16:35 AM

Progress Note

Date: 9/13/2012
Provider: Lawrence Bergmann, Ph.D.
Session Length: 45 mins.
Type of Visit: Scheduled

Patient: [redacted] Benjamin, Victor
Sex: Male

Response to Interventions: good

Benjamin, Victor

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 9/20/2012 10:14:04 AM

Progress Note

Date:	9/27/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he is very frustrated about not being able to get seizure medication and wonders what will happen when it runs out, been irritable at home as well

Session Content: Discussed his status, pain and physical limitations continue to be primary stressors. Much ventilation and anger expressed around medication, the only assistance I was really able to provide there was that he should work not to let these feelings bleed over to others. Has been more irritable with his partner and we discussed the nature of head injury and irritability. Went well today.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) cognitive modification -- development of more appropriate self-talk

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 9/27/2012 10:55:11 AM

Progress Note

Date:	10/4/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: noted increasing frustration with money, delayed checks, pain and losses

Session Content: Spent a good bit of the first part of the session complaining about wc and checks. I confronted this and explained to him that his interests and the insurer are different and they will not meet his expectations. Also further explained that this level of anger is likely impacting him emotionally and physically. Went on to discuss the likely outcome of his wc experience and that it is important to prepare for these likelihoods now, not wait. Most importantly, his level of income will be impacted and planning for thisis important. He explained that this was difficult for him to hear, I noted that.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) cognitive modification -- correction of errors
6) cognitive modification – development of more appropriate self-talk

Response to Interventions: will see

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 10/4/2012 12:48:28 PM

Progress Note

Date:	10/11/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: complaints today regarding pain, frustration with others, wc and money, no new complaints, no change in status, also continues to report disturbing dreams related to threats to him

Session Content: Rambling session with difficulties really getting focused, continues to struggle with the concept and importance of patterns although when we discussed the details of his dreams he is readily able to id poor sleep as responsible. Cannot explain the resistance to seeing a patterns. Much ventilation and anger with not getting money from the carrier and possibility of upcoming hearing.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) review relationship between pain and psychological factors

Response to Interventions: okok

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 10/11/2012 10:16:42 AM

Progress Note

Date:	10/25/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: noted that a family member has been seriously injured and this was a trigger for increased intrusive thoughts of his accident, also reported that he will be having further surgery during the next few weeks, with all the bad, seemed somewhat less anxious

Session Content: Discussed his status and the focus of the session today was on the two issues described above, he provided the details of the incident and how it impacted him, led to a discussion of triggers and managment of intrusive thoughts. Moved to discussing upcoming surgery, past disappointments with mds and wc. Is looking forward to some symptoms relief but also somewhat nervous about the procedure. Has an appointment during the next week or so.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving – assist pt in generating options
5) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 10/25/2012 10:51:18 AM

Progress Note

Date:	11/1/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Benjamin, Victor

Other themes: reported increased neck pain and soreness, reported continued frustration with carrier related to financial matters, reported nightmares and that he has accidentially struck his wife during the nights, depression

Session Content: Reported on his condition, we continued to discuss management of his feelings related to the wc and the monies he feels are owed to him, urged him not to let these matters impact his level of stress although I normalized the frustration. Looking forward to an appointment with surgeon next week and is hopeful for an early appointment for surgery. Also expressed concerns about memory and repeating statements to people, discussed the causes and triggers associated with memory loss.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving – assist pt in generating options
5) review relationship between pain and psychological factors

Response to interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 11/1/2012 2:08:44 PM

Progress Note

Date:	11/8/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: noted continued pain with complaints regarding depressed mood, irritability,frustration with his place in the wc and access to health care issues

Session Content: Reported on his status as above and there is little change today. Reported on his health care status and he is awaiting word on further surgery. Expressed both concerns and hope for some improvement in pain, levels of pain reported as continuing to be a problem. Much ventilation concerning his losses and frustration with status. Provided support for ventilation.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) normalization of trauma related symptoms
4) review relationship between pain and psychological factors

Response to interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 12/21/2012 9:16:49 AM

Progress Note

Date:	11/15/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported continued concerns about health and upcoming surgery, has been asked to participate in a second opinion, concerned that he might further injure himself, reported continued frustration with his status

Session Content: Discussed his status and during the session he learned that he will be having an eval tomorrow. This led to an extended discussion of his experiences with the carrier, frustrations etc., listened and supported but did not reinforce him dwelling on this. Did observe less overt anger and he seems to be working to reduce the stress that his is having. He remains very concerned that without the surgery, he may be more seriously injured. Discussed meds, upcoming holiday period.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving -- assist pt in generating options
5) cognitive modification -- correction of errors

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 11/15/2012 2:20:26 PM

Patient Cancellation Note

Patient:	Benjamin, Victor [redacted]
Sex:	Male
Date:	11/21/2012
Provider:	Lawrence Bergmann, Ph.D.
Type:	Patient Cancellation

Reason: had to make md appointment in MB

Provider: Lawrence Bergmann, Ph.D.
Post Trauma Resources
1811 Bull Street
Columbia, SC 29201

Provider Signature _____ Date _____

Progress Note

Date:	11/29/2012
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: complained of worsening pain, complains of frustration with wc system and issues with carrier, hoping for surgery in the near future and at least some improvement, continues to report depressed mood, irritability, focused on losses associated with his inj

Session Content: Discussed his status and the session began with check in and continued without significant focus. Pt seems most comfortable discussing his problems but grows more resistant when intervention begins. Therefore, the information I inject if given quite tentatively and between periods of his reports of his frustration, loss and grief. Seems to find it very important to have this support, is pretty isolated at home other than for his partner.

Interventions

1) active listening, provision of support for recovery
2) behavioral techniques -- discuss sleep hygiene skills
3) normalization of trauma related symptoms
4) problem solving -- assist pt in generating options
5) cognitive modification -- development of more appropriate self-talk

Response to Interventions: ok

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 12/17/2012 9:00:29 AM

Progress Note

Date:	12/6/2012
Provider:	Lawrence Bergmann, Ph.D.

Session Length: 45 mins.
Type of Visit: Scheduled

Patient: Benjamin, Victor
[redacted]
Sex: Male

Content/Process

Other themes: reported continued pain and physical limitations, reported continued problems associated with gaining approval for medical care and was very focused, very angry

Session Content: Discussed status and activities and the session was primarily ventilation and expsression of anger for his status and situation. Verbalized with support provided and opportunity for ventilation. Not much problem solving possible today. Reviewed medications and is staying up with Dr. Deal.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) normalization of trauma related symptoms
4) review relationship between pain and psychological factors

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 12/9/2012 7:36:57 PM

Progress Note

Date: 12/13/2012
Provider: Lawrence Bergmann, Ph.D.
Session Length: 45 mins.
Type of Visit: Scheduled

Patient: Benjamin, Victor
[redacted]
Sex: Male

Content/Process

Other themes: noted no significant change with continued complaints of pain and physical limitations, depressed mood, irritability, frustration with the way that medical care is going

Session Content: Discussed his status as above and during the first part of the session reviewed his medical status and potential changes in provider. Noted that he was open to other providerrs and seems more able to understand what is happening with the wc process. Continues to report that he hopes for at least some improvement. Also during the session we discussed how his pain continues to imkpact his mood and the management of his stress is so important. This is the general theme of our work together.

Interventions

1) ventilation related to details of current stressors
2) problem solving – assist pt in generating options

3) cognitive modification – development of more appropriate self-talk

Response to interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 12/30/2012 7:34:22 AM

Progress Note

Date:	1/4/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor
Sex:	Male

Content/Process

Other themes: reported that he has been much more irritable and difficult to get along with and he brought his partner in today, noted continued pain and physical limitations, depressed mood

Session Content: Welcomed his partner today and she complained about her partner's behavior recently and describ3d it as irritable and short. We dealt with this after a brief period of ventilation and some excuse giving with basic behavioral tehniques, that is focusing on changing the way in which pt expresses his frustration and feelings. Continued to emphasize cognitive modification but this seems secondary to learning how to manage change in mood. Also today, discussed his medical status and upcoming surgery and appointmenbts.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) behavioral techniques – rehearse coping skills
4) ventilation related to details of current stressors.

Response to Interventions: good response today, much more effective to be confronted by partner than me

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 1/7/2013 6:41:28 AM

Progress Note

Date:	1/8/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor

Sex: Male Benjamin, Victor

Content/Process

Other themes: I apparently made an error in scheduling but we were able to meet, no issues, reported that he is doing better with irritability, noted new pains in his head, medical care delayed, noted no significant change in psychological status

Session Content: Worked through the appointment issue, think it was my error but he was okay and, I apologized and we moved on, reported on the outcome of our last meeting and he is working harder to deal with his anger, reported that his wife has noticed it and he feels good about that. We also discussed issues with medical treatment and continued symptoms, he reported concerns about new head pain. Increased pain has led to increases sleep disruption.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 1/8/2013 1:31:00 PM

Progress Note

Date: 1/15/2013
Provider: Lawrence Bergmann, Ph.D.
Session Length: 45 mins.
Type of Visit: Scheduled

Patient: Benjamin, Victor
[redacted]
Sex: Male

Content/Process

Other themes: reported continued pain and physical limitations with some improved pain control, noted that he is meeting with md next week to learn more about surgery, continues to report depressed mood, feelings of being overwhelmed, frustration

Session Content: First part of the session focused on health and upcoming apppointment, express his concerns about new md, normalized and supported. Went on to discuss the various stressors in his life, noted the connection between stress and depression and pain and we continue both cogn modification and problem solving. Sleep remains an issue.

Interventions

1) active listening, provision of support for recovery
2) behavioral techniques -- teach and/or practice techniques that prevent/delay impulsivity
3) cognitive modification -- development of more appropriate self-talk
4) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 1/16/2013 11:05:58 AM

Progress Note

Date:	1/22/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported relief after a good meeting with the md this am, noted continued physical limitations, depressed mood, irritablity, withdrawal

Session Content: Session was focused on his medical appointment and he felt like the md was thorough and answered all their questions. Is looking to have the surgery scheduled during the next few weeks and feels good about the procedure. Was able to discuss the risks and limits of the procedure. Also during the session today, discussed his irritability and withdrawal, is more able to id when it is happening and make an effort to change his behavior.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 1/22/2013 1:17:18 PM

Progress Note

Date:	1/29/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process Benjamin, Victor

Other themes: has a date for surgery and is anticipating and nervous about the procedure, continues to struggle with losses and psychosocial stressors

Session Content: Discussed his status with a focus during the initial part of the session on his medical status and upcoming surgery. Noted with some disappointment that the delay in treatment means that he will not get the more complete recovery he would hope for. Expressed anger about the delay. Also continued to discuss, primarily with ventilation the losses and limits that he is facing and the more generalized impact on both he, his children and family. Continues complaints about sleep and we discussed potential changes in sleep meds.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 1/29/2013 1:52:44 PM

Progress Note

Date:	2/7/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported pain and issues with medications today, scared by last medication changes, concerns about upcoming surgery in two weeks

Session Content: Discussed status and activities. Had called yesterday to express concerns about his medications. I offered him some possible explanations for what is happening and we are fitting him into Dr Deal's schedule so that we can make some modifications. Also discussed hopes and fears for upcoming surgery.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) information provided regarding development of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 2/7/2013 12:53:43 PM

Progress Note

Date:	2/12/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: frustrated with status, expressed concerns about his wife's worry about his upcoming surgery and he admits to being nervous himself, pain and physical limits remain

Session Content: Discussed his status and the session was focused on his surgery next Monday. Nerves were normalized, of course. Ventilation about the impact of injury on significent others was normalized as well. We made plans to stay in touch while he recovers and before he can drive.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) problem solving -- assist pt in generating options
4) review relationship between pain and psychological factors

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 2/12/2013 1:20:14 PM

Progress Note

Date:	3/11/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: first visit since surgery and pt reported that he is managing the pain, reported that he started having periods of very bad dreams and a sense of whirling that was characteristic of seizures that he was

having Benjamin, Victor

Session Content: Caught up and discussed surgery and recent md appointments, feels like he is improving with continued pain, was very concerned today about the dreams he was having, focused on the content of the dreams. After some ventillation, I explained to him that the content of the dreams were likely not as important as what might be causing his disrupted sleep. Ms. Benjamin was here today and expressed concerns that it might be related to his seizure disorder. They are to see his neurologist later this week. Reinforced the need to rule out all physical causes first. Provided them with information concerning the relationship between pain and sleep and dreams, also identified some simple routine changes in sleep that he can try.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 3/11/2013 1:17:27 PM

Post Trauma Resources
1709 Laurel Street
Columbia, South Carolina 29201
803.765.0700

Progress Note

Date:	3/11/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	46 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: first visit since surgery and pt reported that he is managing the pain, reported that he started having periods of very bad dreams and a sense of whirling that was characteristic of seizures that he was having

Session Content: Caught up and discussed surgery and recent md appointments, feels like he is improving with continued pain, was very concerned today about the dreams he was having, focused on the content of the dreams. After some ventilation, I explained to him that the content of the dreams were likely not as important as what might be causing his disrupted sleep. Ms. Benjamin was here today and expressed concerns that it might be related to his seizure disorder. They are to see his neurologist later this week. Reinforced the need to rule out all physical causes first. Provided them with information concerning the relationship between pain and sleep and dreams, also identified some simple routine changes in sleep that he can try.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 3/11/2013 1:17:27 PM

Progress Note

Date:	3/21/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he continues to recover from his surgery, reported that he continues to experience troubling pain, noted the helpfulness of attending, periods of depression and irritability

Session Content: Session today was somewhat different in the sense that the patient was brighter and more animated, continued to express appreciation of need for treatment here and the value he places on it. Noted the difficulties in making the transition here. Ventilation concerning the losses that he has experienced and he feels that it has been quite difficult for him. Also discussed how his strategy for managing his family and especially his son is begining to show fruit, really reinforced his efforts.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) normalization of trauma related symptoms
4) review relationship between pain and psychological factors

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 3/24/2013 9:00:38 AM

Progress Note

Date:	3/28/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	46 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he has not felt "the same" since his surgery, feels very fatigued and after one or two in the afternoon cannot really do anything, reported that he remains depressed and frustrated with his status

Session Content: Discussed his status as above and this was the main focus of the session today. Discussed several possibilities to explain what is happening and he will be a better observer as to patterns. I suggested to him that as the weather warms, he might want to get up and do some walking, moving around, etc. Also discussed the psychological changes he has experienced and expressed surprise at what an injury like this can do. Normalized and discussed from a loss and grief perspective.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving – assist pt in generating options

Response to Interventions: good, seems less irritable and more comfortable

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 3/28/2013 1:14:37 PM

Progress Note

Date:	4/2/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he believes that he is more depressed, spending more time alone in his room, reported that he is more irritable, is concerned and angry with his parents and has observed that this spills over to others he cares about

Session Content: Discussed his status and we reviewed what has changed since the surgery. None of our hypotheses really seemed to ring true and he will monitor his thoughts and feelings about this. Went on to discuss the frustration he feels with his parents and their decisions and the history of their conflict. He noted that this is directly related to his overall level of frustration and that he notices that he takes it out on others. We reviewed how he might change his thoughts and beliefs about his parents and knowing when to "give up" on advice and hopes that things might change.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) normalization of trauma related symptoms
4) problem solving -- assist pt in generating options
5) cognitive modification -- development of more appropriate self-talk

Response to Interventions: much more thoughtful and open now

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 4/2/2013 11:36:29 AM

Progress Note

Date:	4/9/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: presents today as more calm, more thoughtful and provided examples of improved conflict management, observed that he has now been freed from neck collar, pain reported persists

Session Content: Discussed his status and we reviewed his pt and recent medical appointments. Was having some concerns at pt and handled these well with the staff and was also able to explain how he handled another conflict around purchase the he made. He acknowledges the changes he is experiencing and also that he is responsible for managing them, reinforced efforts.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving – assist pt in generating options
5) cognitive modification -- correction of errors

Response to interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 4/9/2013 2:22:50 PM

Benjamin, Victor

Progress Note

Date:	4/16/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he is having a bad day pain wise, no particular triggers, no new complaints, very focused on his pain

Session Content: Discussed status and activities with a focus on complaints and part of the session was spent in ventilation concerning pain. Moved to the changes in mood and increased irritability that he experiences during these time, reviewed management tools, some of which he is using. Generally pretty irritable with people today. Reviewed meds and he is more satisfied with them at this point.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving – assist pt in generating options
5) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 4/16/2013 12:06:59 PM

Progress Note

Date:	4/25/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he has not been feeling well and has had a difficult several days, multiple physical complaints, also reported irritability with his partner and others

Session Content: Discussed his status and activities, at some length we discussed his physical status and the pain that he is experiencing. Normalized his experiences and discomfort. He noted that he has been irritable and he is again getting feedback from his partner about his behavior. That lead to another discussion of the relationship between pain and psychological status.. We discussed two approaches one behavioral and one cognitive. Practiced scripts for changing behavior. Also reviewed his meds and he is making progress there.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) normalization of trauma related symptoms
4) cognitive modification -- development of more appropriate self-talk

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 4/28/2013 8:42:03 PM

Benjamin, Victor

Progress Note

Date:	5/2/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Others Present:	partner-present
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported continued pain and little relief and this is reported to be impacting his mood, reported that he remains more irritable and depressed

Session Content: Observed today as more with drawn and frustrated, reported that he continues to experience significant pain and is more depressed and withdrawn, not a good day to push any sort of egenda and worked to normalize and provide support. I believe that the is more aware that while the surgery stablized his situation, it did not impact his pain and he is going to have to manage it, although incompletely. Listened, encouraged using support systems and self care.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving -- assist pt in generating options

Response to Interventions: ok

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 5/7/2013 9:26:04 AM

Progress Note

Date:	5/7/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported continued uncontrolled pain, reported that he was informed this morning that his medical care is being transferred to the Columbia area and he was very upset about that

Session Content: Reviewed his medical condition and status. He was very angry as he discussed possible changes in medical care. Forced us to revisit his referral here and how he felt about the transfer of his psychological care. Processed those feelings again during the session. He discussed his options and will contact his atty, not much for us to do about this issue. Also discussed the limits that he is setting with his children.

Interventions

1) active listening, provision of support for recovery
2) problem solving -- assist pt in generating options
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) review relationship between pain and psychological factors

Response to Interventions: ok

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 5/7/2013 7:55:42 PM

Benjamin, Victor

Progress Note

Date:	5/23/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	46 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: presented today as irritable, very upset and angry about proposed changes in neurologist, very focused on his medical care and relationship with providers

Session Content: Session was unfortunately focused on carrier's proposal to change md's. Of course, this was how the pt came here. We discussed the damage done by that change and just how difficult it is to readjustment your relationship with providers, get back into treatmet mode. Pt stated that he is satisfied with his current provider. This was the sole focus of our time today.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 5/23/2013 12:15:37 PM

Progress Note

Date:	5/28/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he has a pretty bad headache today, feeling down, frustrated, sexual issues are a concern today as well as continuing medical access issues

Session Content: Discussed status and activities, discussed pain and sources of frustration. He has not heard anything from the carrier regarding changes in neurologist but this is a stressor for him, he reported. We also discussed the irritability that he is experiencing and this was again tied to his cogn symptoms, continue to help him sort that out.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 5/28/2013 11:54:14 AM

Progress Note

Date:	6/4/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he is experiencing a headache today, appeared thin and somewhat gaunt, depressed mood, more flat, more complaints about his legal and insurance issues

Session Content: Discussed status and activities, various issues during the session today including medical access issues, son leaving town, pain, physical limitations. Good opportunity to discuss how stressors from "regular life" impinge on his recovery. Discussed relationship of pain to anxiety and nature of head injury thrown in as well. Provided support, seems like that is a big part of what he is needing from us here.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) review relationship between pain and psychological factors
5) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 6/4/2013 1:12:22 PM

Benjamin, Victor

Progress Note

Date:	6/11/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: accompanied by wife today and had a disagreement on the way here today. Irritability continues to be a major issues, continued depressed mood, pain

Session Content: Focus today was on interpersonal conflict and it was good that there had been a disagreement and his partner was present. Was actually pretty irritable during the session, used listening and problem solving approach. Also provided information on the relationship between head injury and conflict. Practice skills during the interview. Also tried to distinguish between frustration and behavior.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) behavioral techniques -- rehearse coping skills

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 6/11/2013 12:10:25 PM

Progress Note

Date:	6/18/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: continues to report significant levels of frustration with his situation and others, reports continued pain and physical limitations, depressed mood, sleep disruption

Session Content: After check in, session focused on frustration, I continued to tie his anger to his head injury and promote cognitive modification. He is spending considerable energy being mad at his situation, we and his family. We discussed the consequences and today I used recent family get together as a way of working to modify cognitions that are causing him to be made and are not at all helpful or realistic. Also discussed his use of medication in light of continuing sleep issues. Suggested anger also has a role to play here.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) cognitive modification – correction of errors
4) cognitive modification – development of more appropriate self-talk

Response to interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 6/18/2013 4:06:18 PM

Benjamin, Victor

Progress Note

Date:	6/25/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	46 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported frustration with getting medications, mileage, reported that he is also frustrated with his status, family and others as well

Session Content: Anger and frustration were the theme for this session. We discussed the impact of head injury on feelings especially anger. I reminded him that after a head injury, being more irritable is to be expected and that it is important that he work to be aware of and control his anger. Went on to work with him using cogn modification of anger, identified his beliefs and discussed how they might produce anger and how to change thoughts and perceptions.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) cognitive modification - modification of anger producing cognitions
5) cognitive modification – correction of errors
6) cognitive modification -- development of more appropriate self-talk

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 6/27/2013 7:59:26 AM

Progress Note

Date:	7/2/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: theme of the session continues to be his fruetration and anger, at various times during the session he reported anger with the carrier, partner, children, a lady in parking lot, etc, no new physical complaints

Session Content: Confronted his high level of anger more directly, pointed out again the factors associated with them but the reason's are not so important as management. Reframed anger as tiring and noted that it rarely accomplishes much. Ventilation concerning times when people have not met his expectations, still seems mostly unaware that his distances himself from others with his expectations. Reviewed meds and see Dr. Deal during the next few weeks.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving -- assist pt in generating options

Response to Interventions: ok

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 7/2/2013 12:30:36 PM

Benjamin, Victor

Progress Note

Date:	7/11/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: session focused on his perceptions regarding continuing issues with carrier, continues to report cognitive symptoms, continues to report considerable irritability, depressed mood, pain and physical limitations

Session Content: Session began with check in and quickly moved to ventilation about his medical care, insurer, etc. Provided support and normalization of his experience, have not had much luck in applying cognitive management tools here. Continues to report how much he appreciates the support, reducing second injury.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) normalization of trauma related symptoms
4) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 7/27/2013 2:04:06 PM

Benjamin, Victor

Progress Note

Date:	7/24/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported a difficult two weeks while I was away, continued pain, struggles with the insurer, concerns about his behavior and future, noted that he remains very irritable

Session Content: Session began with check in and discussion of his activities, we focused on his frustrations with medical care and his future and we discussed the changes in his life and current goals. Noted significant losses and these were normalized. Moved to discussed head injuries and irritability and management. Was not doing well today and he briefly saw Dr. Deal.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving -- assist pt in generating options
5) cognitive modification -- development of more appropriate self-talk

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 7/24/2013 1:29:12 PM

Progress Note

Date:	7/30/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported continued irritability, quick to anger, pain continues to be an issue as it is not well controlled, foused on losses associated with injury

Session Content: Discussed status and activities during the first part of the session. Reported his concerns about irritability and anger. Continued to address via cognitive modification as well as normalization. Sleep is more disrupted as pain is a bigger issue. Continued frustration with carrier and medical access.

Interventions

1) active listening, provision of support for recovery
2) cognitive modification -- correction of errors.
3) cognitive modification -- development of more appropriate self-talk
4) review relationship between pain and psychological factors

Response to interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/26/2013 8:26:40 PM

Benjamin, Victor

Progress Note

Date:	8/6/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported a period of exacerbated pain with no immediately identifiable trigger, continues to be irritable, moody, focused on slights by others

Session Content: Discussed his status and worked during the first part of the session to identify potential triggers, after a period of discussion settled on manipulation of his shoulder during recent MRI as likely cause. Went on to discuss his concerns about use of medication, management of periods of increased pain, understanding of the nature of pain management from a psychological perspective, uses avoidance to manage irritability, discussed other options as well. Reviewed his medications.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) problem solving -- assist pt in generating options
4) cognitive modification – correction of errors
5) return to work - discuss options for return to present occupation

Response to interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/6/2013 10:40:48 AM

Progress Note

Date:	8/13/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: noted increased pain over the weekend and today was very focused no only on the pain but on his frustration gaining approval for recommended treatment, noted continued irritability but also awareness of it

Session Content: Discussed his pain status and any triggers, but none were identified. Went on to discuss with much ventilation his feelings about his medical care, legal situation and need for recommended care. Feelings were normalized. I heard him describe the importance of managing his irritability and reinforced his efforts and increased awareness. Discussed management of his frustration with upcoming md appointments.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) cognitive modification -- correction of errors
6) cognitive modification -- development of more appropriate self-talk

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/13/2013 12:45:01 PM

Benjamin, Victor

Progress Note

Date:	8/20/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: presented today as frail, losing weight?, very irritable about the losses he has faced and md appointment later this afternoon, wife present to describe continued frustration and angry outbursts

Session Content: Discussed status and activities, much ventilation with quite a bit of anger for various parties, wife confronted him on two instances of him being very irritable, one time leaving her in a hotel. Defensive throughout. Has an md appointment today and has questions about what is happening with his medication treatment. Urged him to approach the provider in a way that will allow communication and getting the information he needs. Very upset already.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) cognitive modification -- development of more appropriate self-talk

Response to interventions: ok

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/21/2013 7:59:54 AM

Benjamin, Victor

Progress Note

Date:	8/27/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported a quiet weekend with no new complaints, pain and physical limitations continued, reported that he had a good md appointment last week and he will be having shoulder surgery

Session Content: Discussed status and activities, noted that he was able to manage his communication with his md better than he expected and that it went well. Reported that he has some sort of tear in his shoulder and will require further treatment. Discussed management of irritability. Discussed losses he has experienced with injury and other losses.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 8/27/2013 2:15:05 PM

Benjamin, Victor

Progress Note

Date:	9/3/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: complaints of neck pain today, complaints regarding carrier and finances, medical access, theme of the session was his frustration with others and how he shares his feelings

Session Content: We have discussed from the beginning of our time together the residuals of head injury, including disinhibition. Again reinforced this as he provided several examples of this from the last week. Some of the times this is working out, others not at all. Discussed cognitive practice and will continue to strengthen his ability to make a decision what to say and what not to say.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 9/3/2013 10:22:48 AM

Benjamin, Victor

Progress Note

Date:	9/11/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: no significant change noted, continues to complaint of pain, medical access issues, problems with legal issues, depressed mood, irritability

Session Content: Discussed status and activities and during the first part of the session we discussed the issues that he is having with getting appointments and referrals. Moved to his irritation with family members. I did take a chance and gently confronted the irritability he is showing toward his son and options for management. Discussed the importance of managing stress given pain and head injury.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) cognitive modification -- correction of errors
6) cognitive modification -- development of more appropriate self-talk

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 9/11/2013 4:52:33 PM

Progress Note

Date:	9/17/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported no significant change with pain, frustration with his lack of progress in medication care, insurer, limits remaining primary stressors, remains irritable, snappy

Session Content: No major changes reported that he seems about where he has been, did report that he has been focusing on being less irritable and reaction to his son and sees a difference. Continue to frame his issues are an effort required by his head injury. Again today provided information about the emotional and cognitive impacts of head injury. Reviewed discussion from last week, much ventilation about his medical care, not sure just what his permanent physical condition will be.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) problem solving – assist pt in generating options

Response to interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 9/17/2013 11:24:40 AM

Progress Note

Date:	9/24/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that his pain is so severe that he cannot manage it, vague threats of violence, conflict with wc, wife and others, focused only on pain today

Session Content: Discussed his status, discussed level of pain and inaction that he feels from others including his atty and the carrier. I spoke to him via telephone over the weekend about this as well. Reported that he is so angry that he does not know what he will do, discussed any specific threats and there were none, discussed potential consequences of violence. Discussed emergency contact as needed.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: ok

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 9/24/2013 10:12:57 AM

Benjamin, Victor

Progress Note

Date:	10/1/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: remains frustrated, angry, disinhibited, vague threats, pain and physical limitations continued, feels as if his medical and legal assistance is not adequate

Session Content: Discussed status and activities, much ventilation with anger expressed with medical care, atty, md's, carrier and family. Discussed appropriate ways to express anger. Discussed threats, he identified no victims. Discussed hospitalization, if required.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 10/1/2013 10:39:35 AM

Benjamin, Victor

Progress Note

Date:	10/10/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: not doing well, reported continued uncontrolled pain, reported that he remains very frustrated with the insurance carrier and that he had a confrontation with the nurse, sleep is more disrupted, will be trying new meds for rest.

Session Content: Discussed status and activities and it was clear that he was struggling today. Continued to assist via clarification, cognitive management of anger and using information about closed head injury to help him make decisions about his response. Much ventilation today related to insurance carrier.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) normalization of trauma related symptoms
4) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 10/11/2013 8:28:33 PM

Benjamin, Victor

Progress Note

Date:	10/15/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he continues to struggle with pain, reported that he continues to be concerned about his medical treatment, continued headaches, depressed mood, frustration

Session Content: Reported on his recent visit to the md and the impression from his md that his neck was the primary cause of his pain, discussed next steps in his medical treatment. Reported on recent contacts with nurse case management. Reviewed recent weekend and he spent quite a bit of time in bed, avoiding others. Having side effects from medication. Discussed being more assertive given tendency to react without thinking. Will be seeing Dr. Deal today.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) normalization of trauma related symptoms
4) problem solving – assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 10/15/2013 11:08:18 AM

Benjamin, Victor

Progress Note

Date:	10/29/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	46 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported increased head pain, urination during the night, continues to present as easily irritable, noted continued anxiety and depressed mood

Session Content: Discussed his status and the first part of the session focused on his pain and the patterns associated with it, discussed how he could use that information, was able to id drinking tea as putting him at risk for increased urination. Continues to report frustration with wc system and referrals, medical care.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 10/29/2013 10:40:41 AM

Progress Note

Date:	11/5/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor
[redacted]	
Sex:	Male

Content/Process

Other themes: no changes reported, remains irritable and easy to anger and he provided a number of examples of that today, frustrated with medical care and is concerned about upcoming med appointment

Session Content: Discussed his status, theme of the session was the multiple conflicts that he is experiencing and how he to handle them. Conflict with family members discussed at some length. Also conflict with nurse case manager who he did not expect to see again and is now apparently going to be at his next md appointment. Told me how he planned to deal with that and we discussed alternatives, did not seem all that open to using them.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 11/5/2013 10:52:49 AM

Benjamin, Victor

Progress Note

Date:	11/12/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he is somewhat improved in terms of pain and this has helped his psychological status, reported that he is more able to consider his actions and has changed his approach with family members

Session Content: Seems to be doing well today, reported that he was able to give support to his wife when she was not feeling well and has been more on an even keel, reinforced his efforts and I can see the difference. We also discussed how he will approach his md appointment next week and I think that he will do well. Continued ventilation about legal system and his part in it.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 11/12/2013 11:20:18 AM

Benjamin, Victor

Progress Note

Date:	11/19/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he is not feeling well and spend much of the weekend at home with little activity, reported that he is anticipating md appointment this week

Session Content: Discussed his status and activities and he is stable and relatively unchanged, sleep is reported as more disrupted, multiple physical complaints. Discussed his upcoming appointment and we have discussed during previous meetings how he might best approach this, he is working on being less confrontative, see what the md has to offer. Reviewed meds and sleep hygiene.

Interventions

1) active listening, provision of support for recovery
2) behavioral techniques -- teach and/or practice techniques that prevent/delay impulsivity
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 11/19/2013 1:04:23 PM

Progress Note

Date:	12/3/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: noted continued pain and physical limts, reported that he was not satisfied with last md appointment and he is apparently being discharged, remains irritable and easily frustrated

Session Content: Reported on his status and activities, reported on his experiences and frustrations during the holiday, with his parents and others in his family. Noted the details of his meeting with md and he is apparently being referred for an fce, so it appears that no further treatment is likely. Reviewed meds and our schedule, discussed his perception of treatment to date.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) problem solving -- assist pt in generating options
5) cognitive modification -- development of more appropriate self-talk

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 12/4/2013 6:26:45 AM

Benjamin, Victor

Progress Note

Date:	12/10/2013
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported increased pain, complaints about medical access, legal issues, complaints about family and others, remains quite irritable

Session Content: Nothing significant has changed, does seem like with increased pain and issues with insurer that he is more irritable not just with them but with family, friends and others. Continued to provide support while offering alternative ways of thinking about and dealing with the frustrations he is experiencing. Discussed role of pain on his emotional status, reviewed meds and he will return in January.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 1/3/2014 5:15:56 PM

Progress Note

Date:	1/7/2014
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported continued pain and physical limitations, reported considerable frustration with his status, issues with his medical care and family. quite reactive

Session Content: Discussed status and activities, the sessin today was primarily ventilation concerning the various problems that he has been having. Used the time to sort out his concerns using problem solving and listening to help him make better decisions and respond in wayts that he finds helpful. Seems to find this helpful.

Interventions

1) active listening, provision of support for recovery
2) ventilation related to details of current stressors
3) normalization of trauma related symptoms
4) problem solving – assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 1/7/2014 1:46:55 PM

Benjamin, Victor

Progress Note

Date:	1/15/2014
Provider:	Lawrence-Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he has continued to be very irritable, depressed, pain remains a significant stressors, cognitive symptoms remain

Session Content: Discussed status and he has been given feedback by his partner that his irritability is really getting to be an issue. I took this opportunity to give him more direct feedback than I usually do. His wife's report is similar to my perception and so I was able to add to what she said. He seemed to understand this and was able to incorporate the feedback.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 1/18/2014 11:02:52 AM

Progress Note

Date:	1/23/2014
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: reported that he has seen an md and is planning on having further surgery, had issues with the meds for the scans earlier in the week, continues to report that he is working to reduce irritability

Session Content: Most focused today on medical issues, we discussed his appointment, disappointment about care up to this point. Discussed his hopes for further medical treatment. Moved to providing information again about irritability in head injury, stressing important of both awareness and control. Seems to be working hard on getting handle on this. Reinforced efforts, reviewed medications.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 1/28/2014 10:20:03 AM

Benjamin, Victor

Progress Note

Date:	1/28/2014
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: most concerned about medical care and potential further surgery, reported continued irritability, depressed mood, frustration with his life and status, very focused on losses

Session Content: Discussed his status and during the first part of the session we discussed medical appointments and hopes for further medical treatment. Moved to discussion of his relationships and the importance of controlling his frustration, continued to discuss in terms of closed head injury. Emphasized behavioral change.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) cognitive modification – development of more appropriate self-talk
5) problem solving – assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 2/4/2014 9:56:41 AM

Benjamin, Victor

Progress Note

Date:	2/5/2014
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: looking ahead to surgery during the next week, focused on improvement in pain at this point, continues to present as irritable and easily frustrated

Session Content: Discussed status and activities, discussed upcoming surgery and his issues with providers, carrier, etc., listened and moved on. Continue to emphasize the importance of reflecting on thinking and considering multiple response. Noted that his expectations for others play a big role in his anger. Continues to be a challenge for him. Also worked out our schedule for contact while he is recovering from surgery.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) normalization of trauma related symptoms
4) cognitive modification -- correction of errors
5) cognitive modification -- development of more appropriate self-talk
6) review relationship between pain and psychological factors

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 2/18/2014 8:53:09 AM

Progress Note

Date:	3/4/2014
Provider:	Lawrence Bergmann, Ph.D.
Session Length:	46 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor [redacted]
Sex:	Male

Content/Process

Other themes: first in person meeting since surgery, reported concerns about the location of his pain, remains irritable and angry, depressed, easily frustrated

Session Content: Discussed surgery and recovery, discussed upcoming meeting with attending md. I think that he is really learning to consider and temper his responses and this conversation would have been much different a few months ago. I noted that change and reinforced what he is trying to do. It has been slow but I think he is getting the changes that have impacted him and the though and effort required to communicate his concerns in an effective manner.

Interventions

1) active listening, provision of support for recovery
2) check in regarding psychological and physical status
3) ventilation related to details of current stressors
4) normalization of trauma related symptoms
5) problem solving -- assist pt in generating options

Response to Interventions: good

Electronically Signed/Date: Bergmann, Ph.D., Lawrence 3/5/2014 8:06:04 AM

FEB. 2. 2015 4:13PM
333 Main Street, Suite 500 • Post Office
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

Physician's Statement

Claimant's Name: Victor Benjamin
Physician's Name: RW Deal MD/LH Bergmann Ph.D.
Practice/Clinic: Post Trauma Resources
Preparer's Name: lhb
Phone: _____

Employer's Name: _____
Insurance Carrier: _____
SCWCC File No: _____

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

Date of Injury or Illness: _____

Date of first office visit: 6/8/12 Date of last visit: 2/5/15

Diagnosis or nature of injury or illness: Psych

Body part(s) injured: Psyche Body part(s) effected: _____

Date of Maximum Medical Improvement: 2/5/15

Based on the **AMA Guidelines**, the claimant has sustained a 30 **% medical impairment** to whole person for injured body part(s) and a _____ **% medical impairment** to _____ for 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:**

_____

_____

☐ 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:

Medication and med mgt indefinitely/psychotherapy for at least the next two years and possibly more

_____

_____

_____

Treating Physician

2/5/15
Date

07

14B

2/5/15
Physician's Statement

(429)

Post Trauma Resources
1709 Laurel Street
Columbia, South Carolina 29201
803.765.0700

Progress Note

Date:	6/21/2012
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He has gotten started taking the valium and is now at 5 mg twice in the evening without any side effects nor much change in sleep or anxiety.

We reviewed the need for both higher doses of valium as well as a combination of this with trazadone to augment each other.

It is also important to remember that he has had a long period of sleep deprivation and with the pain being intractable he is not likely to see a quick result so he will need to be patient and move slowly from low doses to higher to avoid negative effects.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z-written instructions provided

Response to Interventions: Little change but is learning about the medicine and the condition.

Medications

Medication: Valium 5 mg twice in the evening Start Date: 6/6/2012

Medication Plan: He will go to 10 mg twice in the evening and then add trazadone, starting at 25 mg and adjusting according to his response.

Electronically Signed/Date: Deal, M.D., Roger 6/26/2012 5:30:06 PM

Benjamin, Victor (D)

Progress Note

Date:	7/3/2012
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: We discussed his results with adding trazadone and so far he has found it helps him sleep but is a bit too oversedating when taken with the valium.

We discussed the need for him to now introduce some flexibility in how he adjusts the medicine to take full advantage of the sleep with trazadone and move the valium to earlier times.

He is somewhat more comfortable now that he has seen that he can in fact get some good sleep and that this helps him not feel so irritable and tired all the time.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Making some progress in controlling anxiety and sleep. Remains very easily agitated.

Medications

Medication: Trazadone 50 mg q hs Start Date: 6/21/2012

Medication: Valium 5 mg twice in the evening Start Date: 6/6/2012

Medication Plan: He is going to continue to adjust the valium and trazadone to optimal levels and times.

Electronically Signed/Date: Deal, M.D., Roger 7/8/2012 7:21:54 PM

Progress Note

Date:	7/19/2012
Provider:	Roger Deal, M.D.
Session Length:	45 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He was seen along with his wife in order to discuss the ongoing problems he is having

adjusting the medicines. He is quite discouraged and feels he has tried all the ways I suggested and is not able to get the medicines to work consistently for him.

He has the most trouble with the trazadone, feels this does help with sleep sometimes but oversedates him and makes him feel out of control.

He has less problems with the valium but is now uncertain which medicine is ok and which is not.

His wife offered the observation she did not feel the valium was a problem.

I suggested we start over by dropping out both medicines and in a few weeks when he is back to baseline we will review and decide how to proceed.

He brought in the other medicines he is on and he tells me he has spent a lot of time getting them right but now has no problems with any of them.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Remains very symptomatic.

Medications

Medication: Trazadone 50 mg q hs Start Date: 6/21/2012

Medication: Valium 5 mg twice in the evening Start Date: 6/6/2012

Medication Plan: We are going to stop all the medicines for a few weeks then review at our next appointment and decide how to proceed.

Electronically Signed/Date: Deal, M.D., Roger 7/21/2012 4:32:25 PM

Progress Note

Date:	8/9/2012
Provider:	Roger Deal, M.D.
Session Length:	45 mins.
Type of Visit:	Scheduled

Patient: Benjamin, Victor (D)

Content/Process

Session Content: We reviewed again his symptoms and his pervasive anxiety and sense of impending death, even feels he may not wake up when he tries to go to sleep at night.

We discussed the negative consequences to his outlook and fuctioning as a result of the constant

hypervigilance and changes in the adrenergic system.

I suggested it may help to work further with Dr. Bergmann on the reframing of the fear of not awakening as this seems a particularly negative feeling and not at all rational but a powerful influence on his ability to sleep and also to take medicines without side effects.

I feel we need further work on this before we try any other medicine and he agreed with this approach.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Remains very symptomatic with nightmares, hypervigilance and dysphoria.

Medication Plan: He is going to observe anxiety and next time we may do a test of as-needed medicines for this symptom.

Until then we will not prescribe any medicine.

Electronically Signed/Date: Deal, M.D., Roger 8/12/2012 5:50:05 PM

Progress Note

Date:	8/23/2012
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: Mr. Benjamin and I had a long discussion today about the reasons for using medicine with this condition of chronic pain.

Now that he works more closely with Dr. Bergman he seems to understand more about the role of medicine and is more receptive to taking medicine.

We discussed the fact that with this pain level that he has, it activates a part of his brain that is not under voluntary control and causes a lot of chemical changes in the body which is the reason we use medicine to try and minimize the ill effects from all the chemical changes.

He seems more receptive to this idea so we discussed trying to use a very mild medicine like Xanax at a very low dose initially only taking it in the evening when he is home and not going anywhere.

He agreed to give this a try and we will start with 0.25 mg to be taken early in the evening then again closer to bedtime.

We will get together again next week to review how this is going.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Learning about his condition.

Medication Plan: He is going to do a trial of xanax, starting with 2 doses in the evening.

Electronically Signed/Date: Deal, M.D., Roger 9/4/2012 9:32:00 AM

Progress Note

Date:	8/30/2012
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He is doing well with the low doses of xanax in the evening, not feeling anything negative and a very slight effect of calming.

We reviewed our plan to move the medicine up slowly by adding an earlier half dose rather than moving to a full dose until he has time to get very accustomed to the the way the medicine affects him.

We discussed again the reasons for needing medicine to reduce the negative consequences of chronic pain and the fact the chemical changes are not under voluntary control..

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Continues to learn and to test low doses of xanax.

Medications

Medication: Trazadone 50 mg q hs Start Date: 6/21/2012

Medication: Valium 5 mg twice in the evening Start Date: 6/6/2012

Medication Plan: He is going to add another half dose of xanax late afternoon.

Electronically Signed/Date: Deal, M.D., Roger 9/4/2012 12:41:57 PM

Progress Note

Date:	9/13/2012
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled

Patient: Benjamin, Victor (D)

Content/Process

Session Content: He is still doing fine on the xanax, not having any side effects and now comfortable with the idea of working his way very slowly to a dose that will begin to be able to reduce anxiety and help him be able to get some sleep at night.

He continues to work regularly with Dr. Bergmann and is learning about the ill effects of chronic pain and the increased sensitivity to medicines because of the adrenergic overactivity.

He is more positive by coming here and feeling there is some hope for him.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: No side effects with xanax and working his way into a dose that may begin to help some.

Medications

Medication: Xanax 0.25 mg 1/2 3 in the evening Start Date: 8/23/2012

Medication Plan: Whenever he is ready he will move up on the xanax.

Electronically Signed/Date: Deal, M.D., Roger 9/18/2012 5:00:05 PM

Progress Note

Date:	9/27/2012
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled

Patient: Benjamin, Victor (D)

Benjamin, Victor (D)

Content/Process

Session Content: Mr. Benjamin has moved the Xanax up another step without any negative effects but very little positive effects as well.

He is glad he has been able to tolerate the medicine. We discussed the fact that he is more comfortable and I would like for him to move it up at his own pace.

I suggested that now would be a good time to test taking a whole dose for one of the times.

If he tolerates it he can then move up with full doses and half doses as well and move into taking medication during the day.

He is doing well in his work with Dr. Bergman, unfortunately recently he has had more pain in his neck and is going to have to get further tests done to see if something new is going on.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Getting more comfortable with the xanax.

Medications

Medication: Xanax 0.25 mg 1/2 3 in the evening Start Date: 8/23/2012

Medication Plan: He will move up on the xanax at a pace that he finds comfortable.

Electronically Signed/Date: Deal, M.D., Roger 10/2/2012 10:20:49 AM

Progress Note

Date:	10/25/2012
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He has not had any problem with the xanax but the doses are still too low to give any substantial relief of anxiety.

We discussed this is detail and agreed he will continue to move up at a pace he is able to avoid any side effects.

We reviewed the chemistry of PTSD and chronic pain.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication

Response to Interventions: Still very low on the xanax but tolerating it well.

Medications

Medication: Xanax 0.125 mg twice in the evening; 0.25 at bedtime Start Date: 6/23/2012

Medication Plan: He will continue to move up on the doses of the xanax.

Electronically Signed/Date: Deal, M.D., Roger 10/25/2012 10:49:29 AM

Progress Note

Date:	11/6/2012
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He is much more anxious and worried now as he found out early this week that the cervical spine needs surgery to prevent further harm as it is compressing his spinal cord and if not corrected could do serious damage to him.

He is doing fine with xanax but the dose is still quite low so we agreed in view of this recent negative finding he will go up faster and I gave him a written outline to follow.

We reviewed the recent concerns he has had about the increased pain level and uncertainty about his eventual outcome.

So far he has not had any concern about the xanax causing any problem so I encouraged him to move at a pace that is comfortable for him but now he is used to the xanax he can safely move up to more helpful doses sooner.

Our target is to get him to at least 1 to 1.5 mg over the next 10 days.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Only modest response to the xanax so far.

Medications

Benjamin, Victor (D)

Medication: Xanax 0.25 mg 3 in the evening Start Date: 8/23/2012

Medication Plan: Take 1 and another half for each of the 3 doses and then add a 4th dose. If he is comfotable and not seeing much help from 1 mg he will move higher and let me know what dose works best.

He will take another dose if he awakens during the night

Electronically Signed/Date: Deal, M.D., Roger 11/8/2012 5:22:10 PM

Progress Note

Date:	12/13/2012
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: Mr. Benjamin tells me that he has been able to get up to 3 of the 0.5 mg Xanax, starting late in the afternoon and ending right before bedtime.

This has helped some but as he went higher on Xanax it coincided with a marked increase in interpersonal stressors, so some nights have been good on sleep and others it has not been so good.

We discussed other options and I suggested that he try to get 4 doses into that same time period and see how that works. If he is comfortable he can take 2 at a time right before bed or 4 separate doses for a larget of 2 mg. in 24 hours.

If stressors are not better by our next meeting we will go higher as long as the need is there and he has no side effects, which fortunately has been the case with moving up very slowly.

Interventions

1) z - review targel symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Modest improvement in anxiety and sleep. Remains very symptomatic with intractable pain.

Medications

Medication: Xanax 0.5 mg 3 in the evening Start Date: 8/23/2012

Medication Plan: We are going to move up to 2 mg daily on xanax.

Electronically Signed/Date: Deal, M.D., Roger 1/19/2013 2:01:22 PM

Progress Note

Date:	1/29/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He has added more xanax in the evening but at the same time has had more pain and is more anxious as he is now scheduled for surgery on his lumbar spine.

We reviewed the way his sleep is going and I suggested he consider taking the muscle relaxant along with the xanax in the evening and if the pain is up in the evening he may consider taking the tramadol as he appears to awaken with pain often when he does awaken.

We reviewed how the next few weeks are likely to be and the rehabilitation he will go through, as well as the increase in pain.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Remains with high pain levels.

Anxious about impending surgery.

Medications

Medication: Xanax 1 mg 3 in the evening Start Date: 8/23/2012

Medication Plan: Continue current medicines, taking the tramadol and tizanidine before he goes to sleep every night.

He will take 1 mg xanax if he awakens early in the morning.

Electronically Signed/Date: Deal, M.D., Roger 1/29/2013 5:43:50 PM

Progress Note

Date:	2/7/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Benjamin, Victor (D)

Content/Process

Session Content: Mr. Benjamin having carefully worked his way up to 3mg a day of Xanax and after talking with me on his last visit discusse gradually moving to where he is putting the Tramadol and then the Tizanidine together in the evening with the Xanax.

Unfortunately after being very careful and slowly moving up on the Xanax he then immediately tried putting the 3 of these medicines together at the very same time in the evening and woke up in the middle of the night talking incoherently to his wife and did not remember the next day.

This of course raised his anxiety level and being frightened by this he decided not to take any of the medicines and so then he had a tremendous rebound of anxiety and insomnia.

We discussed the fact that our plan from the time we first met was not to make any rapid changes so I counseled him to go back on the Xanax gradually and get back to where he was then we will meet back to talk.

He is going to have to have surgery soon which is going to complicate things for a while.

I suggested he not put these medicines together until he is finished with the surgery and recovery and can meet again to talk about how to proceed.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Having more difficulty adjusting the medicines.

Medications

Medication: Xanax 1 mg 3 in the evening Start Date: 8/23/2012

Medication Plan: He is going to reduce the xanax some and not try to combine the different medicines but take them separately.

Electronically Signed/Date: Deal, M.D., Roger 2/12/2013 12:12:27 AM

Progress Note

Date:	2/12/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He learned from our talk last week so began to resume the xanax at lower doses in the

late afternoon and right before bed.

He then added back the tramadol and tizanidine at separate times during the evening.

This has led to a marked reduction in withdrawal symptoms and allowed him to sleep much mores soundly.

He is having a bit of oversedation in the morning still so I suggested a slight reduction in the bedtime dose of xanax and then decide if any further change is needed.

He will have surgery on the 18th and will take the medicine as instructed by his surgeon.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Quick improvement with medicine adjustment.

Medications

Medication: Xanax 0.5 mg late afternoon; 0.5 to 1 mg q hs Start Date: 8/23/2012

Medication Plan: He will test taking a reduced bedtime dose on xanax and continue the tramadol and tizanidine separately during the evening.

Electronically Signed/Date: Deal, M.D., Roger 2/12/2013 5:51:42 PM

Post Trauma Resources
1709 Laurel Street
Columbia, South Carolina 29201
803.765.0700

Progress Note

Date:	3/21/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He has had the surgery done and post-operatively he had much more difficulty sleeping. The effect of the xanax seemed to be almost completely overtaken by the post operative pain and the adrenergic effect of the whole procedure.

Fortunately for us both his family doctor saw him and realized his predicament and suggested moving to a longer-acting benzodiazepine, klonopin, which has worked very well once he got the dosing correct.

I told him this is exactly what I would have done and we agreed he will continue this and he will watch for any sign of being oversedated.

As long as he continues to do well we will leave the dose the same but he is now quite familiar with the concept of flexible dosing on benzodiazepines.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: More pain post surgery.

Better since switching to klonopin.

Medications

Medication: Klonopin 2 mg q hs Start Date: 3/16/2013

Medication Plan: Continue on the klonopin with flexible doses depending on how he is feeling.

Benjamin, Victor (D)

Electronically Signed/Date: Deal, M.D., Roger 3/26/2013 5:16:41 PM

Benjamin, Victor (D)

Progress Note

Date:	4/8/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled

Patient: Benjamin, Victor (D)

Content/Process

Session Content: He has had an increase in the intensity level at physical therapy, which has helped him but also has sometimes made him have more pain and he is not sleeping quite as well as before.

We reviewed the medicine and agreed that if he is not sleeping long enough he will take another half of klonopin and perhaps take it earlier in the evening.

He has a number of issues on his mind about his recovery and so far feels it is going as well or better than he anticipated.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Sleep is much improved. Pain remains a major issue for him.

Medications

Medication: Klonopin 2 mg q hs Start Date: 3/15/2013

Medication Plan: He may have to move a little higher on the klonopin to keep the sleep pattern the full number of hours.

Electronically Signed/Date: Deal, M.D., Roger 4/11/2013 5:15:53 PM

Benjamin, Victor (D)

Progress Note

Date:	4/25/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He is still sleeping well and has only needed to go up to 3 mg a couple of times.

We reviewed his experience with the recovery from the surgery and unfortunately he has had a brief period of pain reduction but now is much worse so he is using a patch and taking stronger medicines.

He has done fine sleeping taking the same dose of klonopin despite the pain increase so we agreed he has the option of moving but will only go higher if he sees a consistent pattern of not sleeping as well as before.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Pain remains a major problem for him postoperatively.

Medications

Medication: Klonopin 2 mg q hs Start Date: 3/15/2013

Medication Plan: Stay flexible on the dosing of the klonopin.

Electronically Signed/Date: Deal, M.D., Roger 4/25/2013 5:19:42 PM

Benjamin, Victor (D)

Progress Note

Date:	5/7/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: Mr. Benjamin comes in today very upset about a number of problems, the primary one that the pain levels post-surgery have really not diminished in a way that he would have hoped that they would.

This is quite frustrating to him, because despite being told that there is a chance that it would not make a difference he was hoping that it would of course and since it has not diminished he is very disappointed about it.

He is also angry because he cannot really do much physically which has made him dependent on other people and this dependency is very difficult for him to handle because he is quite proud, but is ashamed that he is not able to work and be productive.

He has some other family issues that are bothering him, having a growing family with the usual issues.

All these things together are really bearing down on him and slowing down his recovery making it more difficult for him to feel better.

He is still taking the Klonopin which has helped tremendously with sleep.

He is very sensitive to medicine and though this is not an optimal way of treating this condition it may be all that we can do for now.

I'm certainly not going to suggest doing anything different with the medicine until I know him better.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Pain remains a major negative factor.

Medications

Medication: Klonopin 2 mg q hs Start Date: 3/16/2013

Medication Plan: No change in the medicines uness symptoms change.

Electronically Signed/Date: Deal, M.D., Roger 5/9/2013 9:12:23 AM

Benjamin, Victor (D)

Progress Note

Date:	5/28/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled

Patient: Benjamin, Victor (D)

Content/Process

Session Content: Mr. Benjamin continues to demonstrate a good deal of agitation and anger and tells me today that his father has been having trouble with his back and has been to the hospital on a number of occasions.

His father does not seem to be as cooperative with the medicines that his doctor recommended as he could be so this is causing a conflict between the two of them.

He continues to have a lot of pain and continues to feel very angry that workers compensation has attempted to change his treatment a number of times so he is really feeling that he is not certain if anyone who has his best interest at heart.

We reviewed the way he has been doing the Klonopin and he tells me most of the time he is sleeping well but has been more symptomatic with agitation and irritability and concerns about family and himself as well as worries as to what his future is going to be.

He is not sleeping as well as we would like but not enough for us to change the medicine now.

I have already told him that if he needs to go higher or if we need to add something to it we can do that but he would like to stay where he is for the time being.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: More symptomatic past few weeks.

Medications

Medication: Klonopin 2 mg q hs Start Date: 3/15/2013

Medication Plan: Continue current medicines.

Electronically Signed/Date: Deal, M.D., Roger 5/29/2013 3:05:54 PM

Benjamin, Victor (D)

Progress Note

Date:	6/11/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: Mr. Benjamin is seen on an urgent basis today because he was hoping he would be able to go out of town but unfortunately in the last few days has developed insomnia as well as night sweats and is really not feeling as well as he did before.

I saw him with his wife and she says a lot of this is related to their son leaving to go to Texas to work and that he has been very emotional about that.

He has had a number of other stressors and as a result is not sleeping well and is more irritable.

We discussed options and he has already tried taking an extra half of Klonopin but it just didn't seem to help any so we agreed that I would write him a prescription for two and one-half of 2 mg Klonopin and we are going to do some testing to see if we can get the sleep back to the way it was with the 2 mg by moving up higher.

If this is not successful we may have to consider an alpha-blocker but we will decide that when he comes back in.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: More insomnia and anxiety and irritability recently.

Medications

Medication: Klonopin 2 mg q hs Start Date: 3/15/2013

Medication Plan: He will go up on the klonopin to see if this will help him regain his sleep pattern.

Electronically Signed/Date: Deal, M.D., Roger 6/13/2013 9:56:26 AM

Benjamin, Victor (D)

Progress Note

Date:	7/24/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled

Patient: Benjamin, Victor (D)

Content/Process

Session Content: He had talked with me some time ago about having been put on vibryd and expressing concern over this medicine since he had side effects with so many other medicines since his injury.

The only medicines he has been able to take with me have been benzodiazepines, which have been fine.

He tells me he had many negative effects from the vibryd so had to stop taking it.

I suggested he talk this over with the doctor who prescribed it for him and during the next few weeks moitor the target symptoms every few days and when he comes back in we will decide if there is anything with medicine that is reasonable to try him on or if wee need to go higher on klonopin.

There is no doubt he is going to remain sensitive to medicines because of the chronic pain and his intense fear of medicine.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Remains in pain and deeply depressed. Sleep is betteer but not consistent.

Medications

Medication: Klonopin 3 mg q hs Start Date: 3/15/2013

Medication Plan: Continue klonopin and monitor the target symptoms regularly.

Electronically Signed/Date: Deal, M.D., Roger 8/2/2013 2:49:55 PM

Benjamin, Victor (D)

Progress Note

Date:	9/11/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He has had more pain and frustration about the delay in getting further treatment, reports that the pain levels are just as high if not higher than before he had surgery.

He is feeling uncertain about the advice he is getting about optimal treatment of his condition and is very angry about not being able to get approval for tests that have been suggested to clarify his treatment needs.

We discussed his response to klonopin and I suggested that the dose that was helpful at the previous pain level is not enough for the current level and that he needs to move to 3 mg every night rather than trying to anticipate what dose he needs as he frequently now is waking up in the middle of the night again and this could be improved if he increases the dose.

He agrees with this and is going to start tonight with a dose of 3 mg and I also reminded him we will likely need to move at least one step higher and the prescription is already written so he can move up when he is ready.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to interventions: Increased pain, insomnia and irritability past few weeks.

Medications

Medication: Klonopin 2 to3 mg q hs Start Date: 3/15/2013

Medication Plan: I suggested he test taking at least 3 mg on klonopin every evening and we will gradually try to get it to a more optimal level.

Electronically Signed/Date: Deal, M.D., Roger 9/12/2013 12:32:29 AM

Benjamin, Victor (D)

Progress Note

Date:	10/15/2013
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled

Patient: Benjamin, Victor (D)

Content/Process

Session Content: He tells me he has continued to have pain that is not well controlled and has changed from taking low doses of klonopin to sometimes taking none.

We discussed that it is not likely he is ever going to have a dose that will cover all situations without oversedating him sometimes and I think he is better off taking higher doses most of the time, then reducing if he feels oversedated.

He is not going to do well trying to guess how much to take and then stopping when he either can't sleep or is oversedated.

He agrees that it makes more sense to make an effort to get the medicine as close as possible but to realize it is not ever likely to be accurate all the time.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Remains in pain and notes sleep control is not consistent.

Medications

Medication: Klonopin 2 to 4 mg q hs Start Date: 3/15/2013

Medication Plan: Variable doses of klonopin, trying to stay as flexible as possible.

- Advised not to have any nights without some klonopin.

Electronically Signed/Date: Deal, M.D., Roger 10/22/2013 3:19:37 PM

Benjamin, Victor (D)

Progress Note

Date:	1/7/2014
Provider:	Roger Deal, M.D.
Session Length:	30 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He tells me he has had continued pain and frustration about his treatment.

He is fearful of getting injections for the pain and is not certain what other options may be available to him.

He is taking variable doses of klonopin and is much more flexible now with this though we discussed again other ways to try to make the dosing more optimal.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: Remains very symptomatic, with pain, depression and agitation.

Medications

Medication: Klonopin 2 to 4 mg q hs Start Date: 3/16/2013

Medication Plan: He will continue to take the klonopin at variable doses to get the maximum benefit with the lowest doses possible.

Electronically Signed/Date: Deal, M.D., Roger 1/8/2014 2:43:13 PM

Benjamin, Victor (D)

Progress Note

Date:	2/5/2014
Provider:	Roger Deal, M.D.
Session Length:	40 mins.
Type of Visit:	Scheduled
Patient:	Benjamin, Victor (D)

Content/Process

Session Content: He reports that he is going to have sugery again on his cervical spine, this time at a higher level and with a posterior approach.

He tells me that the klonopin is getting somewhat easier for him to manage as he changes his expectations and gets more flexible in how he takes it.

We discussed the pressures on him and he is working closely with Dr. Bergmann to deal better with these.

He naturally has depressive symptoms related to his many losses and the chronic pain and feeling of being unproductive for this long.

We have occasionally talked about antidepressants but agreed he is way too sensitive to medicines to expect to get much help from that class of medicine.

Interventions

1) z - review target symptom list
2) z - review of recent stressors
3) z - educate regarding risks and benefits of medication
4) z- educated about relationship of chronic pain and worsening of target symptoms

Response to Interventions: More intense pain over the past few weeks.

Medications

Medication: Klonopin 2 to 4 mg q hs Start Date: 3/15/2013

Medication Plan: He will continue to take the klonopin at variable doses to get the maximum benefit with the lowest doses possible.

Electronically Signed/Date: Deal, M.D., Roger 2/7/2014 2:50:52 PM