THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

Appellate Case No.: 2019-001064

Patricia Pate, Employee/Claimant, ... Appellant,

v.

College of Charleston, Employer,
and State Accident Fund, Carrier, ... Respondents.

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VOLUME 1

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BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO. 1121370

PATRICIA PATE,

Employee/Claimant,

v.

COLLEGE OF CHARLESTON,

Employer, and

STATE ACCIDENT FUND,

Insurer, Defendants.

HEARING:	Held on July 14, 2015 in Goose Creek, South Carolina.
APPEARANCES:	Max C. Sparwasser, Max Sparwasser Law Firm, LLC, appeared on behalf of the Claimant. Kirsten L. Barr, Trask & Howell, LLC, appeared on behalf of the Defendants.
PURPOSE OF HEARING:	To determine all issues raised pursuant to the Form 21 and the Forms 50 and 51.
DATE FILED:	May 16, 2016

STIPULATIONS

1. All parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act.
2. The South Carolina Workers' Compensation Commission has jurisdiction over this claim.
3. Venue, set in Goose Creek, South Carolina, is proper.
4. Notice of the hearing was timely and properly served upon all parties in interest.
5. The Claimant's average weekly wage at the time in question was $553.02 and her applicable compensation rate for this claim is $368.70.

APA SUBMISSIONS

In addition to the transcript of Dr. Marzluff's deposition dated March 13, 2013, the following documents were submitted into evidence by the Claimant:

APA #	DESCRIPTION	DATES	PAGES
1	Dr. J. Edward Nolan – Trident Pain Ce	9/4/14-5/28/15	1 – 126
2	Dr. Joseph Marzluff – Trident Medical Center	5/15/12-9/19/12	127 – 161
3	Dr. William Kee – Charleston Psychological Associates	9/22/14	162 – 165
4	Jean R. Hutchinson	6/26/15	166 – 171
5	Addendum – College of Charleston	2/2/15 and 1/28/14	172 – 173

The following documents were submitted into evidence by the Defendants:

6	Carolina Family Medicine	1/24/11—3/9/15	174-222
7	Dr. J. Edward Nolan Trident Pain Center	5/14/13—10/3/14	223-257

8	Dr. J. Morgan Stuart	11/13/13	258-259
9	Select Physical Therapy Functional Capacity Evaluation	3/11/14	260-272
10	Dr. Jeffrey S. Rose	10/8/14—4/15/15	273-282
11	Dr. Dyana Lowndes-Rosen	12/10/14	283-289

EXHIBITS #	DESCRIPTION	DATES	PAGES
12	Employer Records	5/10/11—1/30/15	290-309

STATEMENT OF THE CASE

The Claimant experienced low back pain while assisting a co-worker with a box on December 14, 2011 and was subsequently diagnosed with degenerative changes in her lumbar spine. The Defendants contend that the Claimant reached maximum medical improvement for this injury by February 14, 2014, when her impairment was rated by Dr. Nolan as 23% to the spine. The Defendants seek a determination of the Claimant's entitlement to benefits under S.C. Code Ann. § 42-9-30 commensurate with that rating and the fact that she was able to return to her regular full time job, earning her regular wages. The Defendants request a credit for all temporary total disability paid after the date of maximum medical improvement and claim that the Claimant has not met her burden of proving entitlement to any additional medical treatment under S.C. Code Ann. § 42-15-60.

The Defendants further contend that the Claimant suffered a subsequent intervening injury in September 2014 when she was hospitalized for multiple pulmonary emboli unrelated to her employment. As a result of this subsequent intervening injury, the Claimant was unable to receive injection therapy for her low back and was placed

out of work by Dr. Nolan. The Defendants contend that, despite her low back problem, the Claimant would be working and earning her regular wages but for her subsequent, intervening pulmonary emboli and resulting treatment (anticoagulant therapy), which broke the chain of causation. Therefore, the Defendants deny that the Claimant's current condition, need for medical treatment, or any alleged loss of wage-earning capacity is the responsibility of the Defendants.

The Claimant agrees that she reached maximum medical improvement by February 13, 2014, but alleges she is permanently and totally disabled based on the fact that Defendants were unable to accommodate the new work restrictions she received following her pulmonary embolisms in September 2014. She requests additional medical treatment to include Percocet, Oxycontin, and Tizanidine. (T. p.10).

EVIDENCE SUMMARY

The Claimant testified on her own behalf. She was born in and is a high school graduate. She was previously employed at The Citadel's copy shop for ten (10) years) and at Ideal Printing for ten (10) years before that. At the time in question, the Claimant was employed by the Copy Center at the College of Charleston. She described her duties as answering the phone, greeting customers, collating and binding papers, and some computer work. She admits that she "didn't do that much lifting." (T. p.14).

According to the Claimant, after the accident on December 14, 2011, she underwent a lumbar fusion surgery performed by Dr. Joseph Marzluff. Following surgery, she returned to work at the College's copy shop, where her her work restrictions were accommodated for over two (2) years without incident. The Claimant stopped

working when blood clots in September 2014 prevented her from working full time. (T. p.17).

The Claimant testified that she has pain daily, which she described as a "nagging pain." (T. p.16, lines 9). She claimed that the pain she experiences is in her lower back and sometimes into her right thigh. When she has pain, she testified she has to sit down, or lie down, or take more medication. The Claimant testified that she spends her time doing "odds and ends" around the house. She takes prescription medications and uses a TENS unit. The Claimant testified that she also has a back brace, but she does not use it because it is "uncomfortable."

On cross-examination, the Claimant was confronted with the medical records of her family physician, Dr. Hanna. According to Dr. Hanna's records, the Claimant was being prescribed Percocet, Flexeril, Lortab, and Flector patches prior to the December 14, 2011 accident. (APA p. 179). However, the Claimant testified that she did not recall seeing Dr. Hanna for low back pain despite Dr. Hanna's records documenting complaints of low back pain extending into her right leg. (APA p. 174).

The Claimant admitted that she began having new and different symptoms in her legs in the summer of 2014, including discoloration, swelling, and numbness and she also began experiencing shortness of breath. She was ultimately diagnosed with multiple pulmonary embolisms and was hospitalized for several days. As a result of the pulmonary embolisms, she was placed on anticoagulant therapy, which she still required at the time of the hearing.

Because of the new need for anticoagulant therapy, the Claimant admitted that the treatment for her low back prescribed by Dr. Nolan changed significantly and she was no longer able to receive injection therapy that had helped her in the past. (T. p.23).

The Claimant admitted that none of the treatments she received for her back after the pulmonary embolisms worked as well as the treatment she received before the pulmonary embolisms and she now takes more medication than before. The Claimant also admitted that her back pain increased significantly after the pulmonary embolisms. According to the Claimant, because she was no longer able to have injection therapy for her back, she was taken out of work by Dr. Nolan and restricted to working only four (f) hours a day and four (4) days per week. (T. p.24–25). Prior to the pulmonary emboli, she worked full time, five (5) days per week, despite her low back problem, for more than two (2) years.

Cheryl Connor, manager of the College of Charleston's copy center, testified on behalf of the Defendants. Ms. Connor testified that after the incident on December 14, 2011, she changed the Claimant's job description to ensure that her work restrictions would be accommodated indefinitely. According to Ms. Connor, things changed in September 2014 when the Claimant was diagnosed with the pulmonary embolisms. In fact, as a result of the pulmonary embolisms, the Claimant was out of work from September until December 2014. In December, the Claimant was restricted to working only four (4) hours per day and four (4) days per week. Ms. Connor explained that she could accommodate these restrictions in December because school was in recess, but she could no longer afford a part-time employee as of January 2015. Ms. Connor testified that she was able to accommodate all of the Claimant's physical work restrictions, only the new time restrictions were problematic. Ms. Connor testified that she really worked hard to retain the Claimant as long as possible.

The records of Carolina Family Medicine were submitted into evidence. In addition to detailing the Claimant's prior need for narcotic pain medication and muscle

relaxers, these records reveal that the Claimant was diagnosed with multiple pulmonary embolisms in September 2014 and was suffering from shortness of breath, in addition to the stress of her brother dying from pancreatic cancer. (APA p.205). In November 2014, the Claimant complained to Carolina Family Medicine that she had a new pain in her left lower leg and behind her left knee, which was aggravated by weight bearing, standing, walking, and bending her knee. (APA p.209).

The record also includes the medical reports of Dr. Joseph Marzluff. Dr. Marzluff performed a lumbar fusion at L4-5 for Spondylolisthesis on May 15, 2012. (APA p. 152). Dr. Marzluff released the Claimant at maximum medical improvement on September 19, 2012, at which time he stated that the Claimant had "returned to work on a limited duty bases [sic] and seems to be tolerating that well." (APA p. 160). Dr. Marzluff rated her impairment at "40% of the spine." (APA p. 160). Dr. Marzluff has not evaluated the Claimant since September 2012.

Dr. J. Edward Nolan's records were also submitted into evidence. Dr. Nolan reported on February 13, 2014 that the Claimant "continues to report good pain relief with her injection therapy and medication management and work restrictions." (APA p.8). Dr. Nolan did not speak to whether the Claimant required additional medical treatment to lessen the period of disability and did not issue any statements regarding future medical treatment to a "reasonable degree of medical certainty." As of February 13, 2014, Dr. Nolan stated that the Claimant was at maximum medical improvement and later issued an impairment rating of 23% to the spine.[1] (APA p.126a). In subsequent records, Dr. Nolan noted that the Claimant "returned to work full time with

[1] According to Dr. Nolan, the 23% impairment rating was inclusive of a prior impairment rating issued by Dr. Marzluff on September 19, 2012 (36% of the whole person). (APA p. 126a).

no restrictions on April 11, 2014;" however, on April 23, 2014, he placed restrictions of no lifting greater than fifteen (15) pounds and no standing more than one (1) hour at a time. (APA p. 29). By September 4, 2014, the Claimant rated her pain as a "4/10 overall," despite the fact that she was working full time. (APA p. 58).

According to a statement issued by Dr. Nolan on October 3, 2014, the Claimant had

> *"been hospitalized on 9/17/14 resulting in a diagnosis of pulmonary embolism which will require daily use of an anticoagulant ...The addition of this medication will hinder my ability to continue injection therapy until this issue has resolved. She has received benefit from injection therapy and with treatment she continued to perform her job duties. She presented to my office today and on exam I am concerned about her ability to continue to perform her job as required. In light of this and our inability to resume injection therapy until her pulmonary embolisms are resolved, I recommend that she be placed out of work for a period of two (2) months and her work status will be evaluated at each visit to our office...Several measures have been taken to try to provide her some form of pain relief to include increasing pain medication strength and frequency and adding physical therapy until we are able to resume treatment with injection therapy."* (APA p. 257).

On September 22, 2014, Dr. Nolan had noted that the Claimant was "*not getting as much relief from the Oxycodone IR 5 mg therefore we will ask her to start doubling what she has to 10 mg.*" (APA p.66).

By October 3, 2014, Dr. Nolan noted that, despite doubling her pain medication, *"she is ultimately unable to perform her job duties as required. Due to her inability to receive needed injection therapy until 02/2015 due to pulmonary embolisms we recommended she be placed out of work at this..."* (APA p. 70). In October 2014, Dr. Nolan recommended that the Claimant start physical therapy *"to help with pain relief, particularly during this period of time that she must remain on a blood thinner."* Because of the blood thinner (anticoagulant therapy), the Claimant was also unable to take Percocet, which she felt had helped more than the pain medications she was forced to take after her pulmonary emboli. (APA p. 81). In fact, with the change in her medical treatment necessitated by the pulmonary emboli, the Claimant informed Dr. Nolan that she was having difficulty coping with her pain. In May 2015, Dr. Nolan recommended monthly trigger point injections because the Claimant was *"unable to get injections with Dr. Nolan due to currently being on Xarelto."* (APA p. 120). The Claimant was still taking the anticoagulant medication Xarelto at the time of the hearing.

Findings of Fact

1. On December 14, 2011, Claimant sustained an admitted injury to her lower back within the course and scope of her employment. Based upon the greater weight of the evidence in the record, the December 14, 2011 accident did not result in injury to, or otherwise affect, any other body member or system.

2. Claimant received all appropriate medical care at the direction of the Defendants with Drs. Marzluff and Nolan.

3. Claimant was initially placed at maximum medical improvement by Dr. Marzluff on September 12, 2012, at which time she returned to regular, full-time employment, with

some accommodations pursuant to her restrictions, on August 30, 2012.

4. Claimant began pain management with Dr. Nolan while working full time and continued to do so until September of 2014 when Claimant suffered multiple pulmonary embolisms, which I find were unrelated to her employment and work injury.

5. Prior to Claimant's pulmonary embolisms, Dr. Nolan placed Claimant at maximum medical improvement from a pain management standpoint as of February 13, 2014, with future medical treatment to include injection therapy.

6. I find Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment. This finding is based on the evidence as a whole including, but not limited to, the following:

a. Dr. Nolan increased Claimant's work restrictions as a direct result of her pulmonary embolisms and she is no longer able to work full time, despite doing so for nearly three (3) years after the December 14, 2011 accident. (APAs p. 70 & 257).

b. Claimant's Employer could not accommodate her increased restrictions required by the pulmonary embolisms after having accommodated the prior restrictions for almost three years.

c. Claimant can no longer receive causally-related injection therapy or other medications (Percocet) due to her need for anti-coagulates and as a result of her pulmonary embolisms. Claimant now requires additional medical treatments as a direct result of the pulmonary embolisms and anticoagulant therapy that she did not otherwise require following the December 14, 2011 accident.

7. Claimant also alleges a psychological injury as a result of her original work injury. I

find Claimant has not met her burden of proving a psychological injury causally-related to her original injury. Her claim is not supported by the preponderance of the evidence. Specifically, no physician has opined that Claimant has any disability or work restrictions as a result of any alleged psychological condition. No physician has opined to a reasonable degree of medical certainty that Claimant's alleged psychological condition is causally-related to her original work injury to her lower back. Claimant's personal history, prior medical history, and current unrelated medical conditions have weighed into this finding as well.

8. Claimant is at maximum medical improvement for her December 14, 2011 low back injury as of February 13, 2014 per Dr. Nolan, the authorized pain management physician.

9. Claimant has sustained a 23% permanent loss of use of her back as a result of her work injury. I base this finding on the impairment rating issued by Dr. Nolan, as well as the fact that the Claimant was able to work full time, with her pain well controlled, prior to the pulmonary embolisms in September 2014. Due to Claimant's subsequent, intervening pulmonary embolisms, I find any increase above the permanent impairment would require impermissible surmise, conjecture and/or speculation. Claimant's current condition, subjective complaints, need for medical treatment, and work restrictions have all been significantly increased and aggravated by the subsequent, intervening pulmonary embolisms.

11. Claimant is not entitled to future medical treatment, as none is currently recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury. The record reveals that the Claimant's pain levels and need for medical treatment have increased significantly as a result of her subsequent,

intervening pulmonary embolisms. Dr. Nolan, the Claimant's current treating physician, has not made any future medical recommendations to the requisite "reasonable degree of medical certainty." While Dr. Marzluff previously testified about Claimant's medical treatment, he has not evaluated Claimant since 2012. Claimant's inability to continue injection therapy due to her subsequent, intervening, personal health issues have weighed into this decision as well.

12. Claimant has an average weekly wage of $553.02, which yields a compensation rate of $368.70.

13. Claimant is entitled to a lump-sum award with Utica Mohawk SSA apportionment language.

14. Although Claimant was placed at MMI as of February 13, 2014 by Dr. Nolan, Defendants did not file a Form 21 requesting a credit until November 6, 2014. As such, Defendants are entitled to a credit back to date of the Form 21 filing only.

CONCLUSIONS OF LAW

1. The Claimant sustained an injury to her low back in an accident arising out of and in the course of her employment with the Employer on December 14, 2011. Based upon the greater weight of the evidence in the record, the Claimant did not sustain any injury to, or impairment of, any other body member as a result of that accident and her alleged psychological problems are not causally-related to her accident or low back injury.

2. The Defendants are entitled to terminate temporary total disability benefits pursuant to S.C. Code Ann. § 42-9-260 on the basis that Claimant was released by her authorized treating physician and returned to work in a full time position with the

Employer on August 30, 2012, at which time the period of temporary disability causally-related to the December 14, 2011 accident ended. The greater weight of the evidence indicates that Claimant is currently out of work due to a non-work-related personal health problem (pulmonary embolisms) and; therefore, any loss of wage-earning capacity is not the proximate result of the December 14, 2011 accident.

3. The Defendants are entitled to a credit for overpayment of temporary total disability compensation benefits after the date the Form 21 was filed, November 6, 2014, pursuant to S.C. Code Ann. § 42-9-210.

4. Claimant is not entitled to and the Defendants are not responsible for any benefits under S.C. Code Ann. § 42-9-10 or § 42-9-20 pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007). Claimant was working in her regular, full time position as the assistant manager of the College of Charleston Copy Center for more than two years after the December 14, 2011 accident and; therefore, her back injury was not disabling as a matter of law. Instead, the proximate cause of her loss of wage-earning capacity is the multiple pulmonary embolisms she suffered in September 2014, which aggravated her pre-existing back condition according to Claimant's own treating physician.

5. Claimant is not entitled to and the Defendants are not responsible for any benefits under S.C. Code Ann. § 42-15-60 pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007). Claimant's current subjective complaints and need for medical treatment are not causally-related to the December 14, 2011 accident because the subsequent intervening personal injury (pulmonary embolisms) resulted in increased pain, decreased function, and both changes and increases in medical treatment Claimant receives for her low back. Furthermore, there

is no medical evidence stated to a reasonable degree of medical certainty that the Claimant currently requires any additional medical treatment to lessen the period of disability directly related to the December 14, 2011 accident.

6. Pursuant to S.C. Code Ann. § 42-9-30(21), Claimant is entitled to benefits representing the 23% loss of use of the back causally-related to the December 14, 2011 accident. Claimant is not entitled to and the Defendants are not responsible for any benefits for loss of use of any other body member.

ORDER

IT IS, THEREFORE, HEREBY ORDERED that the Claimant is entitled to and the Defendants are responsible for sixty-nine (69) weeks of compensation at the rate of Three Hundred Sixty-Eight and 70/100s Dollars ($368.70) per week, subject to the Defendant's credit for all benefits paid after November 6, 2014.

IT IS FURTHER ORDERD that the Claimant is not entitled to and the Defendants are not responsible for any additional medical or compensation benefits under the South Carolina Workers' Compensation Act at this time.

IT IS SO ORDERED!

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).
May 17, 2016

By: Renee Smith, Administrative Assistant to Commissioner Taylor

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STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
Patricia Pate, Claimant, -vs- College of Charleston, Employer, and State Accident Fund, Carrier, Defendants,	)	WCC File Number 1121370 **APPELLATE PANEL** **DECISION AND ORDER**

DATE OF REVIEW HEARING:	Hearing held and oral arguments presented in Columbia, S.C. on August 16, 2016.
APPEARANCES:	Claimant represented by Stephen B. Samuels, Esquire, of Samuels Law Firm, LLC, and Max C. Sparwasser, Esquire, of The Max Sparwasser Law Firm, LLC. Employer & Carrier represented by Kirsten L. Barr, Esquire of Trask and Howell, LLC.
DECISION AND ORDER:	by Commissioners Avery B. Wilkerson, Jr., Melody L. James, and Michael R. Campbell, II.

STATEMENT OF THE CASE

This is an appeal from a hearing set on Forms 21, 50 and 51. The Claimant, Patricia Pate, was employed as an assistant manager at the Copy Center at the College of Charleston. Pate suffered an admitted injury by accident to her back on December 14, 2011.

Pate underwent an instrumented lumbar fusion surgery by Dr. Joseph Marzluff on May 15, 2012. [APA page 134]. Pate returned to work at the Copy Center with restrictions following her surgery. Dr. Marzluff assigned a 40% impairment rating to the spine – based on 30% whole person DRE Category V with an additional 10% for chronic pain. [14B]. Dr. Marzluff noted she was suffering from increasing pain and bowel incontinence. He opined "A lot of the problems that she was having were related to the stuff she was doing at work aggravated her back." [Marzluff dep. Page 5, lines 1-13]. Dr. Marzluff recommended future medical treatment on the Form 14B – a recommendation which was amplified with more specificity in his deposition.

Dr. Marzluff retired. Dr. Edward Nolan of the Trident Pain Center took over Pate's long-term pain management on December 17, 2013. He treated Pate with SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, and medications (OxyContin, Percocet and Tizanidine). He also ordered a lumbar back brace. On February 13, 2014, Dr. Nolan opined Pate was at MMI. He opined she would require ongoing palliative treatment including all these modalities. [APA pages 7-8]. Dr. Nolan assigned a 23% whole person rating based on DRE Category IV. [APA page 126(a)].

On April 23, 2014, Dr. Nolan reported:

> [s]he has returned to work full time with no restrictions on 4/11/14 but reports that her pain and anxiety are elevated. She reports that the getting up and down and standing for prolonged periods of time are a major issue. Her FCE showed that she could perform medium work however pt does report that her pain was elevated after the FCE and she cannot do this type of work daily. In order to keep pt working, pt cannot stand more than 1 hour at a time then must sit for at least 2 hours. She may require breaks during these

times to change positions for a short period of time (5-10 minutes). She cannot lift more than 15 pounds. [APA page 29].

Pate continued seeing Dr. Nolan for treatment once a month. Her pain consistently ranged from 5-7 out of 10. She remained on narcotic pain medication and received injections about every two months.

Pate temporarily stopped working on September 15, 2014 when she was hospitalized for a pulmonary embolism. On the last visit before she stopped working, Dr. Nolan noted "Pt was referred for a low back brace 2/21/14 but has yet to receive it. Will again request this from her w/c today as we have already identified that this would be highly beneficial for her during her work hours." Dr. Nolan also noted she was scheduled to see her psychologist, Dr. Kee, for further discussion regarding her depression. [APA page 59].

On September 22, 2014, Pate returned to Dr. Nolan. Dr. Nolan reported:

> Pt has recently been hospitalized for blood clots in the lungs. Will now be on Xarelto [anti-coagulent] for the next 3-6 months. Percocet has been d/c'd however she is not getting as much relief from the Oxycodone IR 5 mg therefore we will ask her to start doubling what she has to 10 mg and provide her with a new prescription at this time. Also pt will not be eligible for injections for the next 3-6 month period. [APA page 66].

On October 23, 2014, Dr. Nolan wrote:

> She states the increase of OxyContin to BID has helped but she is ultimately unable to perform her job duties as required. Due to her inability to receive needed injection therapy until 2/2015 due to pulmonary embolisms we recommend she be placed out of work at this time and a letter will be drafted to this effect. I will continue to monitor her work status at each visit. Medication management and trigger point injections will be her treatment options at this time. [APA page 70].

On November 24, 2014, Dr. Nolan reported:

> She continues to remain out of work per our last letter requesting 2 months out. She reports improvement in ability to cope with pain since she has been out of work. She has provided an accommodation request from her employer which we will complete and send back. At this point, we recommend pt to plan for return to work after 12/03/14 at 4 hours

per day for 2 weeks with accommodations which will be available per her paperwork brought to be filled out today and then we will re-evaluate her work status 2 weeks after that. [APA page 81, 83].

Pate returned to work at the Copy Center with these restrictions on December 4, 2014. Even with the restrictions, she called out on December 5, 12, 16 and 17. [APA page 307].

On December 22, 2014, Dr. Nolan continued the restrictions of 4 hours per day, 4 days per week, with "No bending, squatting or crawling, no lifting greater than 15 pounds, and no pushing or pulling heavy objects." [APA page 93].

On January 21, 2015, Dr. Nolan performed a Caudal Epidural Steroid Injection. This was the first LESI performed since the injections were suspended due to the pulmonary embolisms. [APA pages 96-98].

On February 5, 2015, Dr. Nolan continued Pate on sedentary restrictions of 4 hours per day, 4 days a week. [APA page 101].

The Copy Center ultimately determined it could not accommodate Pate's restrictions. She was placed on LWOP (leave without pay) on January 29, 2015. [APA pages 308-309]. Defendants resumed payment of temporary total disability compensation (TTD) as of that date. [Form 15 2/5/15]. TTD was being paid as of the hearing before Commissioner Taylor.

On November 6, 2014, Defendants filed a Form 21 (Employer's Request for Hearing) based on Dr. Nolan's MMI report of February 13, 2014. Claimant filed a Form 50 on February 3, 2015. The parties were ordered to mandatory mediation, which resulted in an impasse.

The case was tried before Commissioner Aisha Taylor on July 14, 2015. Commissioner Taylor issued a Decision and Order on May 16, 2016.

Claimant timely filed her Form 30 (Notice of Appeal) on May 27, 2016. Oral argument was held on August 16, 2016.

For reasons set forth below, we Affirm in part and Reverse in part with Remand the Single Commissioner's Decision and Order.

ISSUES ON APPEAL

1. Whether the Single Commissioner erred as a matter of fact and law in finding that "Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment."

2. Whether the Single Commissioner erred as a matter of fact and law in denying additional medical treatment when such treatment was necessary to treat Claimant's chronic pain resulting from her surgery.

3. Whether the Single Commissioner erred as a matter of law in holding an Intervening act can break the chain of causation in a workers' compensation claim when there is no legal authority for such a holding.

4. Whether the Single Commissioner erred as a matter of fact and law in denying psychological injury.

5. Whether the Single Commissioner erred as a matter of fact and law in failing to find Claimant permanently and totally disabled.

6. Whether the Single Commissioner erred as a matter of fact and law in awarding 23% permanent loss of use of the back.

7. Whether the Single Commissioner erred as a matter of fact and law in ruling that "any increase above the permanent impairment would require impermissible surmise, conjecture and/or speculation."

8. Whether the Single Commissioner erred as a matter of fact and law in finding "Claimant's current condition, subjective complaints, need for medical treatment, and work restrictions have all been significantly increased and aggravated by the subsequent, intervening pulmonary embolisms."

9. Whether the Single Commissioner erred as a matter of fact and law in ruling "Claimant is not entitled to future medical treatment, as none is recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury."

10. Whether the Single Commissioner erred as a matter of fact and law in ruling "any loss of wage-earning capacity is not the proximate result of the December 14, 2011 accident."

11. Whether the Single Commissioner erred as a matter of law in misapplying Geathers v. 3V, Inc. 371 S.C. 570, 641 S.E.2d 29 (2007) when there was no later injurious exposure nor an intervening "accident."

12. Whether the Single Commissioner erred as a matter of law in denying further medical treatment by erroneously concluding "there is no medical evidence stated to a reasonable degree of medical certainty that the Claimant currently requires any additional medical treatment to lessen the period of disability directly related to the December 14, 2011 accident when it is undisputed that Claimant's need for pain management arises directly out of the work accident.

13. Whether the Single Commissioner erred as a matter of law in limiting the award to the back.

SINGLE COMMISSIONER FINDINGS OF FACT

1. On December 14, 2011, Claimant sustained an admitted injury to her lower back within the course and scope of her employment. Based upon the greater weight of the evidence in the record, the December 14, 2011 accident did not result in injury to, or otherwise affect, any other body member or system.

2. Claimant received all appropriate medical care at the direction of the Defendants with Drs. Marzluff and Nolan.

3. Claimant was initially placed at maximum medical improvement by Dr. Marzluff on September 12, 2012, at which time she returned to regular, full-time employment, with some accommodations pursuant to her restrictions, on August 30, 2012.

4. Claimant began pain management with Dr. Nolan while working full time and continued to do so until September of 2014 when Claimant suffered multiple pulmonary embolisms, which I find were unrelated to her employment and work injury.

5. Prior to Claimant's pulmonary embolisms, Dr. Nolan placed Claimant at maximum medical improvement from a pain management standpoint as of February 13, 2014, with future medical treatment to include injection therapy.

6. I find Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment. This finding is based on the evidence as a whole including, but not limited to, the following:

a. Dr. Nolan increased Claimant's work restrictions as a direct result of her pulmonary embolisms and she is no longer able to work full time, despite doing so for nearly three (3) years after the December 14, 2011 accident. (APA p. 70 & 257).

b. Claimant's Employer could not accommodate her increased restrictions required by the pulmonary embolisms after having accommodated the prior restrictions for almost three years.

c. Claimant can no longer receive causally-related injection therapy or other medications (Percocet) due to her need for anti-coagulates and as a result of her pulmonary embolisms. Claimant now requires additional medical treatments as a direct result of the pulmonary embolisms and anticoagulant therapy that she did not otherwise require following the December 14, 2011 accident.

7. Claimant also alleges a psychological injury as a result of her original work injury. I find Claimant has not met her burden of proving a psychological injury causally-related to her original injury. Her claim is not supported by the preponderance of the evidence. Specifically, no physician has opined that Claimant has any disability or work restrictions as a result of any alleged psychological condition. No physician has opined to a reasonable degree of

medical certainty that Claimant's alleged psychological condition is causally-related to her original work injury to her lower back. Claimant's personal history, prior medical history, and current unrelated medical conditions have weighed into this finding as well.

8. Claimant is at maximum medical improvement for her December 14, 2011 low back injury as of February 13, 2014 per Dr. Nolan, the authorized pain management physician.

9. Claimant has sustained a 23% permanent loss of use of her back as a result of her work injury. I base this finding on the impairment rating issued by Dr. Nolan, as well as the fact that the Claimant was able to work full time, with her pain well controlled, prior to the pulmonary embolisms in September 2014. Due to Claimant's subsequent, intervening pulmonary embolisms, I find any increase above the permanent impairment would require impermissible surmise, conjecture and/or speculation. Claimant's current condition, subjective complaints, need for medical treatment, and work restrictions have all been significantly increased and aggravated by the subsequent, intervening pulmonary embolisms.

11. Claimant is not entitled to future medical treatment, as none is currently recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury. The record reveals that the Claimant's pain levels and need for medical treatment have increased significantly as a result of her subsequent, intervening pulmonary embolisms. Dr. Nolan, the Claimant's current treating physician, has not made any future medical recommendations to the requisite "reasonable degree of medical certainty." While Dr. Marzluff previously testified about Claimant's medical treatment, he has not evaluated Claimant since 2012. Claimant's inability to continue injection therapy due to her subsequent, intervening, personal health issues have weighed into this decision as well.

12. Claimant has an average weekly wage of $553.02, which yields a compensation rate of $368.70.

13. Claimant is entitled to a lump-sum award with Utica Mohawk SSA apportionment language.

14. Although Claimant was placed at MMI as of February 13, 2014 by Dr. Nolan, Defendants did not file a Form 21requesting a credit until November 6, 2014. As such, Defendants are entitled to a credit back to date of the Form 21filing only.

SINGLE COMMISSIONER CONCLUSIONS OF LAW

1. The Claimant sustained an injury to her low back in an accident arising out of and in the course of her employment with the Employer on December 14, 2011. Based upon the greater weight of the evidence in the record, the Claimant did not sustain any injury to, or impairment of, any other body member as a result of that accident and her alleged psychological problems are not causally-related to her accident or low back injury.

2. The Defendants are entitled to terminate temporary total disability benefits pursuant to S.C. Code Ann. § 42-9-260 on the basis that Claimant was released by her authorized treating physician and returned to work in a full time position with the Employer on August 30, 2012, at which time the period of temporary disability causally-related to the December 14, 2011 accident ended. The greater weight of the evidence indicates that Claimant is currently out of work due to a non-work-related personal health problem (pulmonary embolisms) and; therefore, any loss of wage-earning capacity is not the proximate result of the December 14, 2011 accident.

3. The Defendants are entitled to a credit for overpayment of temporary total disability compensation benefits after the date the Form 21was filed, November 6, 2014, pursuant to S.C. Code Ann.§ 42-9-210.

4. Claimant is not entitled to and the Defendants are not responsible for any benefits under S.C. Code Ann. § 42-9-10 or§ 42-9-20 pursuant to the Supreme Court's holding in Geathers v. 3V. Inc., 371S.C. 570, 641S.E.2d 29 (2007). Claimant was working in her regular, full time position as the assistant manager of the College of Charleston Copy Center for more than two years after the December 14, 2011 accident and; therefore, her back injury was not disabling as a matter of law. Instead, the proximate cause of her loss of wage-earning capacity is the multiple pulmonary embolisms she suffered in September 2014, which aggravated her pre-existing back condition according to Claimant's own treating physician.

5. Claimant is not entitled to and the Defendants are not responsible for any benefits under S.C. Code Ann. § 42-15-60 pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371S.C. 570, 641S.E.2d 29 (2007). Claimant's current subjective complaints and need for medical treatment are not causally-related to the December 14, 2011 accident because the subsequent intervening personal injury (pulmonary embolisms) resulted in increased pain, decreased function, and both changes and increases in medical treatment Claimant receives for her low back. Furthermore, there is no medical evidence stated to a reasonable degree of medical certainty that the Claimant currently requires any additional medical treatment to lessen the period of disability directly related to the December 14, 2011 accident.

6. Pursuant to S.C. Code Ann. § 42-9-30(21), Claimant is entitled to benefits representing the 23% loss of use of the back causally-related to the December 14, 2011 accident.

Claimant is not entitled to and the Defendants are not responsible for any benefits for loss of use of any other body member.

APPELLATE PANEL FINDINGS OF FACT

Based on the preponderance of the evidence, the panel makes the following findings of fact: different from proposed

1. On December 14, 2011, Claimant sustained an admitted injury to her lower back within the course and scope of her employment. Based on the greater weight of the evidence in the record, the December 14, 2011 accident did not result in injury to, or otherwise affect any other body member of system. This finding of the Single Commissioner is affirmed.

2. Claimant received appropriate medical care at the direction of the Defendants with Drs. Marzluff and Nolan. The medical care tended to lessen her degree of disability.

3. Claimant was initially placed at maximum medical improvement by Dr. Marzluff on September 12, 2012, at which time she returned to regular, full-time employment, with some accommodations pursuant to her restrictions, on August 30, 2012.

4. Claimant began pain management on May 14, 2013 with Dr. Nolan while working full time in an accommodated position with the Employer.

5. Pate temporarily stopped working on September 15, 2014 when she was hospitalized for a pulmonary embolism. We affirm the Single Commissioner's Finding that the pulmonary embolism is unrelated to her employment and work injury.

6. On February 13, 2014, Dr. Nolan opined Pate was at MMI. He treated Pate with SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, and

medications (OxyContin, Percocet and Tizanidine). He also ordered a lumbar back brace. He opined she would require ongoing palliative treatment including all these modalities. [APA pages 7-8]. Dr. Nolan assigned a 23% whole person rating based on DRE Category IV. [APA page 126(a)].

7. We reverse the Single Commissioner's finding that "Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment." The reversal of the Single Commissioner's finding is based on the evidence as a whole with particular emphasis on the medical records and events following the development of the blood clots.

8. Claimant also alleges a psychological injury as a result of her original work injury. We find that the Claimant has not met her burden of proving a psychological injury causally-related to her original injury. Her claim is not supported by the preponderance of the evidence. Specifically, no physician has opined that Claimant has any disability or work restrictions as a result of any alleged psychological condition. No physician has opined to a reasonable degree of medical certainty that Claimant's alleged psychological condition is causally-related to her original work injury to her lower back. Claimant's personal history, prior medical history, and current unrelated medical conditions have weighed into this finding as well.

9. We reverse and remand the Single Commissioner's finding that "Claimant has sustained a 23% permanent loss of use of her back as a result of her work injury." It was legal error of the Single Commissioner to conclude that the pulmonary embolisms were an intervening accident or intervening accident. The pulmonary embolisms did not and could not constitute an intervening accident or intervening cause as a matter of law. See McMahan v. S.C. Dept. of Education-Transportation, Op. No. 5415 (S.C.Ct.App. filed June 15, 2016)(Shearouse Adv.Sh.

No. 24 at 56). We note the Single Commissioner did not have the benefit of the McMahan case which was released after the Decision and Order in this case.

10. We reverse the Single Commissioner's Finding that "Claimant is not entitled to future medical treatment, as none is currently recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury." As noted above, the pulmonary embolisms are not a subsequent intervening cause. The matter is to be remanded to the Single Commissioner to address what, if any, future medical is causally related pursuant to the Act.

11. Claimant has an average weekly wage of $553.02, which yields a compensation rate of $368.70.

12. Claimant is entitled to a lump-sum award with James apportionment language. The jurisdictional Commissioner on remand is to make this determination. Claimant will be given leave to submit a supplemental order with an approved Form 61 which is to be incorporated into the Single Commissioner's order by reference.

13. We affirm the Single Commissioner's finding that "Although Claimant was placed at MMI as of February 13, 2014 by Dr. Nolan, Defendants did not file a Form 21 requesting a credit until November 6, 2014. As such, Defendants are entitled to a credit back to date of the Form 21 filing only."

14. This matter is remanded to the jurisdictional commissioner for a determination of causally related disability and for a determination of what, if any, medical treatment is causally related and should be awarded pursuant to the Act.

APPELLATE PANEL CONCLUSIONS OF LAW

15. We reverse the Single Commissioner's legal conclusion that "Claimant is not entitled to and the Defendants are not responsible for any benefits under S.C. Code Ann. § 42-15-60 pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371S.C. 570, 641S.E.2d 29 (2007)."

16. The pulmonary embolus is not a subsequent intervening cause sufficient to break the chain of causation. It was error of the Single Commissioner to deny ongoing medical treatment and disability compensation under the theory that the pulmonary embolus was an intervening cause. The general rule is "Every natural consequence that flows from a work-related compensable injury is also compensable unless the consequence is the result of an independent, intervening cause sufficient to break the chain of causation." Whitfield v. Daniel Constr. Co., 226 S.C. 37, 40-41, 83 S.E.2d 460, 462 (1954).

The case law consistently requires an intervening cause to be a subsequent accident attributable to the claimant's own intentional conduct. See, e.g. Tims v. J.D. Kitts Constr., 393 S.C. 496, 713 S.E.2d 340 (Ct. App. 2011)(rejecting argument that heatstroke suffered by quadriplegic from being left in his caregiver's car was an independent intervening cause because "neither Claimant's decision to ride in his caregiver's car nor his caregiver's negligence was an independent, intervening cause sufficient to break the chain of causation."), citing 1 Arthur Larson & Lex K. Larson, Larson's Workers' Compensation Law § 10.01, 10-1 (2010) (stating that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment, unless it is the result of an independent, intervening cause attributable to the claimant's own intentional conduct).

17. The principle applying to this case is "that a nonwork-related condition is not a superseding, intervening event that breaks the causal connection between a work-related injury and a claimant's disability."[1] Brockel v. N.D. Workforce Safety & Ins., 843 N.W.2d 15, 23-24 (N.D. 2014). The rule was followed in South Carolina in Orr v. Elastomeric Prods., 323 S.C. 342, 474 S.E.2d 448 (Ct. App.1996). In Orr, the claimant unexpectedly became pregnant following back surgery for her injury. Due to the pregnancy, she was unable to participate in physical therapy, spurring the carrier to seek to suspend her compensation. The Court of Appeals rejected this argument, reasoning "The fact that Orr's pregnancy indirectly prolonged the period during which she was unemployable does not change the fact that her injury, not her pregnancy, rendered her unable to work." Id. at 449 (emphasis added).

18. The ruling below regarding Geathers has no support in the law and is an erroneous misapplication of Geathers. In Geathers, the Supreme Court adopted the "last injurious exposure rule." The last injurious exposure rule:

> places full liability upon the carrier covering the risk at the time of the most recent injury that bears a causal relation to the disability. Consistent with the rule that an employer takes its employee as it finds her, the last injurious exposure rule makes the insurer at risk at the time of the second injury liable even if the second injury would have been much less severe in the absence of the prior condition and even if the prior injury significantly contributed to the final condition.

Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007).

The last injurious exposure rule is simply a rule to avoid apportionment and put liability on the carrier covering the most recent injury. It has no application to the facts of this case. It cannot

[1] A majority of jurisdictions – including South Carolina – follow this rule. See, e.g., Thurston v. Guys With Tools, Ltd., 217 P.3d 824 (Alaska 2009); Moore v. Component Assembly Sys., 158 Md.App. 388, 857 A.2d 549 (2004); Schock v. Morristown Mem'l Hosp./Atlantic Health Sys., 2010 WL 2793949 *6 (N.J.Super.A.D. July 2, 2010); Thomas v. Burggraf Restoration, 31 P.3d 402 (Okla.Ct.Civ.App.2001); Workmen's Comp. Appeal Bd. v. Chamberlain Mfg. Corp., 336 A.2d 659 (1975); Orr v. Elastomeric Prods., 323 S.C. 342, 474 S.E.2d 448 (Ct.App.1996); Wood v. Fletcher Allen Health Care, 739 A.2d 1201 (1999)..

be used as a means to deny further benefits when there is no subsequent carrier nor any later injurious exposure. There is no second accident in this case.

ORDER

IT IS THEREFORE ORDERED that the Decision and Order of the Single Commissioner is Affirmed in part, Reversed in part, and Remanded;

IT IS FURTHER ORDERED that the findings and conclusions of the Single Commissioner that the pulmonary embolisms are an intervening accident are reversed.

IT IS FURTHER ORDERED that this case is remanded to the Single Commissioner to determine the compensation due for Claimant's causally related permanent disability and causally related medical treatment pursuant to the Act consistent with the findings of fact and conclusions of law herein.

AND IT IS SO ORDERED.

Commissioner Melody L. James
Appellate Panel Chair

WE CONCUR:

Commissioner R. Michael Campbell, II

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 Eugenia Hollmon on December 22, 2016

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO.: 1121370

Patricia Pate, Claimant, v. University of Charleston, Employer, and SC State Accident Fund, Carrier, Defendants,	**CONSENT ORDER**

The Parties agree that under Bone the Appellate Panel's Orders are not immediately appealable, as the interlocutory order remanded the case to the jurisdictional commissioner for further findings of fact.

It is therefore ordered that this case is not immediately appealable as the order is interlocutory. The parties cannot immediately appeal the Appellate Panel's orders and retain the right to appeal any preserved issues following the issuance of an order on remand by the jurisdictional commissioner.

AND SO IT IS ORDERED.

Jurisdictional Commissioner

March 15th, 2017
Columbia, South Carolina

AGREED AS SET FORTH ABOVE:

BY: Kirsten L. Barr

TRASK & HOWELL, LLC
Kirsten L. Barr, Esquire
Counsel for Defendants
Post Office Box 2167
Mt. Pleasant, SC 29465

BY:

SAMUELS LAW FIRM, LLC
Stephen B. Samuels, Esquire
Counsel for Claimant
1320 Richland Street
Columbia, SC 29201

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 rgsmith on March 16, 2017

STATE OF SOUTH CAROLINA) COUNTY OF CHARLESTON	)	BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
Patricia Pate, Claimant, -vs- College of Charleston, Employer, and State Accident Fund, Carrier, Defendants,	)	WCC File Number 1121370 **DECISION AND ORDER ON REMAND**

DATE OF REVIEW: Pursuant to Remand from the Appellate Panel's Decision and Order filed December 22, 2016.

APPEARANCES: Claimant represented by Stephen B. Samuels, Esquire, of Samuels Law Firm, LLC, and Max C. Sparwasser, Esquire, of The Max Sparwasser Law Firm, LLC. Employer & Carrier represented by Kirsten L. Barr, Esquire, of Trask and Howell, LLC.

DECISION AND ORDER: By Commissioner Aisha Taylor.

STATEMENT OF THE CASE

This case came before the undersigned on a Decision and Order of the Appellate Panel remanding the case "to the Single Commissioner to determine the compensation due for Claimant's causally related permanent disability and causally related medical treatment pursuant to the Act consistent with the findings of fact and conclusions of law herein."

APPELLATE PANEL FINDINGS OF FACT

The following findings of fact made by the Appellate Panel are hereby incorporated into this Decision and Order:

1. On December 14, 2011, Claimant sustained an admitted injury to her lower back within the course and scope of her employment. Based on the greater weight of the evidence in the record, the December 14, 2011 accident did not result in injury to, or otherwise affect, any other body member or system. This finding of the Single Commissioner is affirmed.

2. Claimant received appropriate medical care at the direction of the Defendants with Drs. Marzluff and Nolan. The medical care tended to lessen her degree of disability.

3. Claimant was initially placed at maximum medical improvement by Dr. Marzluff on September 12, 2012, at which time she returned to regular, full-time employment, with some accommodations pursuant to her restrictions, on August 30, 2012.

4. Claimant began pain management on May 14, 2013 with Dr. Nolan while working full time in an accommodated position with the Employer.

5. Pate temporarily stopped working on September 15, 2014 when she was hospitalized for a pulmonary embolism. We affirm the Single Commissioner's Finding that the pulmonary embolism is unrelated to her employment and work injury.

6. On February 13, 2014, Dr. Nolan opined Pate was at MMI. He treated Pate with SI

joint injections, trigger point injections, epidural steroid injections, a TENS unit, and medications (OxyContin, Percocet and Tizanidine). He also ordered a lumbar back brace. He opined she would require ongoing palliative treatment including all these modalities. [APA pages 7-8]. Dr. Nolan assigned a 23% whole person rating based on DRE Category IV. [APA page 126(a)].

7. We reverse the Single Commissioner's finding that "Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment." The reversal of the Single Commissioner's finding is based on the evidence as a whole with particular emphasis on the medical records and events following the development of the blood clots.

8. Claimant also alleges a psychological injury as a result of her original work injury. We find that Claimant has not met her burden of proving a psychological injury causally-related to her original injury. Her claim is not supported by the preponderance of the evidence. Specifically, no physician has opined that Claimant has any disability or work restrictions as a result of any alleged psychological condition. No physician has opined to a reasonable degree of medical certainty that Claimant's alleged psychological condition is causally-related to her original work injury to her lower back. Claimant's personal history, prior medical history, and current unrelated medical conditions have weighed into this finding as well.

9. We reverse and remand the Single Commissioner's Finding that "Claimant has sustained a 23% permanent loss of use of her back as a result of her work injury." It was legal error of the Single Commissioner to conclude "Due to Claimant's subsequent, intervening pulmonary embolisms, I find any increase above the permanent impairment would require impermissible surmise, conjecture and/or speculation. Claimant's current condition, subjective complaints, need for medical treatment, and work restrictions have all been significantly increased

and aggravated by the subsequent, intervening pulmonary embolisms." The pulmonary embolisms did not and could not constitute an intervening accident or intervening cause as a matter of law. See McMahan v. S.C. Dept. of Education-Transportation, Op. No. 5415 (S.C.Ct.App. filed June 15, 2016)(Shearouse Adv.Sh. No. 24 at 56). We note the Single Commissioner did not have the benefit of the McMahan case which was released after the Decision and Order in this case. Moreover, as there is no evidence that Claimant's condition, complaints, medical treatment and work restrictions were increased and aggravated by the pulmonary embolisms, the finding was based on speculation.

10. We reverse the Single Commissioner's Finding that "Claimant is not entitled to future medical treatment, as none is currently recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury." As noted above, the pulmonary embolisms are not a subsequent intervening cause. The matter is to be remanded to the Single Commissioner to address what, if any, future medical is causally related pursuant to the Act.

11. Claimant has an average weekly wage of $553.02, which yields a compensation rate of $368.70.

12. Claimant is entitled to a lump-sum award with James apportionment language. The jurisdictional Commissioner on remand is to make this determination. Claimant will be given leave to submit a supplemental order with an approved Form 61 which is to be incorporated into the Single Commissioner's order by reference.

13. We affirm the Single Commissioner's finding that "Although Claimant was placed at MMI as of February 13, 2014 by Dr. Nolan, Defendants did not file a Form 21 requesting a credit until November 6, 2014. As such, Defendants are entitled to a credit back to date of the Form

21filing only."

14. This matter is remanded to the jurisdictional commissioner for a determination of causally related disability and for a determination of what, if any, medical treatment is causally related and should be awarded pursuant to the Act.

ADDITIONAL FINDINGS OF FACT

Pursuant to the instructions on remand of the Appellate Panel, the following **ADDITIONAL FINDINGS OF FACT** are made:

1. This is a single-member injury affecting Claimant's lower back only. As such, Claimant's requests for benefits is limited to S.C. code Ann. Section 42-9-30 (21).

2. I find Claimant has sustained 40% permanent partial disability as a result of her work injury. This finding is based on the evidence as a whole including Dr. Nolan's permanent impairment rating of 23% to the lumbar spine issued on March 10, 2014 as well as Claimant's work restrictions at the time of separation from her employer which included working 4 hours per day for 4 days per week, with specific restrictions of no bending, squatting, or crawling; no lifting greater than 15 pounds, and no pushing or pulling heavy objects. (Claimant's APA p. 93).

3. Claimant is entitled to future medical treatment to include SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, pain medications (currently OxyContin, Percocet, and Tizanidine). Claimant is also entitled to a lumbar back brace as prescribed by Dr. Nolan. Claimant's future medical treatment is to be provided by Dr. Nolan or another physician authorized by Defendants to carry out the medical award in this matter.

APPELLATE PANEL CONCLUSIONS OF LAW

The following conclusions of law made by the Appellate Panel are hereby incorporated into this Decision and Order:

15. We reverse the Single Commissioner's legal conclusion that "Claimant is not entitled to and the Defendants are not responsible for any benefits under S.C. Code Ann. § 42-9-10 or§ 42-9-20 pursuant to the Supreme Court's holding in Geathers v. 3V. Inc., 371S.C. 570, 641S.E.2d 29 (2007)."

16. The pulmonary embolus is not a subsequent intervening cause sufficient to break the chain of causation. It was error of the Single Commissioner to deny ongoing medical treatment and disability compensation under the theory that the pulmonary embolus was an intervening cause. The general rule is "Every natural consequence that flows from a work-related compensable injury is also compensable unless the consequence is the result of an independent, intervening cause sufficient to break the chain of causation." Whitfield v. Daniel Constr. Co., 226 S.C. 37, 40-41, 83 S.E.2d 460, 462 (1954).

The case law consistently requires an intervening cause to be a subsequent accident attributable to the claimant's own intentional conduct. See, e.g. Tims v. J.D. Kitts Constr., 393 S.C. 496, 713 S.E.2d 340 (Ct. App. 2011)(rejecting argument that heatstroke suffered by quadriplegic from being left in his caregiver's car was an independent intervening cause because "neither Claimant's decision to ride in his caregiver's car nor his caregiver's negligence was an independent, intervening cause sufficient to break the chain of causation."), *citing* 1 Arthur Larson & Lex K. Larson, Larson's Workers' Compensation Law § 10.01, 10-1 (2010) (stating that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment, unless it is the result

of an independent, intervening cause attributable to the claimant's own intentional conduct).

17. The principle applying to this case is "that a nonwork-related condition is not a superseding, intervening event that breaks the causal connection between a work-related injury and a claimant's disability."[1] Brockel v. N.D. Workforce Safety & Ins., 843 N.W.2d 15, 23-24 (N.D. 2014). The rule was followed in South Carolina in Orr v. Elastomeric Prods., 323 S.C. 342, 474 S.E.2d 448 (Ct. App.1996). In Orr, the claimant unexpectedly became pregnant following back surgery for her injury. Due to the pregnancy, she was unable to participate in physical therapy, spurring the carrier to seek to suspend her compensation. The Court of Appeals rejected this argument, reasoning "The fact that Orr's pregnancy indirectly prolonged the period during which she was unemployable does not change the fact that *her injury, not her pregnancy, rendered her unable to work.*" Id. at 449 (emphasis added).

18. The ruling below regarding Geathers has no support in the law and is an erroneous misapplication of Geathers. In Geathers, the Supreme Court adopted the "last injurious exposure rule." The last injurious exposure rule:

> places full liability upon the carrier covering the risk at the time of the most recent injury that bears a causal relation to the disability. Consistent with the rule that an employer takes its employee as it finds her, the last injurious exposure rule makes the insurer at risk at the time of the second injury liable even if the second injury would have been much less severe in the absence of the prior condition and even if the prior injury significantly contributed to the final condition.

Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007).

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[1]A majority of jurisdictions – including South Carolina – follow this rule. See, e.g., Thurston v. Guys With Tools, Ltd., 217 P.3d 824 (Alaska 2009); Moore v. Component Assembly Sys., 158 Md.App. 388, 857 A.2d 549 (2004); Schock v. Morristown Mem'l Hosp./Atlantic Health Sys., 2010 WL 2793949 *6 (N.J.Super.A.D. July 2, 2010); Thomas v. Burggraf Restoration, 31 P.3d 402 (Okla.Ct.Civ.App.2001); Workmen's Comp. Appeal Bd. v. Chamberlain Mfg. Corp., 336 A.2d 659 (1975); Orr v. Elastomeric Prods., 323 S.C. 342, 474 S.E.2d 448 (Ct.App.1996); Wood v. Fletcher Allen Health Care, 739 A.2d 1201 (1999).

The last injurious exposure rule is simply a rule to avoid apportionment and put liability on the carrier covering the most recent injury. It has no application to the facts of this case. It cannot be used as a means to deny further benefits when there is no subsequent carrier nor any later injurious exposure. There is no second accident in this case.

ADDITIONAL CONCLUSION OF LAW

Pursuant to the instructions on remand of the Appellate Panel, the following **ADDITIONAL CONCLUSION OF LAW** is made:

19. An order reversed on appeal is a nullity. See Tolbert v. Fouche, 123 S.E. 859 (SC 1924). The original order of the Single Commissioner provided that Defendants were not liable for providing ongoing treatment. As that order was reversed by the Appellate Panel, it is a nullity – as if it never existed. Accordingly, Defendants are liable for paying for causally related treatment incurred by Claimant prior to this order to be paid pursuant to the South Carolina Workers' Compensation Fee Schedule. Claimant is entitled to reimbursement for any and all causally-related out of pocket expenses incurred during this time.

ORDER

IT IS THEREFORE ORDERED that the Claimant is entitled to a lump sum award for permanent partial disability of 120 weeks based on a loss of use of 40% of the back which shall be apportioned over Claimant's life expectancy pursuant to James v. Anne's;

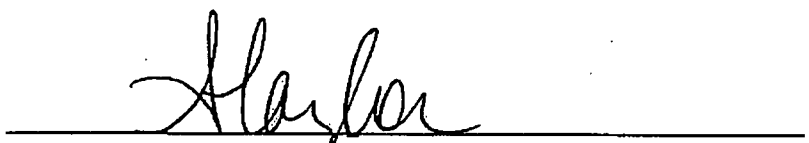
IT IS FURTHER ORDERED that Claimant is entitled to causally-related future medical treatment pursuant to Section 42-15-60 to include SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, pain medications (currently OxyContin, Percocet, and Tizanidine). Claimant is also entitled to a lumbar back brace as prescribed by Dr. Nolan. Claimant's future medical treatment is to be provided by Dr. Nolan or another physician authorized

by Defendants to carry out the medical award in this matter.

IT IS FURTHER ORDERED that the Defendants shall pay for causally-related medical expense incurred during the period the Single Commissioner's order was in effect and no treatment was authorized pursuant to the South Carolian Workers' Compensation Fee Schedule. Claimant is entitled to reimbursement for any and all causally related out-of-pocket expenses incurred during this same period.

AND IT IS SO ORDERED.

May 22, 2018



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.
May 24, 2018

By: Renee Smith, Administrative Assistant to Commissioner Taylor

BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION'S APPELLATE PANEL

Patricia Pate v. Employee/Claimant, Appellant -vs- College of Charleston, Employer, and State Accident Fund Carrier, Respondents.	W.C.C. FILE NO. 1121370 **DECISION & ORDER FOLLOWING REMAND**

STATEMENT OF THE CASE

The Claimant experienced low back pain while assisting a co-worker with a box on December 14, 2011, and was diagnosed with degenerative changes in her lumbar spine. A hearing was held before Commissioner Aisha Taylor on July 14, 2015, to determine issues as set forth in the Form 21 and Forms 50 and 51. The Defendants contended that the Claimant reached maximum medical improvement ("MMI") for this injury by February 14, 2014, when she was assigned a 23% impairment rating to the spine by Dr. Nolan. They also sought a determination of the Claimant's entitlement to benefits under S.C. Code Ann. § 42-9-30 pursuant to the impairment rating and the fact that she was able to return to her regular full time job, earning her regular wages. The Defendants sought a credit for all temporary total disability paid after the date of MMI. Furthermore, the Defendants contended that the Claimant had not met her burden of

proving entitlement to any additional medical treatment under S.C. Code Ann. § 42-15-60.

The Defendants further contended that the Claimant had a subsequent intervening injury in September 2014, when she was hospitalized for multiple pulmonary emboli, which was unrelated to her employment. Due to the subsequent intervening injury, she was unable to receive injection therapy for her low back and was placed out of work by Dr. Nolan. Accordingly, the Defendants argued that the Claimant would be working and earning her regular wages despite her low back issues, but for her subsequent intervening pulmonary emboli and resulting treatment, which broke the chain of causation. Thus, the Defendants denied that the Claimant's current condition, need for medical treatment, or any alleged loss of wage-earning capacity was the responsibility of the Defendants.

The Claimant agreed that she reached MMI by February 13, 2014. However, she alleged permanent and total disability because the Defendants were unable to accommodate the new work restrictions she received following the pulmonary embolisms in September 2014. Lastly, the Claimant requested additional medical treatment.

Commissioner Taylor filed the Decision and Order on May 16, 2016, issuing the following:

Findings of Fact

1. On December 14, 2011, Claimant sustained an admitted injury to her lower back within the course and scope of her employment. Based upon the greater weight of the evidence in the record, the December 14, 2011 accident did not result in injury to, or otherwise affect, any other body member or system.

2. Claimant received all appropriate medical care at the direction of the Defendants with Drs. Marzluff and Nolan.

3. Claimant was initially placed at maximum medical improvement by Dr. Marzluff on September 12, 2012, at which time she returned to regular, full-time employment, with some accommodations pursuant to her restrictions, on August 30, 2012.

4. Claimant began pain management with Dr. Nolan while working full time and continued to do so until September of 2014 when Claimant suffered multiple pulmonary embolisms, which I find were unrelated to her employment and work injury.

5. Prior to Claimant's pulmonary embolisms, Dr. Nolan placed Claimant at maximum medical improvement from a pain management standpoint as of February 13, 2014, with future medical treatment to include injection therapy.

6. I find Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment. This finding is based on the evidence as a whole including, but not limited to, the following:

   a. Dr. Nolan increased Claimant's work restrictions as a direct result of her pulmonary embolisms and she is no longer able to work full time, despite doing so for nearly three (3) years after the December 14, 2011 accident. (APAs p. 70 & 257).

   b. Claimant's Employer could not accommodate her increased restrictions required by the pulmonary embolisms after having accommodated the prior restrictions for almost three years.

   c. Claimant can no longer receive causally-related injection therapy or other medications (Percocet) due to her need for anti-coagulates and as a result of her pulmonary embolisms. Claimant now requires additional medical treatments as a direct result of the pulmonary embolisms and anticoagulant therapy that she did not otherwise require following the December 14, 2011 accident.

7. Claimant also alleges a psychological injury as a result of her original work injury. I find Claimant has not met her burden of proving a psychological injury causally-related to her original injury. Her claim is not supported by the preponderance of the evidence. Specifically, no physician has opined that Claimant has any disability or work restrictions as a result of any alleged psychological condition. No physician has opined to a reasonable degree of medical certainty that Claimant's alleged psychological condition is causally-related to her original work injury to her lower back. Claimant's personal history, prior medical history, and current unrelated medical conditions have weighed into this finding as well.

8. Claimant is at maximum medical improvement for her December 14, 2011 low back injury as of February 13, 2014 per Dr. Nolan, the authorized

pain management physician.

9. Claimant has sustained a 23% permanent loss of use of her back as a result of her work injury. I base this finding on the impairment rating issued by Dr. Nolan, as well as the fact that the Claimant was able to work full time, with her pain well controlled, prior to the pulmonary embolisms in September 2014. Due to Claimant's subsequent, intervening pulmonary embolisms, I find any increase above the permanent impairment would require impermissible surmise, conjecture and/or speculation. Claimant's current condition, subjective complaints, need for medical treatment, and work restrictions have all been significantly increased and aggravated by the subsequent, intervening pulmonary embolisms.

11. Claimant is not entitled to future medical treatment, as none is currently recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury. The record reveals that the Claimant's pain levels and need for medical treatment have increased significantly as a result of her subsequent, intervening pulmonary embolisms. Dr. Nolan, the Claimant's current treating physician, has not made any future medical recommendations to the requisite "reasonable degree of medical certainty." While Dr. Marzluff previously testified about Claimant's medical treatment, he has not evaluated Claimant since 2012. Claimant's inability to continue injection therapy due to her subsequent, intervening, personal health issues have weighed into this decision as well.

12. Claimant has an average weekly wage of $553.02, which yields a compensation rate of $368.70.

13. Claimant is entitled to a lump-sum award with Utica Mohawk SSA apportionment language.

14. Although Claimant was placed at MMI as of February 13, 2014 by Dr. Nolan, Defendants did not file a Form 21 requesting a credit until November 6, 2014. As such, Defendants are entitled to a credit back to date of the Form 21 filing only.

CONCLUSIONS OF LAW

1. The Claimant sustained an injury to her low back in an accident arising out of and in the course of her employment with the Employer on December 14, 2011. Based upon the greater weight of the evidence in the record, the Claimant did not sustain any injury to, or impairment of, any other body member as a result of that accident and her alleged psychological problems are not causally-related to her accident or low back injury.

2. The Defendants are entitled to terminate temporary total disability benefits pursuant to S.C. Code Ann. § 42-9-260 on the basis that Claimant

was released by her authorized treating physician and returned to work in a full time position with the Employer on August 30, 2012, at which time the period of temporary disability causally-related to the December 14, 2011 accident ended. The greater weight of the evidence indicates that Claimant is currently out of work due to a non-work-related personal health problem (pulmonary embolisms) and; therefore, any loss of wage-earning capacity is not the proximate result of the December 14, 2011 accident.

3. The Defendants are entitled to a credit for overpayment of temporary total disability compensation benefits after the date the Form 21 was filed, November 6, 2014, pursuant to S.C. Code Ann. § 42-9-210.

4. Claimant is not entitled to and the Defendants are not responsible for any benefits under S.C. Code Ann. § 42-9-10 or § 42-9-20 pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007). Claimant was working in her regular, full time position as the assistant manager of the College of Charleston Copy Center for more than two years after the December 14, 2011 accident and; therefore, her back injury was not disabling as a matter of law. Instead, the proximate cause of her loss of wage-earning capacity is the multiple pulmonary embolisms she suffered in September 2014, which aggravated her pre-existing back condition according to Claimant's own treating physician.

5. Claimant is not entitled to and the Defendants are not responsible for any benefits under S.C. Code Ann. § 42-15-60 pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007). Claimant's current subjective complaints and need for medical treatment are not causally-related to the December 14, 2011 accident because the subsequent intervening personal injury (pulmonary embolisms) resulted in increased pain, decreased function, and both changes and increases in medical treatment Claimant receives for her low back. Furthermore, there is no medical evidence stated to a reasonable degree of medical certainty that the Claimant currently requires any additional medical treatment to lessen the period of disability directly related to the December 14, 2011 accident.

6. Pursuant to S.C. Code Ann. § 42-9-30(21), Claimant is entitled to benefits representing the 23% loss of use of the back causally-related to the December 14, 2011 accident. Claimant is not entitled to and the Defendants are not responsible for any benefits for loss of use of any other body member.

ORDER

IT IS, THEREFORE, HEREBY ORDERED that the Claimant is entitled to and the Defendants are responsible for sixty-nine (69) weeks of compensation at the rate of Three Hundred Sixty-Eight and 70/100s Dollars

($368.70) per week, subject to the Defendant's credit for all benefits paid after November 6, 2014.

IT IS FURTHER ORDERD that the Claimant is not entitled to and the Defendants are not responsible for any additional medical or compensation benefits under the South Carolina Workers' Compensation Act at this time.

IT IS SO ORDERED!

Within the statutory period, on May 27, 2016, the Claimant/Appellant filed a Form 30 Request for Commission Review in the case setting forth thirteen (13) grounds for appeal. Such, together with all documentary evidence, was delivered by oral argument to the individual members of the Appellate Panel.

In her first Form 30 Application for Review dated May 27, 2016, the Claimant/Appellant raised the following issues:

1. *Whether the Single Commissioner erred as a matter of fact and law in finding tha*[sic] *"Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment."*

2. *Whether the Single Commissioner erred as a matter of fact and law in denying additional medical treatment when such treatment was necessary to treat Claimant's chronic pain resulting from her surgery.*

3. *Whether the Single Commissioner erred as a matter of law in holding an intervening act can break the chain of causation in a workers' compensation claim when there is no legal authority for such a holding.*

4. *Whether the Single Commissioner erred as a matter of fact and law in denying psychological injury.*

5. *Whether the Single Commissioner erred as a matter of fact and law in failing to find Claimant permanently and totally disabled.*

6. *Whether the Single Commissioner erred as a matter of fact and law in awarding 23% permanent loss of use of the back.*

7. *Whether the Single Commissioner erred as a matter of fact and law in ruling that "any increase above the permanent impairment would require impermissible surmise, conjecture and/or speculation."*

8. *Whether the Single Commissioner erred as a matter of fact and law in finding "Claimant's current condition, subjective complaints, need for medical treatment, and work restrictions have all been significantly increased and aggravated by the subsequent, intervening pulmonary embolisms.*

9. *Whether the Single Commissioner erred as a matter of fact and law in ruling "Claimant is not entitled to future medical treatment, as none is recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury."*

10. *Whether the Single Commissioner erred as a matter of fact and law in ruling "any loss of wage-earning capacity is not the proximate result of the December 14, 2011 accident."*

11. *Whether the Single Commissioner erred as a matter of law in misapplying Geathers v. 3V, Inc.[,] 371 S.C. 570, 641 S.E.2d 29 (2007) when there was no later injurious exposure nor an intervening "accident."*

12. *Whether the Single Commissioner erred as a matter of law in denying further medical treatment by erroneously concluding "there is no medical evidence stated to a reasonable degree of medical certainty that the Claimant currently requires any additional medical treatment to lessen the period of disability directly related to the December 14, 2011 accident when it is undisputed that Claimant's need for pain management arises directly out of the work accident.*

13. *Whether the Single Commissioner erred as a matter of law in limiting the award to the back.*

The Claimant submitted her brief to the Appellate Panel on July 18, 2016, making the following arguments: (1) "An unrelated medical condition cannot constitute an intervening cause sufficient to break the chain of causation"; (2) "Claimant's work restrictions and need for ongoing medical treatment are directly related to her workplace injury"; (3) "Claimant met the legal standard for post-MMI medical treatment"; (4) Claimant's injury was not limited to her back in that she suffered from

radiculopathy and psychological overlay"; and (5) "[t]he 23% permanent partial disability award to the back is based on legal error in that the Single Commissioner mistakenly concluded she could not award more than Dr. Nolan's impairment rating."

The Defendants filed their brief on August 1, 2016. In response, the Defendants argued that it was improper for the Claimant to raise new claims for the first time on appeal, referring to the Claimant's argument that she was entitled to a general disability award based upon an unscheduled injury to the sacroiliac joint. The Claimant had previously made no allegation concerning a sacroiliac joint injury in her three previous Form 50s, Form 58, hearing before Commissioner Taylor, or in the Form 30.

Additionally, the Defendants contended that the Hearing Commissioner properly concluded that the Claimant was not entitled to benefits for an alleged psychological injury because no physician opined to a reasonable degree of medical certainty that the Claimant's alleged psychological condition was causally-related to her original work injury to the lower back. The Defendants also argued that the Hearing Commissioner's conclusion that the Claimant is not entitled to benefits under S.C. Code Ann. § 42-9-10 or § 42-9-20 should be affirmed in accordance with the greater weight of the evidence and the applicable law given the Supreme Court's holding in Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007), which reaffirmed the "Gordon Rule." Lastly, the Defendants/Respondents argued that the hearing commissioner properly determined that the Claimant is not entitled to any additional medical benefits as a matter of law due to the Claimant's September 2014 subsequent, intervening pulmonary emboli broke the chain of legal causation. Furthermore, Dr. Nolan, the Claimant's treating physician, had not made any future medical recommendations to the required "reasonable degree of medical certainty" standard.

The Claimant submitted her Reply Brief on August 7, 2016, making two arguments. She argued that an unrelated medical condition could not constitute an intervening cause sufficient to break the chain of causation. Additionally, she contended that she had preserved her claim for general disability under Section 42-9-10. She requested that an order be entered finding the Claimant permanently and totally disabled, the pulmonary embolus was not a sufficient intervening cause to break the chain of causation, and that the Claimant was entitled to ongoing treatment for her back, SI joint, psychological overlay, and radicular symptoms.

The parties were heard by the Appellate Panel, consisting of Commissioners James, Wilkerson, and Campbell, on August 16, 2016, to determine issues as set forth in the Claimant's Form 30. The Appellate Panel issued its Decision and Order on December 22, 2016, affirming the Single Commissioner's findings and conclusions regarding the nature and extent of her injury but determined that the Single Commissioner erred in concluding that the Claimant's non-work-related pulmonary emboli did not constitute a subsequent intervening accident and remanded the issue of the Claimant's causally-related loss of use of the back to the Single Commissioner for further determination, issuing the following:

APPELLATE PANEL FINDINGS OF FACT

Based on the preponderance of the evidence, the panel makes the following findings of fact:

1. On December 14, 2011, Claimant sustained an admitted injury to her lower back within the course and scope of her employment. Based on the greater weight of the evidence in the record, the December 14, 2011 accident did not result in injury to, or otherwise affect any other body member of system. This finding of the Single Commissioner is affirmed.

2. *Claimant received appropriate medical care at the direction of the Defendants with Drs. Marzluff and Nolan. The medical care tended to lessen her degree of disability.*

3. *Claimant was initially placed at maximum medical improvement by Dr. Marzluff on September 12, 2012, at which time she returned to regular, full-time employment, with some accommodations pursuant to her restrictions, on August 30, 2012.*

4. *Claimant began pain management on May 14, 2013 with Dr. Nolan while working full time in an accommodated position with the Employer.*

5. *Pate temporarily stopped working on September 15, 2014 when she was hospitalized for a pulmonary embolism. We affirm the Single Commissioner's Finding that the pulmonary embolism is unrelated to her employment and work injury.*

6. *On February 13, 2014, Dr. Nolan opined Pate was at MMI. He treated Pate with SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, and medications (OxyContin, Percocet and Tizanidine). He also ordered a lumbar back brace. He opined she would require ongoing palliative treatment including all these modalities. [APA pages 7-8]. Dr. Nolan assigned a 23% whole person rating based on DRE Category IV. [APA page 126(a)].*

7. *We reverse the Single Commissioner's finding that "Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment." The reversal of the Single Commissioner's finding is based on the evidence as a whole with particular emphasis on the medical records and events following the development of the blood clots.*

8. *Claimant also alleges a psychological injury as a result of her original work injury. We find that the Claimant has not met her burden of proving a psychological injury causally-related to her original injury. Her claim is not supported by the preponderance of the evidence. Specifically, no physician has opined that Claimant has any disability or work restrictions as a result of any alleged psychological condition. No physician has opined to a reasonable degree of medical certainty that Claimant's alleged psychological condition is causally-related to her original work injury to her lower back. Claimant's personal history, prior medical history, and current unrelated medical conditions have weighed into this finding as well.*

9. *We reverse and remand the Single Commissioner's finding that "Claimant has sustained a 23% permanent loss of use of her back as a result of her work injury." It was legal error of the Single Commissioner to*

conclude that the pulmonary embolisms were an intervening accident or intervening accident. The pulmonary embolisms did not and could not constitute an intervening accident or intervening cause as a matter of law. See McMahan v. S.C. Dept. of Education-Transportation, Op. No. 5415 (S.C.Ct. App. filed June 15, 2016) (Shearouse Adv.Sh. No. 24 at 56). We note the Single Commissioner did not have the benefit of the McMahan case which was released after the Decision and Order in this case.

10. We reverse the Single Commissioner's Finding that "Claimant is not entitled to future medical treatment, as none is currently recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury." As noted above, the pulmonary embolisms are not a subsequent intervening cause. The matter is to be remanded to the Single Commissioner to address what, if any, future medical is causally related pursuant to the Act.

11. Claimant has an average weekly wage of $553.02, which yields a compensation rate of $368.70.

12. Claimant is entitled to a lump-sum award with James apportionment language. The jurisdictional Commissioner on remand is to make this determination. Claimant will be given leave to submit a supplemental order with an approved Form 61 which is to be incorporated into the Single Commissioner's order by reference.

13. We affirm the Single Commissioner's finding that "Although Claimant was placed at MMI as of February 13, 2014 by Dr. Nolan, Defendants did not file a Form 21 requesting a credit until November 6, 2014. As such, Defendants are entitled to a credit back to date of the Form 21 filing only."

14. This matter is remanded to the jurisdictional commissioner for a determination of causally related disability and for a determination of what, if any, medical treatment is causally related and should be awarded pursuant to the Act.

APPELLATE PANEL CONCLUSIONS OF LAW

1. We reverse the Single Commissioner's legal conclusion that "Claimant is not entitled to and the Defendants are not responsible for any benefits under S.C. Code Ann. § 42-15-60 pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371[]S.C. 570, 641 S.E.2d 29 (2007)."

2. The pulmonary embolus is not a subsequent intervening cause sufficient to break the chain of causation. It was error of the Single Commissioner to deny ongoing medical treatment and disability compensation under the theory that the pulmonary embolus was an

intervening cause. The general rule is "Every natural consequence that flows from a work-related compensable injury is also compensable unless the consequence is the result of an independent, intervening cause sufficient to break the chain of causation." Whitfield v. Daniel Constr. Co., 226 S.C. 37, 40-41, 83 S.E.2d 460, 462 (1954).

The case law consistently requires an intervening cause to be a subsequent accident attributable to the claimant's own intentional conduct. See, e.g. Tims v. J.D. Kitts Constr., 393 S.C. 496, 713 S.E.2d 340 (Ct. App. 2011)(rejecting argument that heatstroke suffered by quadriplegic from being left in his caregiver's car was an independent intervening cause because "neither Claimant's decision to ride in his caregiver's car nor his caregiver's negligence was an independent, intervening cause sufficient to break the chain of causation."), citing 1 Arthur Larson & Lex K. Larson, Larson's Workers' Compensation Law § 10.01, 0-1 (2010) (stating that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment, unless it is the result of an independent, intervening cause attributable to the claimant's own intentional conduct).

3. The principle applying to this case is "that a nonwork-related condition is not a superseding, intervening event that breaks the causal connection between a work-related injury and a claimant's disability."[1] Brockel v. N.D. Workforce Safety & Ins., 843 N.W.2d 15, 23-24 (N.D. 2014). The rule was followed in South Carolina in Orr v. Elastomeric Prods., 323 S.C. 342, 474 S.E.2d 448 (Ct. App. 1996). In Orr, the claimant unexpectedly became pregnant following back surgery for her injury. Due to the pregnancy, she was unable to participate in physical therapy, spurring the carrier to seek to suspend her compensation. The Court of Appeals rejected this argument, reasoning "The fact that Orr 's pregnancy indirectly prolonged the period during which she was unemployable does not change the fact that her injury, not her pregnancy, rendered her unable to work." Id. at 449 (emphasis added).

4. The ruling below regarding Geathers has no support in the law and is an erroneous misapplication of Geathers. In Geathers, the Supreme

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[1] *A majority of jurisdictions – including South Carolina – follow this rule. See, e.g., Thurston v. Guys With Tools, Ltd., 217 P.3d 824 (Alaska 2009); Moore v. Component Assembly Sys., 158 Md.App. 388, 857 A.2d 549 (2004); Schock v. Morristown Mem'l Hosp./Atlantic Health Sys., 2010 WL 2793949 *6 (N.J.Super.A.D. July 2, 2019); Thomas v. Burggraf Restoration, 31 P.3d 402 (Okla.Ct.Vic.App.2001); Workmen's Comp. Appeal Bd. v. Chamberlain Mfg. Corp., 336 A.2d 659 (1975); Orr v. Elastomeric Prods., 323 S.C. 342, 474 S.E.2d 448 (Ct.App. 1996); Wood v. Fletcher Allen Health Care, 739 A.2d 1201 (1999).[]*

Court adopted the "last injurious exposure rule." The last injurious exposure rule:

places full liability upon the carrier covering the risk at the time of the most recent injury that bears a causal relation to the disability. Consistent with the rule that an employer takes its employee as it finds her, the last injurious exposure rule makes the insurer at risk at the time of the second injury liable even if the second injury would have been much less severe in the absence of the prior condition and even if the prior injury significantly contributed to the final condition. Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007).

The last injurious exposure rule is simply a rule to avoid apportionment and put liability on the carrier covering the most recent injury. It has no application to the facts of this case. It cannot be used as a means to deny further benefits when there is no subsequent carrier nor any later injurious exposure. There is no second accident in this case.

ORDER

IT IS THEREFORE ORDERED that the Decision and Order of the Single Commissioner is Affirmed in part, Reversed in part, and Remanded;

IT IS FURTHER ORDERED that the findings and conclusions of the Single Commissioner that the pulmonary embolisms are an intervening accident are reversed.

IT IS FURTHER ORDERED that this case is remanded to the Single Commissioner to determine the compensation due for Claimant's causally related permanent disability and causally related medical treatment pursuant to the Act consistent with the findings of fact and conclusions of law herein.

AND IT IS SO ORDERED.

The Claimant filed a Petition for Rehearing or Reconsideration on January 23, 2017, regarding the Appellate Panel's findings in the December 22, 2016 Appellate Panel Decision and Order, specifically whether the Claimant's back injury affected the buttocks and left leg and the Claimant's allegations of psychological overlay. The Claimant's Petition was denied on February 21, 2017.

Pursuant to a March 15, 2017 Consent Order, the parties agreed that under the Bone case, the Appellate Panel's orders are not immediately appealable, as the interlocutory order remanded the case to the jurisdictional commissioner for further findings of fact.

The Single Commissioner then issued the Decision and Order on Remand on May 24, 2018, with the following:

ADDITIONAL FINDINGS OF FACT

*Pursuant to the instructions on remand of the Appellate Panel, the following **ADDITIONAL FINDINGS OF FACT** are made:*

1. This is a single-member injury affecting Claimant's lower back only. As such, Claimant's requests for benefits is limited to S.C. code Ann. Section 42-9-30 (21).

2. I find Claimant has sustained 40% permanent partial disability as a result of her work injury. This finding is based on the evidence as a whole including Dr. Nolan's permanent impairment rating of 23% to the lumbar spine issued on March 10, 2014 as well as Claimant's work restrictions at the time of separation from her employer which included working 4 hours per day for 4 days per week, with specific restrictions of no bending, squatting, or crawling; no lifting greater than 15 pounds, and no pushing or pulling heavy objects. (Claimant's APA p. 93).

3. Claimant is entitled to future medical treatment to include SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, pain medications (currently OxyContin, Percocet, and Tizanidine). Claimant is also entitled to a lumbar back brace as prescribed by Dr. Nolan. Claimant's future medical treatment is to be provided by Dr. Nolan or another physician authorized by Defendants to carry out the medical award in this matter.

***

ADDITIONAL CONCLUSION OF LAW

*Pursuant to the instructions on remand of the Appellate Panel, the following **ADDITIONAL CONCLUSION OF LAW** is made:*

19. An order reversed on appeal is a nullity. See Tolbert v. Fouche, 123 S.E. 859 (SC 1924). The original order of the Single

Commissioner provided that Defendants were not liable for providing ongoing treatment. As that order was reversed by the Appellate Panel, it is a nullity — as if it never existed. Accordingly, Defendants are liable for paying for causally related treatment incurred by Claimant prior to this order to be paid pursuant to the South Carolina Workers' Compensation Fee Schedule. Claimant is entitled to reimbursement for any and all causally-related out of pocket expenses incurred during this time.

ORDER

IT IS THEREFORE ORDERED that the Claimant is entitled to a lump sum award for permanent partial disability of 120 weeks based on a loss of use of 40% of the back which shall be apportioned over Claimant's life expectancy pursuant to James v. Anne's;

IT IS FURTHER ORDERED that Claimant is entitled to causally-related future medical treatment pursuant to Section 42-15-60 to include SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, pain medications (currently OxyContin, Percocet, and Tizanidine). Claimant is also entitled to a lumbar back brace as prescribed by Dr. Nolan. Claimant's future medical treatment is to be provided by Dr. Nolan or another physician authorized by Defendants to carry out the medical award in this matter.

IT IS FURTHER ORDERED that the Defendants shall pay for causally-related medical expense incurred during the period the Single Commissioner's order was in effect and no treatment was authorized pursuant to the South Carolina[sic] Workers' Compensation Fee Schedule. Claimant is entitled to reimbursement for any and all causally related out-of-pocket expenses incurred during this same period.

AND IT IS SO ORDERED.

Within the statutory period, on June 7, 2018, the Claimant filed her second Form 30 Request for Commission Review of the Hearing Commissioner's Order on Remand, setting forth four grounds for appeal. Oral argument was requested. Such, together with all documentary evidence, was delivered by oral argument to the individual members of the Appellate Panel on October 22, 2018.

In her second Form 30 Application for Review dated June 7, 2018, the Claimant raised the following issues:

1. *Whether the Single Commissioner and Appellate panel erred as a matter of fact and law in denying psychological injury.*

2. *Whether the Single Commissioner on remand erred as a matter of fact and law in failing to find Claimant permanently and totally disabled when her restrictions prevent her from obtaining suitable gainful employment.*

3. *Whether the Single Commissioner on remand erred as a matter of fact and law in awarding 40% permanent loss of use of the back when the evidence shows Claimant is presumed permanently and totally disabled due to 50% loss of use of her back and there is no evidence to rebut the presumption.*

4. *Whether the Single Commissioner and Appellate Panel erred as a matter of law in finding this is a single member case when Claimant suffers from radiculopathy affecting her left leg and an SI joint injury which is an injury to her back and pelvis.*

The Claimant submitted her brief to the Appellate Panel on September 17, 2018, making the following arguments: (1) the Claimant is presumed permanently and totally disabled as she has lost more than 50% use of her back; and (2) the Claimant's injury should not be limited to her back as she suffers from radiculopathy and psychological overlay. The Claimant request that the Hearing Commissioner's Order on remand be reversed and that a new Order be issued by the Appellate Panel, finding that the Claimant is permanently and totally disabled, the pulmonary embolus was not an intervening cause sufficient to break the chain of causation, and that the Claimant is entitled to ongoing treatment for her back, radicular symptoms, SI joint, and

psychological overlay. The Claimant also argued that, in the alternative, she is entitled to a permanent partial disability award based on the totality of the evidence.

The Defendants timely filed their Brief to the Appellate Panel on October 1, 2018, contending that the Hearing Commissioner properly determined that the Claimant is not permanently and totally disabled under Section 42-9-30 because the Claimant's loss of use of the back does not exceed 50%. The Defendants request that the Hearing Commissioner's Order on remand be affirmed, subject to the Defendants' right to appeal the Appellate Panel's reversal of the Hearing Commissioner's original Decision and Order and Findings of Fact and Conclusions of Law contained in the Appellate Panel's December 22, 2016 interlocutory order. The Defendants argue that the Claimant is not entitled to a presumption of permanent and total disability because the Claimant's inability to work is the result of her non-work-related emboli in September 2014.

Furthermore, the Defendants contend the Claimant is not entitled to an award of permanent and total disability based on the economic model because her work injury is a single-scheduled injury to the back. Instead, the Claimant's remedy is restricted to the medical model under S.C. Code Ann. § 42-9-30. The Claimant did not take issue with Dr. Nolan's 23% impairment rating and otherwise misstated Dr. Marzluff's impairment rating. Furthermore, the Claimant's assertion that her condition worsened after her impairment ratings were issued is untenable because the Claimant admitted that the worsening of her condition following her pulmonary emboli in September 2014 was not causally-related to the December 14, 2011 work accident, meaning that the

worsening of her condition was not relevant to a determination of the loss of use of the back causally-related to the December 14, 2011 accident.

The Claimant responded with her Reply Brief on October 11, 2018, reiterating that she should be presumed permanently and totally disabled under S.C Code Ann. § 42-9-30.

On October 22, 2018, counsel for the Defendants wrote the Commission to alert the Appellate Panel about an error in the Record, which is relevant to the issue on appeal. The Hearing Commissioner's May 22, 2019 Order on remand misquoted the Appellate Panel's Finding of Fact #9 by adding two additional sentences. At the Appellate Hearing, during oral argument, the Appellant and Respondents argued according to their submitted briefs.

DISCUSSION

In an appellate review, the Panel shall, pursuant to S.C. Code Ann. § 42-17-50, review the award, weigh the evidence as presented at the initial hearing and, if good grounds be shown therefore, make its own Findings of Fact and reach its own Conclusion of Law consistent with or inconsistent with those of the Hearing Commissioner. Based upon a review of the foregoing, the Panel **Affirms with Amendments** the Hearing Commissioner's Decision and Order on Remand. The single change to the Hearing Commissioner's Order on Remand is a deletion of two sentences from the Hearing Commissioner's reference to the Appellate Panel's prior Findings of Fact #9, which mistakenly added two sentences and attributed the same to the Appellate Panel, though

not included in the Appellate Panel's December 22, 2016 Decision and Order. The Appellate Panel's original Finding of Fact #9 correctly reads as follows:

> 9. *We reverse and remand the Single Commissioner's finding that "Claimant has sustained a 23% permanent loss of use of her back as a result of her work injury." It was legal error of the Single Commissioner to conclude that the pulmonary embolisms were an intervening accident or intervening accident. The pulmonary embolisms did not and could not constitute an intervening accident or intervening cause as a matter of law. See McMahan v. S.C. Dept. of Education-Transportation, Op. No. 5415 (S.C.Ct.App. filed June 15, 2016) (Shearouse Adv.Sh. No. 24 at 56). We note the Single Commissioner did not have the benefit of the McMahan case which was released after the Decision and Order in this case.*

CONCLUSION

After thoroughly reviewing the Record in this case and the arguments of the parties, the Appellate Panel affirms the Hearing Commissioner's decision on remand as follows:

Findings of Fact

1. On December 14, 2011, Claimant sustained an admitted injury to her lower back within the course and scope of her employment. Based on the greater weight of the evidence in the record, the December 14, 2011 accident did not result in injury to, or otherwise affect, any other body member or system.

2. Claimant received appropriate medical care at the direction of the Defendants with Drs. Marzluff and Nolan. The medical care tended to lessen her degree of disability.

3. Claimant was initially placed at maximum medical improvement by Dr. Marzluff on September 12, 2012, at which time she returned to regular, full-time employment, with some accommodations pursuant to her restrictions, on August 30, 2012.

4. Claimant began pain management on May 14, 2013 with Dr. Nolan while working full time in an accommodated position with the Employer.

5. Pate temporarily stopped working on September 15, 2014 when she was hospitalized for a pulmonary embolism. The Claimant's pulmonary embolism is unrelated to her employment and work injury.

6. On February 13, 2014, Dr. Nolan opined Pate was at MMI. He treated Pate with SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, and medications (OxyContin, Percocet and Tizanidine). He also ordered a lumbar back brace. He opined she would require ongoing palliative treatment including all these modalities. [APA pages 7-8]. Dr. Nolan assigned a 23% whole person rating based on DRE Category IV. [APA page 126(a)].

7. Claimant also alleges a psychological injury as a result of her original work injury. We find that Claimant has not met her burden of proving a psychological injury causally-related to her original injury. Her claim is not supported by the preponderance of the evidence. Specifically, no physician has opined that Claimant has any disability or work restrictions as a result of any alleged psychological condition. No physician has opined to a reasonable degree of medical

certainty that Claimant's alleged psychological condition is causally-related to her original work injury to her lower back. Claimant's personal history, prior medical history, and current unrelated medical conditions have weighed into this finding as well.

8. Claimant has an average weekly wage of $553.02, which yields a compensation rate of $368.70.

9. Although Claimant was placed at MMI as of February 13, 2014 by Dr. Nolan, Defendants did not file a Form 21 requesting a credit until November 6, 2014. As such, Defendants are entitled to a credit back to date of the Form 21 filing only.

10. This is a single-member injury affecting Claimant's lower back only. As such, Claimant's requests for benefits is limited to S.C. Code Ann. § 42-9-30(21).

11. Claimant has sustained 40% loss of use of the back as a result of her work injury. This finding is based on the evidence as a whole, including Dr. Nolan's permanent impairment rating of 23% to the lumbar spine issued on March 10, 2014, as well as Claimant's work restrictions at the time of separation from her employer, which included working 4 hours per day for 4 days per week, with specific restrictions of no bending, squatting, or crawling; no lifting greater than 15 pounds, and no pushing or pulling heavy objects. (Claimant's APA p. 93).

12. Claimant is entitled to future medical treatment to include SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, pain medications (currently OxyContin, Percocet, and Tizanidine). Claimant is also entitled to a lumbar back brace as prescribed by Dr. Nolan. Claimant's future medical treatment is to be provided by Dr. Nolan or another physician authorized by Defendants to carry out the medical award in this matter.

Conclusion of Law

1. An order reversed on appeal is a nullity. See Tolbert v. Fouche, 123 S.E. 859 (SC 1924). The original Order of the Hearing Commissioner provided that Defendants were not liable for providing ongoing treatment. As that Order was reversed by the Appellate Panel, it is a nullity — as if it never existed. Accordingly, Defendants are liable for paying for causally related treatment incurred by Claimant prior to this order to be paid pursuant to the South Carolina Workers' Compensation Fee Schedule. Claimant is entitled to reimbursement for any and all causally-related out of pocket expenses incurred during this time.

ORDER

IT IS THEREFORE ORDERED that the Claimant is entitled to a lump sum award for permanent partial disability of 120 weeks based on a loss of use of 40% of the back, which shall be apportioned over Claimant's life expectancy pursuant to James v. Anne's;

IT IS FURTHER ORDERED that Claimant is entitled to causally-related future medical treatment pursuant to Section 42-15-60 to include SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, pain medications (currently OxyContin, Percocet, and Tizanidine). Claimant is also entitled to a lumbar back brace as prescribed by Dr. Nolan. Claimant's future medical treatment is to be provided by Dr. Nolan or another physician authorized by Defendants to carry out the medical award in this matter.

IT IS FURTHER ORDERED that the Defendants shall pay for causally-related medical expense incurred during the period the Hearing Commissioner's order was in effect and no treatment was authorized pursuant to the South Carolina Workers'

Compensation Fee Schedule. Claimant is entitled to reimbursement for any and all causally related out-of-pocket expenses incurred during this same period.

AND IT IS SO ORDERED.

S.C. WORKERS' COMPENSATION COMMISSION

Gene McCaskill, Commissioner
Appellate Panel Chair

WE CONCUR:

Susan S. Barden, Commissioner

T. Scott Beck, Commissioner

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 May 31, 2019

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

WCC File #: 1121370
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Patricia A. Pate SSN: ___-___-___
Address: [redacted]
City: [redacted] State: ___ Zip: _____
Home Phone: ( ) - Work Phone: ( ) -

Employer's Name: College of Charleston
Address: 81 St. Phillips Street
City: Charleston State: SC Zip: 29403
Insurance Carrier: State Accident Fund

Preparer's Name: Max C. Sparwasser Law Firm: John Price Law Firm Preparer's Phone #: (843) 552 - 6011

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

A claim for workers' compensation benefits is made based on the following grounds: **Date of Injury or Illness: 12/14/2011**
☒ Injury ☐ Illness ☐ Repetitive Trauma

1a. The claimant sustained an injury to Back (Part(s) of Body Injured) on 12/14/2011 (Month/Day/Year) in Charleston county, state of South Carolina.
1b. Body part(s) affected are: Back

Briefly describe how the accident occurred. Lifting Box

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 12/15/2012 (Month/Day/Year) in the following manner:
Verbally to Cheryl

☒ 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: Back

☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
Date of accident and continuing

☒ 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:

10a. At the time of the injury, the Claimant was paid weekly wages of $_____, and demands accounting of days worked and wages earned as provided by law.
10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
College of Charleston

11a. Further grounds or unusual aspects of claim: Any and all benefits available under the South Carolina Workers' Compensation Act.
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:
Joseph Marzluff, MD; Trident Hospital
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: 30 minutes

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

Max C. Sparwasser — Attorney — maxsparwasser@johnpricelawfirm.com — 11/9/12
Preparer's Signature — Title — Email — Date

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

WCC Form # 50
Revised 9/07

50

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

South Carolina Workers' Compensation Commission
1612 Marion Street • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5739
www.wcc.sc.gov

WCC File #: **1121370**
Carrier File #: **2011-4217**
Carrier Code #:
Employer FEIN #:

Claimant's Name: Patricia Pate SSN:
Address:
City: State: Zip:
Home Phone: ( ) - Work Phone: ( ) -
Date of Injury: 12/14/11

Employer's Name: College of Charleston
Address: Payroll Dept.
City: Charleston State: SC Zip: 29424
Insurance Carrier: State Accident Fund

Preparer's Name: Ellen Goodwin, Esq. Law Firm: State Accident Fund Preparer's Phone #: (803) 896-5891

Date of Injury or Illness: 12/14/11

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

1. It is Admitted the employee sustained an injury or illness on or about the date set forth in the Form 50. The reasons for denial are:
Defendants admit injury to the back only; however, extent of injury and all other body parts affected are denied.

2. It is Admitted both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are:

3. It is Admitted the relationship of employer and employee existed at the time in question. The reasons for denial are:

4. It is Admitted at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are:

5. It is Admitted notice of injury was given the employer. The reasons for denial are:

6. It is Denied the employee **Needs / Is Entitled to Additional** medical care as a result of injury or illness. The reasons for denial are:
To be determined.

7. It is Denied the employee is entitled to temporary total disability for the period(s) of :
Claimant has been paid for all compensable lost time.

8. It is Denied the employee is permanently disabled. The reasons for denial are:
Disability, if any, to be determined by W.C.C.

9. It is Denied the employee has serious disfigurement.

10. It is contended that an average weekly wage of **$ 553.02** applies, according to attached Form 20 as provided by law.

11. Further contentions, grounds of defense, or unusual aspects are:

12. Estimated time needed for hearing: 30 minutes

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

Name: Max C. Sparwasser, Esquire — Judicial Director, SCWCC

Address: P.O. Box 40637, North Charleston, SC 29423-6840 — P.O. Box 1715, Columbia, SC 29202-1715

on the 10th day of December, 2012 by ☒ first class mail ☐ personal service ☐ certified mail.
I verify the contents of this form are accurate and true to the best of my knowledge.

Ellen Goodwin — Asst. Chief Counsel — Egoodwin@saf.sc.gov — Dec 10, 2012
Preparer's Signature — Title — Email — 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 Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

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

WCC File #: **1121370**
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Patricia A. Pate SSN: ___ _ Employer's Name: College of Charleston

Address: _____ _____ Address: 81 St. Phillips Street

City: _____ State: __ Zip: _____ City: Charleston State: SC Zip: 29403

Home Phone: ( ) - Work Phone: ( ) - Insurance Carrier: State Accident Fund

Preparer's Name: Max C. Sparwasser Law Firm: Max Sparwasser Law Firm, LLC Preparer's Phone #: (843) 864 - 6444

A claim for workers' compensation benefits is made based on the following grounds: **Date of Injury or Illness: 12/14/2011**

☒ Injury ☐ Illness ☐ Repetitive Trauma ☐ Occupational Disease ☐ Physical Brain Injury ☐ Concurrent Jurisdiction

1. The claimant sustained an injury to back, legs, depression (Part(s) of Body Injured) on 12/14/2011 (Month/Day/Year) in Charleston county, state of SC.
2. Body part(s) affected are: back, legs, and depression
   Briefly describe how the accident occurred. Lifting box
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 12/15/2012 (Month/Day/Year) in the following manner:
   Verbally to Cheyl

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

☒ (a) medical examination and treatment for: psyche, back, legs, and depression

☐ (b) additional medical examination and treatment for: _____

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

☐ 9. 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

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 $_____, 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:
College of Charleston

11. Further grounds or unusual aspects of claim: Seeking approval to treat with psychiatrist, Dr. William Kee
Any and all benefits available under the South Carolina Workers' Compensation Act

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:
Joseph Marziuff, MD; Trident Hospital; Charleston Neurosurgical Associates; Roper Hospital; Lowcountry Orthopaedics; Trident Pain Center

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.** 14. Estimated time needed for hearing: 30 minutes

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

☐ **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 certify I have served this document pursuant to Reg. 67-211 by delivering a copy to State Accident Fund _____ address P.O. Box 102100, Columbia, SC 29221-5000 on the 28th day of August 2014, by ☒ 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	Title	Email	Date
	Attorney	max@maxlawsc.com	8/28/2014

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

WCC Form # 50
Revised 7/13

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

WCC File #: 1121370
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Patricia Pate SSN:
Address:
City: State: Zip:
Home Phone: Work Phone:

Employer's Name: College of Charleston
Address: 81 St. Phillip Street
City: Charleston State: Zip: 29403
Insurance Carrier: State Accident Fund

Preparer's Name: Max Sparwasswer Law Firm: Max Sparwasser Law Firm Preparer's Phone #: 843-864-6444

A claim for workers' compensation benefits is made based on the following grounds: **Date of Injury or Illness:** 12/14/2011
☑ Injury ☐ Illness ☐ Repetitive Trauma ☐ Occupational Disease ☐ Physical Brain Injury ☐ Concurrent Jurisdiction

1. The claimant sustained an injury to back legs, pscyhe (depression) (Part(s) of Body Injured) on 12/14/2011 (Month/Day/Year) in Charleston county, state of _____. Body part(s) affected are: back, legs and psyche (depression)
2. Briefly describe how the accident occurred. lifting a box
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 12/15/11 (Month/Day/Year) in the following manner: Verbally to Cheryl
7. ☑ Due to injury, the claimant is in need of (check one):
   ☑ (a) medical examination and treatment for: Psyche (depression), back, legs
   ☐ (b) additional medical examination and treatment for:
8. ☐ Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
9. ☑ 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
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 $_____, 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:
College of Charleston
11. Further grounds or unusual aspects of claim:
Seeking approval to treat with psychiatrist Dr William Kee. Any and all benefits available under SC Workers' Compensation Act.
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:
Joseph Marzuff, MD; Trident Hospital; Charleston Neurosurgical Associates; Roper Hospital; Lowcountry Orthopedics; Trident Pain Center
11b. To the best of your knowledge, did you have any prior permanent disability?
If yes, describe:
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 13a. **I am filing a claim. I am not requesting a hearing at this time.**
14. Estimated time needed for hearing: 30 min
☑ 13b. **I am requesting a hearing. A $25 fee is required.**
☐ **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 certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Jennifer Stone - South Carolina State Accident Fund **address** PO Box 102100 Columbia, SC 29221 **on the** 10th **day of** September **20**14 **,by** ☑ **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 | Esquire (Title) | max@maxlawsc.com (Email) | 9/10/14 (Date)

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

WCC Form # 50
Revised 7/13

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) 737-5739 www.wcc.sc.gov

WCC File #: **1121370**
Carrier File #: **2011-4217**
Carrier Code #: **500 SF**
Employer FEIN #: **570000H15**

Claimant's Name: Patricia Pate SSN: _ _
Address: _____
City: _ _____ State: _ _ Zip: _ _
Home Phone: (843) 509-6704 Work Phone: ( ) -
Date of Injury: 12/14/2011

Employer's Name: College of Charleston
Address: _____
City: Charleston State: SC Zip: 29424
Insurance Carrier: State Accident Fund

Preparer's Name: Mikell H. Wyman, Esquire Law Firm: Collins & Lacy, P.C. Preparer's Phone #: 843.714.2500

Date of Injury or Illness: 12/14/2011 **Estimated time for hearing: 45 minutes**

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 Form 50. The reasons for denial are: Defendants admit the Claimant suffered a compensable injury by accident on 12/14/11 during the scope and course of her employment, but deny any resulting disability. Defendants specifically deny compensability for any and all alleged psychiatric/psychological illness, depression or injury.

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:

3. It is ☒ Admitted ☐ Denied the relationship of employer and employee existed at the time in question. The reasons for denial are

4. It is ☒ Admitted ☐ Denied at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are

5. It is ☒ Admitted ☐ Denied notice of injury was given the employer. The reasons for denial are

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

7. It is ☐ Admitted ☒ Denied the employee is entitled to temporary total disability for the period(s) of :

8. It is ☐ Admitted ☒ Denied the employee is permanently disabled. The reasons for denial are: No proof

9. It is ☐ Admitted ☒ Denied the employee has serious disfigurement.

10. It is contended that an average weekly wage of **$ See Form 20** applies, according to attached Form 20 as provided by law.

11. Further contentions, grounds of defense, or unusual aspects are: While the Defendants admit the Claimant suffered a compensable injury by accident arising out of and in the scope and course of her employment on 12-14-11, the Defendants deny the nature and extent of her injury and any resulting disability. Defendants specifically deny compensability for any and all alleged psychiatric/psychological illness, depression or injury. The Defendants reserve the right to supplement and/or amend this answer as additional discovery is conducted.

☐ **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.

J. Wyman for JFM
Preparer's Signature

Attorney
Title

mwyman@collinsandlacy.com
Email

September 29, 2014
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 at 803-737-5675 or judicial@wcc.sc.gov or mediation@wcc.sc.gov. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737.5675 www.wcc.sc.gov

WCC File #: **1121370**
Carrier File #: **2011-4217**
Carrier Code #: **500 SF**
Employer FEIN #: **570000H15**

Claimant's Name: Patricia Pate SSN: [redacted] Employer's Name: College of Charleston

Address: [redacted] Address: [redacted]

City: [redacted] State: [redacted] Zip: [redacted] City: Charleston State: SC Zip: 29424

Home Phone: (843) 509-6704 Work Phone: ( ) - Insurance Carrier: State Accident Fund

Preparer's Name: Mikell H. Wyman, Esquire Law Firm: Collins & Lacy, P.C. Preparer's Phone #: 843.714.2500

The date of injury reported on Form 12A is: 12/14/2011 (m/d/yyyy)

Check appropriate section(s). The Employer's Representative requests a hearing to:

I. ☐ **Stop payment of compensation.** Claimant has reached maximum medical improvement and Claimant continues to receive temporary compensation payments. The employer's representative requests a hearing pursuant to § 42-9-260(D) to stop payment of temporary compensation. A hearing requested pursuant to this section must be held within sixty days of the date of the request.

Claimant reached maximum medical improvement on_____ (m/d/yyyy) (copy of medical report must be attached).
Compensation payments are current as of _____ (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.
A Form 17 was offered and refused on _____ (m/d/yyyy).

II. ☐ **Address suspension, termination, or reduction of temporary disability payments for any cause.**

☐a. At any time pursuant to § 42-9-260(E).

☐b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.

The basis for the termination/ suspension is _____

III. ☒ **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

Claimant has been released at maximum medical improvement by her authorized treating physicians and been assigned an impairment rating of 23% to the spine. Medical records attached.

Claimant reached maximum medical improvement on 2/13/2014 (m/d/yyyy) (copy of medical report must be attached).

IV. ☒ **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**

V. ☐ **Determine amount of compensation for claims involving a fatality.**

☐a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.

☐b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

VI. ☐ **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.

Failure to respond pursuant to Reg. 67-208 B in writing or by submission of a Form 22 may result in ordered mediation pursuant to Reg. 67-1801 B. 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 Max C. Sparwasser, Esquire, P.O. Box 2307 Mt. Pleasant, South Carolina 29465 on November 6, 2014 by ☒ first class postage ☐certified mail ☐personal service.

A $25.00 filing fee and updated Form 18 is required.

Preparer's Signature | Attorney Title | mwyman@collinsandlacy.com Email | November 6, 2014 Date

Questions about the use of this form should be directed to the Judicial Department at 803-737-5675, or judicial@wcc.sc.gov or mediation@wcc.sc.gov
Refer to Regulations 67-211, 67-504, 67-505, 67-506; and 67-510.

WCC Form # 21
Revised 7/13

21

Employer's 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

WCC File #: 1121370
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Patricia Pate SSN:
Address:
City: State: Zip:
Home Phone: Work Phone:

Employer's Name: College of Charleston
Address: 81 St. Phillip Street
City: Charleston State: Zip: 29403
Insurance Carrier: State Accident Fund

Preparer's Name: Max Sparwasswer Law Firm: Max Sparwasser Law Firm Preparer's Phone #: 843-864-6444

A claim for workers' compensation benefits is made based on the following grounds: **Date of Injury or Illness:** 12/14/2011
☑ Injury ☐ Illness ☐ Repetitive Trauma ☐ Occupational Disease ☐ Physical Brain Injury ☐ Concurrent Jurisdiction

1. The claimant sustained an injury to back legs, pscyhe (depression) (Part(s) of Body Injured) on 12/14/2011 (Month/Day/Year) in Charleston county, state of _____. Body part(s) affected are: back, legs and psyche (depression)
2. Briefly describe how the accident occurred. lifting a box
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 12/15/11 (Month/Day/Year) in the following manner: Verbally to Cheryl
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: Psyche (depression), back, legs
8. ☐ Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
9. ☑ 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
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 $ 553.02, 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:
College of Charleston
11. Further grounds or unusual aspects of claim:
Seeking approval to treat with psychiatrist Dr William Kee. Any and all benefits available under SC Workers' Compensation Act.
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:
Joseph Marzuff, MD; Trident Hospital; Charleston Neurosurgical Associates; Roper Hospital; Lowcountry Orthopedics; Trident Pain Center
11b. To the best of your knowledge, did you have any prior permanent disability?
If yes, describe:
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 13a. **I am filing a claim. I am not requesting a hearing at this time.**
14. Estimated time needed for hearing: 45 min
☑ 13b. **I am requesting a hearing. A $25 fee is required.**
☐ **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 certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Mikell H. Wyman 200 Meeting Street Ste 403 **address** Charleston, SC 29401 **on the** 3rd **day of** February **20**15, **by** ☑ **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	Esquire (Title)	max@maxlawsc.com (Email)	2/3/15 (Date)

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

WCC Form # 50
Revised 7/13

50

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

South Carolina Workers' Compensation Commission
1333 Marion Street, Suite 500
P.O. Box 1715
Columbia, South Carolina 29202-1715

(803) 737-5739

WCC File # 1121370
Carrier File # 2011-4217
Carrier Code #
Employer FEIN 576036895

Patricia Pate			5	College of Charleston	
Claimant's Name			SSN	Employer's Name	
				66 George Street	Charleston, SC 29424
Address		City	State Zip	Address	City State Zip
(843) 509-6704				State Accident Fund	
Home Phone	Work Phone			Insurance Carrier:	
Date of Injury: December 14, 2011					

Preparer's Name: Kirsten L. Barr Law Firm: Trask & Howell, LLC Preparer's Phone #: (843) 881-4228

Date of Injury or Illness: December 14, 2011 **Estimated time for hearing: 45 minutes**

Complete each information blank. Specify clearly 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 Form 50. The reasons for denial are: Defendants admit low back injury only and deny any other alleged injury.
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:
3. It is ☒ **Admitted** ☐ **Denied** the relationship of employer and employee existed at the time in question. The reasons for denial are:
4. It is ☒ **Admitted** ☐ **Denied** at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are: Admit as to low back only.
5. It is ☐ **Admitted** ☒ **Denied** notice of injury was given the employer. The reasons for denial are:
6. It is ☐ **Admitted** ☒ **Denied** the employee ☒ **Needs** ☒ **Is Entitled to Additional** medical care as a result of injury. The reason for denial are: There is no additional medical treatment that would tend to lessen period of disability.
7. It is ☐ **Admitted** ☒ **Denied** the employee is entitled to temporary total disability for the period(s) of: N/A
8. It is ☐ **Admitted** ☒ **Denied** the employee is permanently disabled. The reasons for denial are: Claimant has no loss of wage-earning capacity.
9. It is ☐ **Admitted** ☒ **Denied** the employee has a serious disfigurement.
10. It is contended that an average weekly wage of $ 553.02 applies, according to attached Form 20 as provided by law.
11. Further contentions, grounds of defense, or unusual aspects are: Reserve the right to amend.

☒ **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 certify that I have served this document pursuant to R.67-212 by delivering a copy to: Ms. Amy Bracy, SCWCC, P. O. Box 1715, Columbia, SC 29202-1715 and Max C. Sparwasser, Esq., P.O. Box 2307, Mt. Pleasant, SC 29465

on the 3rd day of March ,2015 by ☒ first class mail; ☐ personal service; ☒ certified mail.

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

Kirsten L Barr	Attorney for Defendant(s).	kbarr@trask-howell.com	March 3, 2015
Preparer's Signature	Title	Email	Date

Refer to R.67-204 through R.67-210 and R.67-601through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

uth Carolina Workers' Compensation Commission
33 Main Street, Suite 500
O. BOX 1715
olumbia, SC 29202-1715
303) 737-5739 www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No: 1121370

Claimant's Name: Patricia Pate
Address:
City: State: Zip:
Home Phone: ( ) - Work Phone: ( ) -
Preparer's Name: Max Sparwasser

Employer's Name: College of Charleston
Address: 81 St. Phillip Street
City: Charleston State: SC Zip: 29403
Carrier: State Accident Fund
Preparer's Phone #: (843) 864-6444

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

1. Compensation Rate: $368.70 2. AWW: $553.02 **Date of Injury:** 12/14/2011
3. Type of injury and body part(s): Back, legs, psyche (depression)
4. Facts in controversy: Extent of disability/body parts, future medical treatment
5. Legal issues involved: S.C. Code §42-9-10, S.C. Code §42-9-30
6. Unusual aspects:
7. Witnesses (designate if expert):* Patricia Pate, Donald Pate
8. Exhibits: See APA submissions; claimant reserves the right to submit exhibits/evidence in response to exhibits/evidence submitted by Defendants.
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
See APA submissions; claimant reserves the right to submit medical evidence in response to evidence submitted by Defendants.
10. Name, address, and specialty, if any, of the treating physician: Trident Pain Center; J. Edward Nolan, M.D.; Trident Medical Center, Joseph M. Marzluff, M.D.; Charleston Psychological Associates, P.A., William G. Kee, Ph.D.; Jean Hutchinson, M.ED., CRC, CVE
11. Impairment rating(s); body part(s); physician and date of opinion: 40% to spine and 36% to whole body by Dr. Marzluff on 11/7/2012, 23% by Dr. Nolan on 3/10/2014
12. I am amending my Form 50/51 in the following manner: n/a

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**.

erify the contents of this form are accurate and true to the best of my knowledge.
ertify I have served this document pursuant to Reg. 67-211 by delivering a copy to Kirsten L. Barr, Esquire, Trask & Howell, LLC, P.O. x 2167, Mt. Pleasant, SC 29464 on the 2nd day of June 2015 by: ☐ first class postage ☐ certified mail ☒ personal service.

Signature:
Date of hearing: July 14, 2015
Email: max@maxlawsc.com
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 67-11 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

PRE-HEARING BRIEF

TRIDENT
PAIN CENTER

PATE, PATRICIA

[illegible] PATE, P[illegible]
ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

12/17/2013

Allison Davis, NP-C

Current Medications
omeprazole
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Ambien
OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Tizanidine Hydrochloride
Claritin-D
quinine

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain

History of Present Illness
Driver::
Present in office: No.
Anticoagulants::
None: Patient denies anticoagulant use.
Description of pain::
Location: lower back. Onset of pain: lifting injury. Date of Onset: 12/15/11. Nature: dull, aching. Severity: 5/10 overall. Timing: constant. Helping factors: injections by this clinic, pain medications, rest. Aggravating factors: bending, getting up and down.

Vital Signs
Wt 183, Ht 5'6", BP Initial 129/87, HR Initial 90, Temp Initial 97.2, PO2 Initial 94, Pain Initial 5/10, D/C BP 121/84, D/C HR 86, D/C PO2 99, D/C Pain 5/10.

Examination
General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments
1. SI JOINT PAIN - 724.6 (Primary)

Treatment
1. SI JOINT PAIN
Pt's SI joint pain is the area of greatest pain and we will treat it today.

Procedures

Sedation::
Versed Patient refused.
Supplies/Services::
Skin Prep Betadine x 3.
Needles 25 gauge x 3.5 inch spinal needle.
Local Anesthetic Lidocaine 1% 2 cc (preservative free).
Steroid Celestone 4.5 mg (preservative free) Wasted --- Celestone 4-5 mg (preservative free).
Omnipaque No Omnipaque was used.
Other Procedure Tray Fluoroscopy.

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.

Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.

Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.

Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.

Neurology:
Negative for headaches, dizziness, insomnia. Positive for tingling, numbness, arm weakness, leg weakness.

Sacro-Iliac Joint Injection::
Location Left.
Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The sacro-iliac joints were identified using fluoroscopic imaging. The injection site overlying the sacro-iliac joint was anesthetized as noted above. A spinal needle as noted above was advanced to each sacro-iliac joint under fluoroscopic guidance. Placement was confirmed with multiple views. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected in divided doses at each site. No evidence of intravascular or intrathecal placement was observed. A solution containing the appropriate medication as noted above was injected in divided doses. The needle was flushed and removed intact from the skin. The skin was cleansed and a sterile dressing applied to the injection sites.
Fluoroscopy Time 5 sec.
Complications None, the patient tolerated the procedure well and no complications were encountered.
Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition.
Discharge The patient was instructed to avoid driving for 24 hours discharge instructions were given to the patient, patient was discharged with vital signs stable.

Follow Up
Keep previous appointment



Electronically signed by JOSEPH NOLAN , MD on 01/08/2014 at 03:07 PM EST

Electronically co-signed by ALLISON DAVIS (NP-C) on 08/11/2014 at 09:32 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: Allison Davis, NP-C 12/17/2013**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(3)

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-509-0704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

01/24/2014

Kristen Giet, PA

Current Medications
quinine
Claritin-D
Tizanidine Hydrochloride
OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Ambien
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
omeprazole

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: lower back. Onset of pain: lifting injury. Date of Onset: 12/11. Nature: dull, aching. Severity: 3-4/10 overall. Timing: constant. Helping factors: trigger point injection, medications. Aggravating factors: bending, standing for long periods of time.

Vital Signs
Ht 5'6", BP Initial 124/90, HR Initial 95, Temp Initial 98.1, PO2 Initial 99, Pain Initial 3/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination
Lumbo/Sacral::
Lumbar: mild to moderate pain in the left lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation radiating over iliac crest.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. MUSCLE SPASMS - 728.85

Treatment

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.

Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.

Genitourinary:
Negative for urinary tract infections, kidney disease, bladder problems.

Musculoskeletal:
Negative for joint stiffness, arthritis. Positive for muscle pain, joint pain.

Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness, leg weakness.

1. LUMBAR POST-LAMINECTOMY

Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, DO NOT FILL UNTIL 1/28/14, 30
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, DO NOT FILL UNTIL 1/28/14, 90, Refills 0
Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed. Pt would benefit from a lumbar back brace. She has one that she has had since surgery however she can no longer wear it due to it no longer fitting.
Referral To:DME
Reason:DME eval (lumbar back brace)

2. THERAPEUTIC DRUG MONITOR

DHEC database reviewed and shows pt recently filled a small rx of Hydrocodone. Pt had a dental procedure performed. Reminded pt to contact our office is she is scheduled for procedures requiring additional meds. Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate.

3. MUSCLE SPASMS

Continue Tizanidine Hydrochloride tablet, 4 mg, 2 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 2

Labs

Lab: UDS Testing	
Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	NEG

TODD,SHAKIMA L 1/24/2014 8:25:13 AM > urine collected, in house lab only ADKINS(MLT),GINA 1/24/2014 12:03:14 PM > IN HOUSDE UDS

Procedure Codes

82570 ASSAY OF URINE CREATININE
82055 ASSAY OF ETHANOL
80101 DRUG SCREEN, SINGLE

Follow Up

4 Weeks, Medication refill, for Kristen Giet, PA-C



Electronically signed by JOSEPH NOLAN , MD on 02/13/2014 at 02:59 PM EST

Electronically co-signed by KRISTEN (PA-C) GIET on 03/26/2014 at 09:50 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: Kristen Giet, PA 01/24/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(6)

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-509-0704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

02/13/2014

J. Edward Nolan, MD

Current Medications
OxyContin 10 mg tablet, extended release 1 tab(s) qhs
omeprazole
Ambien
Tizanidine Hydrochlorides
Claritin-D
quinine
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2008.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major

Reason for Appointment
1. Left side of body

History of Present Illness
Pain relief from previous injection::
Date: 12/13/13 and 12/17/13. Injection: Lumbar transforaminal epidural injection and Sacro-Iliac injection. Pain relief: significant (>80%) initial pain relief of low back pain and of leg pain. Duration of relief: the pain is slowly returning in the area treated, the pain is still not back to its original level.
Driver::
Present in office: Yes, Donald.
Anticoagulants::
None: Patient denies anticoagulant use.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 2011. Nature: sharp, aching. Severity: 4/10 overall. Timing: constant. Helping factors: rest. Aggravating factors: activity.

Vital Signs
Wt 183, Ht 5'6", BP Initial 127/85, HR Initial 82, Temp Initial 97.8, PO2 Initial 97, Pain Initial 4/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: mild to moderate pain in the left lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation radiating over iliac crest. Sacro-Iliac Joint: moderate pain on the left with pelvic compression and to palpation.
Hip/Lower extremities::

Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.
Musculoskeletal:
Negative for muscle pain, joint pain, joint stiffness, arthritis.
Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness, leg weakness.

Piriformis/Sciatic nerve: mild pain in the left piriformis muscle over the sciatic nerve to palpation intermittent in nature.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. MUSCLE SPASMS - 728.85
3. SI JOINT PAIN - 724.6

Treatment
1. LUMBAR POST-LAMINECTOMY
Pt continues to report good pain relief with her injection therapy and medication management and work restrictions. Pt.'s low back pain is the area with the greatest pain and we will treat it upon return to clinic after authorization. We will continue to treat with a lumbar transforaminal as that has proven to be the most effective treatment for her at this point. Patient is at maximum medical improvement and will need ongoing palliative treatment to include steroid injections (no more than 6 per year), trigger point injections, therapeutic exercises, modalities and medication management as needed.
Referral To:Physical Therapist
Reason:FCE to determine permanent work restrictions

2. SI JOINT PAIN
Will treat patient's sacro-iliac pain on return to clinic after authorization.

Procedures
Transforaminal Steroid Injection, Lumbar::
Level Left L4 nerve root and L5 nerve root.
Procedure note Plan to perform on return to clinic, after authorization.
Sacro-Iliac Joint Injection::
Location Left.
Procedure note plan to perform on return to clinic, after authorization.

Follow Up
Keep previous appointment, Block only, for Dr. Nolan,after authorization

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 02/18/2014 at 08:55 AM EST

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: J. Edward Nolan, MD 02/13/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(9)

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-509-[illegible]
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

02/21/2014

Kristen Giet, PA

Current Medications
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
quinine
Claritin-D
Tizanidine Hydrochloride
Ambien
omeprazole
OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2009.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major

Reason for Appointment
1. Side pain
2. Low back pain
3. Buttocks pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: low back, leg. Onset of pain: work injury. Date of Onset: 2011. Nature: dull, sharp, aching, burning. Severity: 5/10 overall. Timing: constant. Helping factors: rest, pain medications. Aggravating factors: lifting, up and down.

Vital Signs
Ht 5'6", BP Initial 120/84, HR Initial 96, Temp Initial 97.6, PO2 Initial 98, Pain Initial 5/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints into left buttocks. Radiating Symptoms: intermittent mild to moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)

Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness, leg weakness.

2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. LUMBAR FACET ARTHROPATHY - 721.3
5. MUSCLE SPASMS - 728.85

Treatment

1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, DO NOT FILL UNTIL 2/26/14, 30
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, DO NOT FILL UNTIL 2/26/14, 90, Refills 0
Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed.

2. THERAPEUTIC DRUG MONITOR
Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate.

3. LUMBAR FACET ARTHROPATHY
Received referral for lumbar back brace on 1/24/14 . Pt is here today to be evaluated for the proper lumbar orthotic that will reduce the motion that creates his/her pain. We also desire to support weak musculature in the lumbar spine and increase stability of the spine. She has suffered with low back pain since 2011. Pt states they have used a back brace however her previous brace no longer fits her. Her pain will likely remain chronic. Pt states pain is particulary difficult when standing lifting. Use of this brace, should help acheive this goal and improve daily quality of life. Upon examination, I have chosen a L0627 for her today. We will plan to review her pain relief and her progress toward goals at the next scheduled visit. Pt is being fit for the Horizon LSO (L0627) today. Pt has been instructed on proper method of wearing the brace, the allowable methods of cleaning and recommended time to wear the brace. We reviewed how to adjust for sitting versus standing, proper manner in tightening orthosis for increased support for upper and lower lumbar. All questions regarding the brace were answered and pt was observed demonstrating use of the brace. 15 minutes was spent with patient for educating and fitting.
Referral To:
Reason:LSO Delivery Request

4. MUSCLE SPASMS
Referral To:
Reason:TENS unit

Labs

Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG

Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	POS

Seagraves,Lindsay 2/21/2014 8:15:20 AM > Collected specimen in house only ADKINS(MLT),GINA 2/21/2014 12:12:22 PM > IN HOUSE UDS

Procedure Codes
82570 ASSAY OF URINE CREATININE
82055 ASSAY OF ETHANOL
80101 DRUG SCREEN, SINGLE

Follow Up
4 Weeks from 2/26/14, Medication refill, for Kristen Giet, PA-C

Electronically signed by JOSEPH NOLAN , MD on 02/27/2014 at 10:42 AM EST

Electronically co-signed by KRISTEN (PA-C) GIET on 04/30/2014 at 09:55 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

TRIDENT
PAIN CENTER

PATE, PATRICIA

B: [illegible]

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

03/06/2014

J. Edward Nolan, MD

Current Medications
omeprazole
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Ambien
OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Tizanidine Hydrochloride
Claritin-D
quinine

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: Donald.
Description of pain::
Location: lower back, legs. Onset of pain: lifting heavy box. Date of Onset: 2011. Nature: dull, sharp, aching, burning, tingling. Severity: 7/10 overall. Timing: constant. Helping factors: injections by this clinic, pain medications, rest. Aggravating factors: movement, getting up and down.

Vital Signs
Wt 182, Ht 5'6, BP Initial 126/88, HR Initial 103, Temp Initial 98.1, PO2 Initial 96, Pain Initial 7/10, BP Proc 112/75, HR Proc 91, PO2 Proc 98, D/C BP 107/81, D/C HR 88, D/C PO2 99, D/C Pain 5/10.

Examination
General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. SI JOINT PAIN - 724.6

Treatment
1. LUMBAR POST-LAMINECTOMY
Pt.'s low back pain is the area with the greatest pain and we will treat it today. Will perform transforaminal epidural's to treat the axial low back pain caused at the nerve root level.

2. SI JOINT PAIN
Will treat patient's SI joint pain on return to clinic.

Procedures
Sedation::
Versed 7 mg BLAZEJEWICZ (RN),SYLVIA 3/6/2014 2:30:06 PM

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.

Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.

Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.

Musculoskeletal:
Positive for muscle pain, joint pain, joint stiffness, arthritis.

Neurology:
Negative for headaches, dizziness, insomnia, arm weakness, leg weakness. Positive for tingling, numbness.

> .

Synera patch applied lumbar region 30 minutes prior to procedure BLAZEJEWICZ (RN),SYLVIA 3/6/2014 2:34:50 PM > .

Location left deltoid.

Sedation Level 3/5 (OAA/S).

Supplies/Services::

Skin Prep Betadine x 3.

Needles 25 gauge x 5 inch spinal needle.

Local Anesthetic Lidocaine 1% 2 cc (preservative free).

Steroid Celestone 9 mg (preservative free).

Omnipaque No Omnipaque was used.

Other Procedure Tray, Fluoroscopy, Conscious Sedation.

Transforaminal Steroid Injection, Lumbar::

Level Left L4 nerve root and L5 nerve root.

Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The appropriate levels were identified using fluoroscopic imaging. The injection site was anesthetized as noted above. A 25 gauge Quincke spinal needle as noted above was directed to the 6 o'clock position of the pedicle using a line of site approach with the C-arm rotated in an oblique view and advanced to the mid-point of the neural foramen. Needle position was confirmed using both AP and oblique views with lateral views used as needed. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected as noted above to confirm needle placement. No evidence of intravascular or intrathecal placement was observed. The steroid noted above was injected in equal doses at each site. The needle was flushed with the local anesthetic noted above and removed intact. The skin was then cleansed and a sterile dressing applied to the injection sites.

Fluoroscopy Time 9 sec.

Complications None, the patient tolerated the procedure well and no complications were encountered.

Sacro-Iliac Joint Injection::

Location Left.

Procedure note plan to perform on return to clinic.

Electrical Stimulation/Modalities::

Application of Modalities Patient refused ice pack.

Recovery and Discharge:

Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition.

Discharge The patient was instructed to avoid driving for 24 hours, discharge instructions were given to the patient, patient was discharged with vital signs stable Pt escorted to driver with written discharge instructions BLAZEJEWICZ (RN),SYLVIA 3/6/2014 3:46:58 PM > .

Follow Up

Block only for Allison Davis, NP-C



Electronically signed by JOSEPH NOLAN , MD on 03/21/2014 at 10:25 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA Progress Note: J. Edward Nolan, MD 03/06/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(15)

TRIDENT PAIN CENTER

PATE. PATRICIA

Rx .

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

03/10/2014

J. Edward Nolan, MD

Current Medications
Ambien
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
omeprazole
quinine
Claritin-D
Tizanidine Hydrochloride
OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major

Reason for Appointment
1. Low back pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: lower back. Onset of pain: lifting injury; Date of Onset: 12/15/11. Nature: sharp. Severity: 8/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: movement.

Vital Signs
Wt 183, Ht 5'6", BP Initial 121/83, HR Initial 91, Temp Initial 97.2, PO2 Initial 96, Pain Initial 7-8/10, BP Proc 141/83, HR Proc 86, PO2 Proc 99, D/C BP 128/89, D/C HR 85, D/C PO2 99, D/C Pain 3/10.

Examination
General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments
1. SI JOINT PAIN - 724.6 (Primary)

Treatment
1. SI JOINT PAIN
Patient's low back pain is significant and we will treat it today with sacroiliac injection.

Procedures
Sedation::
Versed Patient refused.
Supplies/Services::
Skin Prep Betadine x 3.
Needles 25 gauge x 3.5 inch spinal needle.
Local Anesthetic Lidocaine 1% 2 cc (preservative free).
Steroid Celestone 4.5 mg (preservative free), Wasted ---, Celestone 4.5 mg (preservative free).
Omnipaque No Omnipaque was used.

ocedure
hospitalization

tems

Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness, leg weakness. Positive for tingling, numbness.

Other Procedure Tray, Fluoroscopy.
Sacro-Iliac Joint Injection::
Location Left.
Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The sacro-iliac joints were identified using fluoroscopic imaging. The injection site overlying the sacro-iliac joint was anesthetized as noted above. A spinal needle as noted above was advanced to each sacro-iliac joint under fluoroscopic guidance. Placement was confirmed with multiple views. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected in divided doses at each site. No evidence of intravascular or intrathecal placement was observed. A solution containing the appropriate medication as noted above was injected in divided doses. The needle was flushed and removed intact from the skin. The skin was cleansed and a sterile dressing applied to the injection sites.
Fluoroscopy Time 5 sec.
Complications None, the patient tolerated the procedure well and no complications were encountered.
Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition.
Discharge The patient was instructed to avoid driving for 24 hours, discharge instructions were given to the patient, patient was discharged with vital signs stable, Seagraves,Lindsay 3/10/2014 10:41:06 AM > .

Follow Up
2 Months, for Allison Davis, NP-C, Injection Eval to see if patient requires further injections

Electronically signed by JOSEPH NOLAN , MD on 03/24/2014 at 03:07 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER

9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA --, --, ---- Progress Note: J. Edward Nolan, MD 03/10/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(18)

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-509-0704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

03/18/2014

Allison Davis, NP-C

Current Medications
quinine
omeprazole
Percocet-5/325
Ambien
OxyContin
Tizanidine Hydrochloride
Claritin-D
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain
2. Left leg pain

History of Present Illness
Driver::
Present in office: Yes, Donald.
Anticoagulants::
None: Patient denies anticoagulant use.
Description of pain::
Location: lower back, leg. Onset of pain: lifting injury. Date of Onset: 12/15/11. Nature: sharp, aching, burning, throbbing, tingling, shooting. Severity: 8/10 overall. Timing: constant. Helping factors: sitting, lying down. Aggravating factors: movement.
Pain relief from previous injection::
Date: 03/06/14 and 03/10/14. Injection: Lumbar transforaminal epidural injection and Sacro-Iliac injection. Pain relief: significant (>80%) initial pain relief of low back pain and of leg pain. Duration of relief: 2 days, then increased significantly after SI injection upon completing her FCE.

Vital Signs
Wt 183, Ht 5'6", BP Initial 127/90, HR Initial 102, Temp Initial 98.1, PO2 Initial 93, Pain Initial 8/10, D/C BP 122/92, D/C HR 98, D/C PO2 97, D/C Pain 5/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in mild distress. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Sensory function: decreased sensation in left lower extremity. Motor Function: Coordination is normal. Muscle strength is decreased 4/5 (good) left lower extremity. Gait is antalgic Tone is normal. Gait is antalgic.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.

Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.

Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.

Musculoskeletal:
Positive for muscle pain, joint pain, joint stiffness, arthritis.

Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness, leg weakness.

musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints into left buttocks. Radiating Symptoms: intermittent mild to moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. SI JOINT PAIN - 724.6

Treatment

1. LUMBAR POST-LAMINECTOMY

Start Physical Therapy, eval and treat Treat for low back and radiating leg pain Dx:722.83, as directed, 15 visits
Pt reports significant increase in pain after completing her FCE. She states that she was able to return to work on Thursday and Friday of last week but was not able to work on Monday. She is sitting uncomfortably in the chair today upon exam. Due to the significant pain that this FCE has caused, I would like to see her in some intensive rehab to see if this can improve her stamina. Will also treat her with Toradol today to alleviate her exacerbated symptoms. Will also request a lumbar transforaminal steroid injection on return to clinic after authorization, to treat her lower back and leg pain.

Procedures

Transforaminal Steroid Injection, Lumbar::
Level Left L5 nerve root and S1 nerve root.
Procedure note Plan to perform on return to clinic, after authorization.

Toradol/Ketorolac Injection:
30mg After verifying allergies, toradol (30mg/1ml) injection was administered IM into upper and outer quadrant in the, left gluteal muscle, Patient tolerated the injection well, lot: 36-429-DK, exp:12/1/2015.

Follow Up

Next available appointment, Block only,after authorization, for Dr. Nolan

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 03/19/2014 at 10:48 AM EDT

Electronically co-signed by ALLISON DAVIS (NP-C) on 08/08/2014 at 10:53 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA [illegible] **Progress Note: Allison Davis, NP-C 03/18/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(21)

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

03/26/2014

Kristen Giet, PA

Current Medications
Taking Claritin-D
Taking Tizanidine Hydrochloride
Taking OxyContin
Taking Ambien
Taking Percocet-5/325
Taking Physical Therapy, eval and treat Treat for low back and radiating leg pain Dx:722.83 as directed
Taking omeprazole
Taking quinine

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major

Reason for Appointment
1. Low back pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: lower back, leg. Onset of pain: lifting injury. Date of Onset: 12/15/11. Nature: dull, sharp, aching, burning, tingling, shooting. Severity: 5/10 overall. Timing: constant. Helping factors: rest, pain medications. Aggravating factors: standing too long, bending, getting up and down.

Vital Signs
Ht 5'6", BP Initial 121/83, HR Initial 80, Temp Initial 97.5, PO2 Initial 99, Pain Initial 5/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in mild distress. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Motor Function: Coordination is normal. Gait is antalgic Tone is normal.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints, L>>R. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution to the calf.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69

Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.
Musculoskeletal:
Negative for arthritis. Positive for joint stiffness, joint pain, muscle pain.
Neurology:
Negative for headaches, dizziness, arm weakness. Positive for tingling, numbness, insomnia, leg weakness.

3. THERAPEUTIC DRUG MONITOR - V58.83

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, 30
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, 90, Refills 0
Notes: Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed. Pt reports that pain is still elevated from FCE. She will be scheduled for an injection as soon as auth is received from work comp. She has been using the TENS unit which she feels has helped some.

2. THERAPEUTIC DRUG MONITOR
Notes: Urine drug analysis performed in house today to verify compliance with current drug therapy. DHEC database reviewed and is appropriate. In office screen today was appropriate.

Labs

Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	POS

PHILLIPS,AMANDA 3/26/2014 8:25:42 AM > IN HOUSE ONLY ADKINS(MLT),GINA 3/26/2014 11:24:24 AM > IN HOUSE UDS

Procedure Codes
82570 ASSAY OF URINE CREATININE
82055 ASSAY OF ETHANOL
80101 DRUG SCREEN, SINGLE

Follow Up
4 Weeks, Medication refill, for Kristen Glet, PA-C

Electronically signed by JOSEPH NOLAN , MD on 04/07/2014 at 10:38 AM EDT

Electronically co-signed by KRISTEN (PA-C) GIET on 05/07/2014 at 10:38 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA --, --. **Progress Note: Kristen Giet, PA 09/26/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(24)

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

04/03/2014

J. Edward Nolan, MD

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Taking Claritin-D
Taking Tizanidine Hydrochloride
Taking OxyContin
Taking Ambien
Taking Physical Therapy, eval and treat Treat for low back and radiating leg pain Dx:722.83 as directed
Taking omeprazole
Taking quinine
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012
Tooth extraction 9/13/2013

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Reason for Appointment

1. Low back pain
2. Leg pain

History of Present Illness

Description of pain::
Location: lower back, left leg. Onset of pain: lifting injury. Date of Onset: 12/15/11. Nature: aching, burning, throbbing. Severity: 7/10 overall. Timing: constant. Helping factors: Bed. Aggravating factors: movement.
Driver::
Present in office: Yes, Donald.
Anticoagulants::
None: Patient denies anticoagulant use.

Vital Signs

Wt 173, Ht 5'6", BP Initial 129/85, HR Initial 89, Temp Initial 98.1, PO2 Initial 97, Pain Initial 7/10, BP Proc 132/86, HR Proc 88, PO2 Proc 95, D/C BP 130/91, D/C HR 83, D/C PO2 98, D/C Pain 3/10.

Examination

General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)

Treatment

1. LUMBAR POST-LAMINECTOMY
Notes: Pt.'s low back pain and leg pain are the areas with the greatest pain and we will treat them today.

Procedures

Sedation::
Versed 7 mg, BLAZEJEWICZ (RN),SYLVIA 4/3/2014 3:03:05 PM > . Synera patch applied, lumbar region, 30 minutes prior to procedure, BLAZEJEWICZ (RN),SYLVIA 4/3/2014 3:07:13 PM > . Location left, deltoid. Sedation Level 3/5 (OAA/S).
Supplies/Services::
Skin Prep Betadine x 3. Needles 25 gauge x 5 inch spinal

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.
Musculoskeletal:
Negative for joint pain, joint stiffness, arthritis. Positive for muscle pain.
Neurology:
Negative for headaches, dizziness, arm weakness. Positive for insomnia, leg weakness.

needle. Local Anesthetic Lidocaine 1% 2 cc (preservative free). Steroid Celestone 9 mg (preservative free). Omnipaque 1 cc. Other Procedure Tray, Epiduragram, Conscious Sedation.
Transforaminal Steroid Injection, Lumbar::
Level Left L_5 nerve root and S1 nerve root. Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The appropriate levels were identified using fluoroscopic imaging. The injection site was anesthetized as noted above. A 25 gauge Quincke spinal needle as noted above was directed to the 6 o'clock position of the pedicle using a line of site approach with the C-arm rotated in an oblique view and advanced to the mid-point of the neural foramen. Needle position was confirmed using both AP and oblique views with lateral views used as needed. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected as noted above to confirm needle placement. No evidence of intravascular or intrathecal placement was observed. The steroid noted above was injected in equal doses at each site. The needle was flushed with the local anesthetic noted above and removed intact. The skin was then cleansed and a sterile dressing applied to the injection sites. Fluoroscopy Time 9 sec. Complications None, the patient tolerated the procedure well and no complications were encountered.
Epiduragram::
Procedure Note : An epiduragram was performed using fluoroscopic guidance with the following results:. Omnipaque dye 1 cc injected into the epidural space. Bony structure intact. Pressure required normal. Pain on injection moderate. Filling defects a moderate amount of filling defects superiorly inferiorly on the left. Contrast flow no significant obstruction to flow. IMPRESSION moderate epidural inflammation, no obstruction to contrast flow within the epidural space.
Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition. Discharge The patient was instructed to avoid driving for 24 hours, discharge instructions were given to the patient, patient was discharged with vital signs stable Pt escorted to driver with written discharge instructions WEST (RN),BRITTNEY 4/3/2014 4:19:18 PM > .

Follow Up
2 Months, for Allison Davis, NP-C, Injection Eval to see if patient requires further injections

Electronically signed by JOSEPH NOLAN , MD on 04/22/2014 at 08:36 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: J. Edward Nolan, MD 04/03/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(27)

TRIDENT PAIN CENTER

PATE, PATRICIA

Home: 843-509-9704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

04/23/2014

J. Edward Nolan, MD

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Taking Claritin-D
Taking Tizanidine Hydrochloride
Taking OxyContin
Taking Ambien
Taking Physical Therapy, eval and treat Treat for low back and radiating leg pain Dx:722.83 as directed
Taking omeprazole
Taking quinine
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012
Tooth extraction 9/13/2013

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2008.
no Alcohol.

Reason for Appointment

1. Low back pain
2. Leg pain

History of Present Illness

Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: lower back, left leg. Onset of pain: lifting injury. Date of Onset: 12/11. Nature: sharp, burning, tingling, shooting. Severity: 5/10 overall. Timing: constant. Helping factors: rest, medications. Aggravating factors: getting up and down, standing for long period of time.

Vital Signs

Ht 5'6", BP Initial 134/86, HR Initial 93, Temp Initial 97.5, PO2 Initial 99, Pain Initial 5/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in mild distress. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Motor Function: Coordination is normal. Gait is antalgic Tone is normal.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilatrral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints L>>R. Sacro-Iliac Joint: moderate pain bilaterally with pelvic compression and to palpation L>>R. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left S1 nerve distribution to the knee.

Assessments

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness, leg weakness. Positive for tingling, numbness.

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. THERAPEUTIC DRUG MONITOR - V58.83
3. LONG-TERM USE MEDS NEC - V58.69
4. LUMBAR FACET ARTHROPATHY - 721.3
5. SI JOINT PAIN - 724.6

Treatment

1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, 30
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, 90, Refills 0
Notes: Patient in office today for medication management. She reports that she has returned to work full time with no restrictions on 04/11/14 but reports that her pain and anxiety are elevated. She reports that the getting up and down and standing for prolonged periods of time are a major issue. Her FCE showed that she could perform medium work however pt does report that her pain was elevated after the FCE and she cannot do this type of work daily. In order to keep pt working, pt cannot stand more than 1 hour at a time then must sit for at least 2 hours. She may require breaks during these times to change position for a short period of time (5-10 minutes). She cannot lift more than 15 pounds.

2. THERAPEUTIC DRUG MONITOR
Notes: Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate.

3. LUMBAR FACET ARTHROPATHY
Notes: Will treat her low back pain after authorization with lumbar facet injections.

4. SI JOINT PAIN
Notes: Will address sacro-iliac pain after authorization and after performing the lumbar facets injections.

Procedures
Facet, Lumbar Injection::
Level Bilateral L3/L4, L4/L5, L5/S1. Procedure note Plan to perform on return to clinic after authorization.
Sacro-Iliac Joint Injection::
Location Bilateral. Procedure note plan to perform on return to clinic after authorization after facets injection.

Labs

Lab: UDS Testing	
Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG

Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	POS

RIVERS,NANETTA 4/23/2014 8:30:19 AM > specimen collected in house only ADKINS(MLT),GINA 4/23/2014 9:41:54 AM > IN HOUSE UDS

Procedure Codes
82570 ASSAY OF URINE CREATININE
82055 ASSAY OF ETHANOL
80101 DRUG SCREEN, SINGLE

Follow Up
4 Weeks, Medication refill, for Kristen Giet, PA-C, Cancel 05/05/14 appointment, Block only after authorization

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 04/24/2014 at 08:32 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(30)

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

05/05/2014

J. Edward Nolan, MD

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Taking Claritin-D
Taking Tizanidine Hydrochloride
Taking Ambien
Taking Physical Therapy, eval and treat Treat for low back and radiating leg pain Dx:722.83 as directed
Taking omeprazole
Taking quinine
Discontinued OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Discontinued Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Discontinued OxyContin
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012
Tooth extraction 9/13/2013

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: Yes, Donald.
Description of pain::
Location: lower back. Onset of pain: work injury, lifting injury. Date of Onset: 12/15/11. Nature: aching, burning, throbbing, tingling, shooting. Severity: 7/10 overall. Timing: constant. Helping factors: rest, injections by this clinic. Aggravating factors: getting up and down, movement.

Vital Signs

Wt 185, Ht 5'6", BP Initial 138/83, HR Initial 97, Temp Initial 98.5, PO2 Initial 99, Pain Initial 7/10, BP Proc 135/91, HR Proc 90, PO2 Proc 95, D/C BP 119/82, D/C HR 88, D/C PO2 96, D/C Pain 0/10.

Examination

General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments

1. LUMBAR FACET ARTHROPATHY - 721.3 (Primary)
2. SI JOINT PAIN - 724.6

Treatment

1. LUMBAR FACET ARTHROPATHY
Continue Tizanidine Hydrochloride tablet, 4 mg, 2 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 2
Notes: Pt.'s low back pain is the area with the greatest pain and we will treat it today.

2. SI JOINT PAIN
Notes: Will treat patient's SI joint pain on return to clinic.

Procedures

Sedation::

Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness, leg weakness.

Versed 7 mg WEST (RN),BRITTNEY 5/5/2014 2:33:58 PM > . Synera patch applied lumbar region 30 minutes prior to procedure WEST (RN),BRITTNEY 5/5/2014 2:40:16 PM > . Location left deltoid. Sedation Level 3/5 (OAA/S).
Supplies/Services::
Skin Prep Betadine x 3. Needles 25 gauge x 3.5 inch spinal needle. Local Anesthetic Lidocaine 1% 5 cc (preservative free). Steroid Celestone 12 mg+4 mg (preservative free). Omnipaque No Omnipaque was used. Other Procedure Tray, Fluoroscopy, Conscious Sedation.
Facet, Lumbar Injection::
Level Bilateral L3/L4, L4/L5, L5/S1. Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above. The appropriate levels were identified by fluoroscopic imaging. The injection site was anesthetized as noted above. A spinal needle as noted above was advanced to each facet joint using fluoroscopic guidance. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Needle placement was confirmed with multiple views. Radiopaque dye was injected as noted above to confirm needle placement. No evidence of intravascular, epidural, or intrathecal placement was observed. The steroid noted above was injected in equally divided doses at each site. A solution containing the other medication as noted above were combined. 0.5 cc of this solution was injected at each site. The needle was flushed and removed intact from the skin. The skin was cleansed and a sterile dressing applied to the injection sites. Fluoroscopy Time 16 SEC. Complications None, the patient tolerated the procedure well and no complications were encountered.
Sacro-Iliac Joint Injection::
Location Bilateral. Procedure note plan to perform on return to clinic.
Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition. Discharge The patient was instructed to avoid driving for 24 hours discharge instructions were given to the patient, patient was discharged with vital signs stable Pt escorted to driver with written discharge instructions BLAZEJEWICZ (RN),SYLVIA 5/5/2014 4:20:47 PM > .

Follow Up
Block only, for Allison Davis, NP-C, 1 Week, 3 Months, for Allison Davis, NP-C, Injection Eval to see if patient requires further injections



Electronically signed by JOSEPH NOLAN , MD on 05/27/2014 at 09:39 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: J. Edward Nolan, MD 05/05/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(33)

TRIDENT PAIN CENTER

PATE, PATRICIA

[redacted]
Home: 843-309-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

05/15/2014 J. Edward Nolan, MD

Current Medications
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Taking Claritin-D
Taking Ambien
Taking Physical Therapy, eval and treat Treat for low back and radiating leg pain Dx:722.83 as directed
Taking omeprazole
Taking quinine
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Reason for Appointment
1. Low back pain

History of Present Illness
Description of pain::
Location: lower back. Onset of pain: work injury. Date of Onset: 12/14/2011. Nature: sharp, aching, shooting. Severity: 5/10 overall. Timing: constant. Helping factors: injections by this clinic, pain medications, rest. Aggravating factors: standing, over ativity.
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.

Vital Signs
Wt 185, Ht 5'6", BP Initial 125/89, HR Initial 98, Temp Initial 97.3, PO2 Initial 97, Pain Initial 5/10, BP Proc 129/80, HR Proc 93, PO2 Proc 95, D/C BP 128/86, D/C HR 83, D/C PO2 99, D/C Pain 2/10.

Examination
General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments
1. SI JOINT PAIN - 724.6 (Primary)

Treatment
1. SI JOINT PAIN
Notes: Patient is in the offie today for sacroiliac joint injections.

Procedures
Sedation::
Versed Patient refused.
Supplies/Services::
Skin Prep Hibicleanse x 3. Needles 25 gauge x 3.5 inch spinal needle, Local Anesthetic Lidocaine 1% 2 cc (preservative free). Steroid Celestone 9 mg (preservative free). Omnipaque No Omnipaque was used. Other Procedure Tray, Fluoroscopy.
Sacro-Iliac Joint Injection::
Location Bilateral. Procedure note Informed consent was obtained

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness. Positive for leg weakness, dizziness.

from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The sacro-iliac joints were identified using fluoroscopic imaging. The injection site overlying the sacro-iliac joint was anesthetized as noted above. A spinal needle as noted above was advanced to each sacro-iliac joint under fluoroscopic guidance. Placement was confirmed with multiple views. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected in divided doses at each site. No evidence of intravascular or intrathecal placement was observed. A solution containing the appropriate medication as noted above was injected in divided doses. The needle was flushed and removed intact from the skin. The skin was cleansed and a sterile dressing applied to the injection sites. Fluoroscopy Time 8 sec. Complications None, the patient tolerated the procedure well and no complications were encountered.
Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition. Discharge discharge instructions were given to the patient, patient was discharged with vital signs stable Pt escorted with written discharge instructions WEST (RN),BRITTNEY 5/15/2014 4:33:46 PM > .

Follow Up
Keep previous appointment

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 05/29/2014 at 11:35 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

TRIDENT PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

05/21/2014 Kristen Glet, PA

Current Medications
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Discontinued Physical Therapy, eval and treat
Treat for low back and radiating leg pain
Dx:722.83 as directed

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Reason for Appointment
1. Low back pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: lower back. Onset of pain: work injury. Date of Onset: 12/2011. Nature: sharp, aching. Severity: 5/10 overall. Timing: constant. Helping factors: pain medications, rest. Aggravating factors: standing, walking, bending, standing.

Vital Signs
Ht 5'6", BP Initial 122/85, HR Initial 88, Temp Initial 97.9, PO2 Initial 98, Pain Initial 5/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in mild distress. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Motor Function: Coordination is normal. Gait is antalgic Tone is normal.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints, radiating up left lumbar spine intermittently.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, arm weakness, leg weakness. Positive for insomnia.

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, 30, Refills 0
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, 90, Refills 0
Notes: Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed. Pt reports that her and her husband walked approx 1 mile yesterday fo exercise but this increased her pain. Discussed cutting back distance some but doing more frequently. Also discussed exercise bike and swimming as less physically demanding exercises.

2. THERAPEUTIC DRUG MONITOR
Notes: Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate.

Labs

Lab: UDS Testing	
Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	POS

GRISSETT,SHAKIMA L 5/21/2014 9:06:26 AM > urine collected, in house lab only ADKINS(MLT),GINA 5/21/2014 10:35:29 AM > IN HOUSE UDS

Procedure Codes
82570 ASSAY OF URINE CREATININE
82055 ASSAY OF ETHANOL
80101 DRUG SCREEN, SINGLE

Follow Up
4 Weeks, Medication refill, for Kristen Glet, PA-C



Electronically signed by JOSEPH NOLAN , MD on 06/02/2014 at 02:53 PM EDT

Electronically co-signed by KRISTEN (PA-C) GIET on 06/09/2014 at 09:44 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: Kristen Giet, PA 05/21/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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TRIDENT PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

06/18/2014 Kristen Giet, PA

Current Medications
Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: lower back, leg. Onset of pain: work injury. Date of Onset: 12/2011. Nature: aching. Severity: 7/10 overall. Timing: constant. Helping factors: pain medications, rest. Aggravating factors: standing, walking, bending, standing, increased work load.

Vital Signs
Ht 5'6", BP Initial 137/94, HR Initial 86, Temp Initial 97.9, PO2 Initial 97, Pain Initial 7/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in mild distress. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Motor Function: Coordination is normal. Gait is antalgic Tone is normal.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Sacro-Iliac Joint: moderate pain bilaterally with pelvic compression and to palpation. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the bilateral L5 nerve distribution and S1 nerve distribution to the knee.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness. Positive for tingling, numbness, leg weakness.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, DO NOT FILL UNTIL 6/25, 30, Refills 0, Notes: Pharmacy
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, DO NOT FILL UNTIL 6/25, 90, Refills 0, Notes: Pharmacy
Notes: Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed.

2. THERAPEUTIC DRUG MONITOR
Notes: DHEC database reviewed and is appropriate, last filled 05/27/14. Urinary drug screen performed today to assess patient's compliance in taking prescribed medications as well as to assess for the use of non prescribed prescription medications and illicit substances.

Labs
Lab: UDS Testing
RIVERS,NANETTA 6/18/2014 2:37:40 PM > specimen collected for Millennium

Follow Up
4 Weeks, Eval patients needs for further treatment, Medication refill, for Allison Davis, NP-C

Electronically signed by JOSEPH NOLAN , MD on 06/25/2014 at 11:35 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER

9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: Kristen Gict, PA 06/18/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(41)

TRIDENT PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

07/08/2014 J. Edward Nolan, MD

Current Medications
Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs, Notes: Pharmacy
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN, Notes: Pharmacy
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Reason for Appointment
1. Low back pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Pain relief from previous injection::
Date: 05/05/14 and 05/15/14. Injection: Lumbar facet injection and Sacro-Iliac injection. Pain relief: significant (>80%) initial pain relief of low back pain. Duration of relief: the pain has slowly returned since the last injection.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 12/2011. Nature: sharp, aching, burning, throbbing, tingling, shooting. Severity: 7/10 overall. Timing: constant. Helping factors: pain medications, rest. Aggravating factors: standing too long, bending, increased work load/trying to meet production quota.

Vital Signs
Wt 187, Ht 5'6", BP Initial 129/86, HR Initial 61, Temp Initial 97.8, PO2 Initial 97, Pain Initial 7/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Teaful today. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Motor Function: Coordination is normal. Gait is antalgic.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints, with palpable paraspinous myospasms present L>>R. Sacro-Iliac Joint:

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness. Positive for insomnia, tingling, numbness, arm weakness, leg weakness.

moderate pain bilaterally to palpation.
Hip/Lower extremities::
Piriformis/Sciatic nerve: moderate pain bilateral piriformis muscle over the sciatic nerve to palpation. Lower extremity darkened and reddened skin to BLE.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. SI JOINT PAIN - 724.6
3. MUSCLE SPASMS - 728.85
4. LUMBAR FACET ARTHROPATHY - 721.3

Treatment
1. LUMBAR POST-LAMINECTOMY
Notes: Pt is tearful today stating that she has returned to work but is unable to meet her quotas required of her if she works within the restrictions we placed on her 04/29/14. She states she has been in contact with someone at the college to see if she could qualify for a different job but has not heard back from them to date.

2. SI JOINT PAIN
Notes: We will also plan to treat SI pain on return to clinic after authorization.

3. LUMBAR FACET ARTHROPATHY
Notes: Pt.'s low back pain is the area with the greatest pain and we will treat it on return to clinic after authorization.

4. Others
Notes: Doppler studies to be ordered to evaluate lower extremity discoloration.
Action Started- AUTHORIZATION

Procedures
Facet, Lumbar Injection::
Level Bilateral L3/L4, L4/L5, L5/S1. Procedure note Plan to perform on return to clinic after authorization.
Sacro-Iliac Joint Injection::
Location Bilateral. Procedure note plan to perform on return to clinic after authorization.

Follow Up
Block only, for Dr. Nolan,after authorization



Electronically signed by JOSEPH NOLAN , MD on 07/15/2014 at 12:18 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA [illegible] **Progress Note: J. Edward Nolan, MD 07/08/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

TRIDENT PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

07/16/2014 Kristen Giet, PA

Current Medications
Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs, Notes: Pharmacy
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN, Notes: Pharmacy
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Hospitalization/Major

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Adjuvant therapies::
Other significant meds: Patient is taking Lipozeneor a dietary supplement.
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: low back, leg. Onset of pain: work injury. Date of Onset: 12/2011. Nature: dull, aching. Severity: 4/10 overall. Timing: constant. Helping factors: pain medication, lying down/relaxing. Aggravating factors: increased activity.

Vital Signs
Ht 5'6", BP Initial 105/76, HR Initial 89, Temp Initial 97.1, PO2 Initial 100, Pain Initial 4/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Teaful today. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Motor Function: Coordination is normal. Gait is antalgic.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Sacro-Iliac Joint: moderate pain bilaterally with pelvic compression and to palpation. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to

Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness. Positive for tingling, numbness, leg weakness.

the knee.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. THERAPEUTIC DRUG MONITOR - V58.83
3. LONG-TERM USE MEDS NEC - V58.69

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, DO NOT FILL UNTIL 7/25, 30, Refills 0
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, DO NOT FILL UNTIL 7/25, 90, Refills 0
Notes: Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed. We are currently obtaining auth for injection.

2. THERAPEUTIC DRUG MONITOR
Notes: DHEC database reviewed and is appropriate. Urine drug analysis performed in house today to verify compliance with current drug therapy. Discussed previous urine results with pt. She is aware she cannot take meds that are prescribed to her husband and she denies taking any BZOs. We will obtain urine again today and will verify this is not in her system at this time. In office screen today was appropriate.

3. Others
Notes: Verified patient's PCP today: Dr. Hanna. Pt has seen Dr. Hanna due to concern over skin color of legs. They have done blood work and will be further evaluating/ruling out medical issues such as diabetes, vascular issues.

Labs
Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	POS
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	POS

GRISSETT,SHAKIMA L 7/16/2014 11:26:44 AM > in house lab only ADKINS(MLT),GINA 7/16/2014 12:02:34 PM > IN HOUSE UDS

Procedure Codes
82570 ASSAY OF URINE CREATININE

82055 ASSAY OF ETHANOL
80101 DRUG SCREEN QUAL SINGLE DRUG CLASS METHOD, EA DRUG CLASS

Follow Up
4 Weeks from 7/25, Medication refill, for Kristen Giet, PA-C

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 08/05/2014 at 10:24 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: Kristen Giet, PA 07/16/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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TRIDENT PAIN CENTER

PATE. PATRICIA

[redacted]
Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

07/31/2014 J. Edward Nolan, MD

Current Medications
Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years. Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Hospitalization/Major

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Description of pain::
Location: lower back, leg pain. Onset of pain: work injury. Date of Onset: 12/2011. Nature: aching, burning, tingling. Severity: 7/10 overall. Timing: constant. Helping factors: pain medications, rest. Aggravating factors: everything. Significant issues: Pt states she spoke with her PCP about the leg discoloration and that she is to have a Doppler study next month.
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: Donald.

Vital Signs
Wt 187, Ht 5'6", BP Initial 130/94, HR Initial 102, Temp Initial 97.8, PO2 Initial 100, Pain Initial 7/10, D/C BP 125/87, D/C HR 79, D/C PO2 98, D/C Pain 1/10.

Examination
General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments
1. LUMBAR FACET ARTHROPATHY - 721.3 (Primary)
2. SI JOINT PAIN - 724.6

Treatment
1. LUMBAR FACET ARTHROPATHY
Notes: Pt.'s low back pain is the areas with the greatest pain and we will treat them today.

2. SI JOINT PAIN
Notes: Bilateral SI joint pain is significant and will treat upon RTC.

Procedures
Sedation::

Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for muscle pain, joint pain, joint stiffness, arthritis.
Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness, leg weakness.

Versed 7 mg BLAZEJEWICZ (RN),SYLVIA 7/31/2014 3:29:39 PM > . Synera patch applied lumbar region 30 minutes prior to procedure BLAZEJEWICZ (RN),SYLVIA 7/31/2014 3:33:16 PM > . Location left deltoid.
Supplies/Services::
Skin Prep Betadine x 3. Needles 25 gauge x 3.5 inch spinal needle. Local Anesthetic Lidocaine 1% 5 cc (preservative free). Steroid Celestone 12 mg+4 mg (preservative free). Omnipaque No Omnipaque was used. Other Procedure Tray, Fluoroscopy, Conscious Sedation.
Facet, Lumbar Injection::
Level Bilateral L3/L4, L4/L5, L5/S1. Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above. The appropriate levels were identified by fluoroscopic imaging. The injection site was anesthetized as noted above. A spinal needle as noted above was advanced to each facet joint using fluoroscopic guidance. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Needle placement was confirmed with multiple views. Radiopaque dye was injected as noted above to confirm needle placement. No evidence of intravascular, epidural, or intrathecal placement was observed. The steroid noted above was injected in equally divided doses at each site. A solution containing the other medication as noted above were combined. 0.5 cc of this solution was injected at each site. The needle was flushed and removed intact from the skin. The skin was cleansed and a sterile dressing applied to the injection sites. Fluoroscopy Time 26 SEC. Complications None, the patient tolerated the procedure well and no complications were encountered.
Sacro-Iliac Joint Injection::
Location Bilateral. Procedure note plan to perform on return to clinic.
Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition, The patient was monitored for side effects and to ensure alert, awake, and in oriented condition. Discharge The patient was instructed to avoid driving for 24 hours, discharge instructions were given to the patient, patient was discharged with vital signs stable, Pt escorted to driver with written discharge instructions MCGUINESS,KELLI 7/31/2014 5:03:07 PM > .

Follow Up
1 Week, Block only, for Dr. Nolan

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 08/08/2014 at 11:23 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: J. Edward Nolan, MD 07/31/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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TRIDENT PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

08/08/2014 J. Edward Nolan, MD

Current Medications
Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Hospitalization/Major

Reason for Appointment
1. Low back pain

History of Present Illness
Description of pain::
Location: lower back. Onset of pain: work injury. Date of Onset: 12/2011. Nature: sharp, aching. Severity: 5/10 overall. Timing: constant. Helping factors: pain medications, Lidoderm patches, rest. Aggravating factors: activity.
Driver::
Present in office: Donald.
Anticoagulants::
None: Patient denies anticoagulant use.

Vital Signs
Wt 187, Ht 5'6", BP Initial 147/97, HR Initial 94, Temp Initial 98.0, PO2 Initial 97, Pain Initial 5/10, BP Proc 170/91, HR Proc 93, PO2 Proc 93, D/C BP 154/90, D/C HR 83, D/C PO2 94, D/C Pain 2/10.

Examination
General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments
1. SI JOINT PAIN - 724.6 (Primary)

Treatment
1. SI JOINT PAIN
Notes: SI joint pain significant and will treat today.

Procedures
Sedation::
Versed Patient refused.
Supplies/Services::
Skin Prep Betadine x 3. Needles 25 gauge x 3.5 inch spinal needle. Local Anesthetic Lidocaine 1% 2 cc (preservative free). Steroid Celestone 9 mg (preservative free). Omnipaque No Omnipaque was used. Other Fluoroscopy, Procedure Tray.
Sacro-Iliac Joint Injection::
Location Bilateral Procedure note Informed consent was obtained

Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, skin cancer. Positive for recent skin sores.

Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness, leg weakness. Positive for tingling, numbness.

from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The sacro-iliac joints were identified using fluoroscopic imaging. The injection site overlying the sacro-iliac joint was anesthetized as noted above. A spinal needle as noted above was advanced to each sacro-iliac joint under fluoroscopic guidance. Placement was confirmed with multiple views. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected in divided doses at each site. No evidence of intravascular or intrathecal placement was observed. A solution containing the appropriate medication as noted above was injected in divided doses. The needle was flushed and removed intact from the skin. The skin was cleansed and a sterile dressing applied to the injection sites. Fluoroscopy Time 8 sec. Complications None, the patient tolerated the procedure well and no complications were encountered. Procedure peformed by J. Edward Nolan, MD.
Electrical Stimulation/Modalities::
Application of Modalities Ice pack, 10 mins. Indication post-procedural pain. Complications None. The patient tolerated the procedure well. No complications were encountered .
Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition. Discharge The patient was instructed to avoid driving for 24 hours, discharge instructions were given to the patient, patient was discharged with vital signs stable Pt escorted with written discharge instructions BLAZEJEWICZ (RN),SYLVIA 8/8/2014 2:44:57 PM > .

Follow Up
2 Months, Eval patients needs for further treatment, for Allison Davis, NP-C



Electronically signed by JOSEPH NOLAN , MD on 08/21/2014 at 04:43 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: J. Edward Nolan, MD 08/08/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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TRIDENT PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

08/21/2014 Allison Davis, NP-C

Current Medications
Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking atorvastatin 10 mg tablet once a day

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: low back, leg. Onset of pain: work injury. Date of Onset: 12/15/11. Nature: sharp, aching, throbbing, shooting. Severity: 6/10 overall. Timing: constant. Helping factors: pain medications, rest. Aggravating factors: bending, standing, sitting.
Pain relief from previous injection::
Date: 07/31/14 and 08/08/14. Injection: Lumbar facet injection and Sacro-Iliac injection. Pain relief: significant (>80%) initial pain relief of low back pain. Duration of relief: two weeks, the pain is slowly returning in the area treated.

Vital Signs
Ht 5'6", BP Initial 130/100, HR Initial 106, Temp Initial 98.7, PO2 Initial 98, Pain Initial 6/10, D/C BP 139/102, D/C HR 106, D/C PO2 96, D/C Pain 6/10.

Examination
General examination:
Appearance: Patient is mildly obese female in mild distress. Patient is well groomed with a depressed affect. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Motor Function: Coordination is normal. Gait is antalgic, shifting often in chair.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate to severe pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness.

rotation of the spine with tenderness to palpation overlying the facet joints, with palpable paraspinous myospasms present. Radiating Symptoms: moderate to severe lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the knee.

Assessments
1. LUMBAR FACET ARTHROPATHY - 721.3 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. DEPRESSION - 311
5. MUSCLE SPASMS - 728.85

Treatment
1. LUMBAR FACET ARTHROPATHY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, 30 day(s), 30, Refills 0
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, 30 day(s), 90, Refills 0
Notes: Counseled patient on their current medication regimen and discussed how they are tolerating it. Discussed this patient with the attending physician and this treatment and procedure plan was decided upon. Patient denies any significant side effects that need to be addressed.

2. LONG-TERM USE MEDS NEC
Notes: DHEC database reviewed and is appropriate.

3. THERAPEUTIC DRUG MONITOR
Notes: Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate.

4. DEPRESSION
Start Effexor tablet, 50 mg, 1 tab(s), orally, 2 times a day, 30 day(s), 60
Notes: Pt is significantly depressed due s/t pain and increased pressures/stressors. I would like to refer her to Dr. Kee for psychological workup. She states that she feels work is "trying to push her out, that they don't want her there anymore". She does not appear to be coping well. Will see if she can work with Dr. Kee to develop /improve these skills. Will also start her on Effexor 50 mg BID and see how she does. Will have her back in 2 weeks to assess her response.
Referral To:Psychology
Reason:Eval and Treat for Depression (prefer Dr. Kee)

5. MUSCLE SPASMS
Continue Tizanidine Hydrochloride tablet, 4 mg, 2 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 2
Notes: Will treat myospasm today with trigger point injections.

Procedures
Supplies/Services::
Skin Prep Alcohol swab. Needles 27 gauge x 1.25 inch

needle. Local Anesthetic Lidocaine 1% 10 cc.
Trigger Point Injection - Diagnosis: Myofascial Pain/Muscle Spasms:
Location Bilateral Lumbar Paravertebral. Procedure note Informed consent was obtained from patient. The myofascial trigger points were identified by palpation. The skin was prepped as noted above. The needle noted above was advanced into the deep musculature at each site. Aspiration was negative for heme, parasthesias, and air. The appropriate medicine as noted above was injected at each site in equally divided doses. The needles were flushed and withdrawn intact from the skin. The skin was cleaned and a sterile dressing applied as needed. Complications None, the patient tolerated the procedure well and no complications were encountered. Procedure performed by Allison Davis, NP-C.
Electrical Stimulation/Modalities;:
Premodulation Current 46-50. Time spent 15 min. Electrodes/Pair 2. Indication muscle spasm. Complications None. The patient tolerated the procedure well. No complications were encountered .
Recovery and Discharge:
Recovery The patient was monitored for side effects and to ensure alert, awake, and in oriented condition. Discharge discharge instructions were given to the patient, patient was discharged with vital signs stable.

Labs

Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	POS
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	121.1/POS

GRISSETT,SHAKIMA L 8/21/2014 8:44:03 AM > in house lab only CROSBY (MLT),CHRISTINE 8/21/2014 11:01:47 AM > IN HOUSE UDS

Procedure Codes

G0431 DRUG SCR QUAL; MULTI CLASS PT ENC
82055 ASSAY OF ETHANOL
82570 ASSAY OF URINE CREATININE

Follow Up

2 Weeks, for Allison Davis, NP-C, Eval patients needs for further treatment



Electronically signed by JOSEPH NOLAN , MD on 08/22/2014 at 02:59 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA D(**Progress Note: Allison Davis, NP-C 08/21/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(57)

TRIDENT
PAIN CENTER

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

09/04/2014

Allison Davis, NP-C

Current Medications

Unknown OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Unknown Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Unknown Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Unknown Effexor 50 mg tablet 1 tab(s) 2 times a day
Unknown Claritin-D
Unknown Ambien
Unknown omeprazole
Unknown quinine
Unknown Paxil
Unknown atorvastatin 10 mg tablet once a day
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 12/15/2011. Nature: dull, sharp, aching, burning, throbbing, tingling, shooting. Severity: 4/10 overall. Timing: constant. Helping factors: rest, pain medication, injections by this clinic. Aggravating factors: activity, work, standing, walking, sitting.

Vital Signs

Wt 187, Ht 5'6, BP Initial 128/80, HR Initial 93, Temp Initial 97.1, PO2 Initial 98, Pain Initial 4/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints, with palpable paraspinous myospasms present. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the knee.

Assessments

1. LUMBAR FACET ARTHROPATHY - 721.3 (Primary)
2. DEPRESSION - 311

no Alcohol.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea. Positive for GERD.
Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.
Musculoskeletal:
Negative for arthritis. Positive for joint stiffness, joint pain, muscle pain.
Neurology:
Negative for dizziness, arm weakness. Positive for headaches, tingling, numbness; leg weakness.

3. MUSCLE SPASMS - 728.85

Treatment
1. LUMBAR FACET ARTHROPATHY
Start LUMBAR SUPPORT ORTHOTIC, Horizon 627 LSO, as directed, 1
Notes: Pt was referred for a low back brace 02/21/14 but has yet to receive it. Will again request this from her w/c today as we have already identified that this would be highly beneficial for her during her work hours.

2. DEPRESSION
Notes: Pt is scheduled to see Dr. Kee on 09/22/14 for further discussion.

3. MUSCLE SPASMS
Start TENS Unit & Monthly Supplies E0730 / A4595, Pain Management Technologies, Use as directed
Notes: We have also referred for a TENS unit on 02/21/14 which she has also not received. We will again request w/c to approve this device to better control her ongoing muscle spasms.

Follow Up
4 Weeks from 9/21/14, for Allison Davis, NP-C, Medication refill

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 09/09/2014 at 03:24 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

NO meds

15

PATRICIA PATE (---/1966) w/ DAVIS (NP-C), ALLISON F 09/04/2014 @ 8:30 AM

ADDRESS:

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) (YES) NO **If no, last day of work?** _____

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)
N/A

Are you a Diabetic? (circle one) YES (NO)

Please list any medications changes (including dosage):

COMPLAINT: Low Back

Location: Back

Started: 12-15-11

How: Lifting

Quality: (Dull Sharp Ache Burn Throb Ting Shoot)

Severity: 4 / 10 VAS overall

Timing: AM PM (Constant) Intermittent

Recent MRI, XRAYS, EMG/NCS studies: N/A

What makes your pain better: Rest Meds. Shots

What makes your pain worse: Rest Active work, Standing

Recent ER/Urgent Care Visit: N/A w/ Kidney stones Can't Ketoferi

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	● Yes	O No	urinary tract infections	O Yes	● No	headaches	● Yes	O No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	● Yes	O No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	O Yes	● No
RECENT constipation	O Yes	● No				arm weakness	O Yes	● No
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Patricia Pate Date:

FOR OFFICE USE ONLY!!!!!!!

Driver: Ø Blood Thinner: Ø

Pre-OP Vital Signs: BP 128/80 P 93 Sat 98 T 97.1 Ht ____ Wt ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P____ Sat ____ T ____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

60

TRIDENT
PAIN CENTER

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

09/10/2014

J. Edward Nolan, MD

Current Medications

Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Unknown OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Unknown Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Unknown Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Unknown Effexor 50 mg tablet 1 tab(s) 2 times a day
Unknown Claritin-D
Unknown Ambien
Unknown omeprazole
Unknown quinine
Unknown Paxil
Unknown atorvastatin 10 mg tablet once a day
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.

Reason for Appointment

1. Low back pain
2. Leg pain

History of Present Illness

Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: Yes.
Description of pain::
Location: low back, leg. Onset of pain: work injury. Date of Onset: 12/2011. Nature: dull, sharp, aching, burning, throbbing, tingling, shooting. Severity: 7/10 overall. Timing: constant. Helping factors: injections by this clinic, rest, pain medications. Aggravating factors: work, standing, activity, lifting.

Vital Signs

Wt 182, Ht 5'5", BP Initial 135/98, HR Initial 101, Temp Initial 97.9, PO2 Initial 96, Pain Initial 9/10, BP Proc 134/101, HR Proc 96, PO2 Proc 96, D/C BP 133/93, D/C HR 96, D/C PO2 95, D/C Pain 2/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. No response to deep tendon reflexes achilles tendon reflex in the left achilles tendon reflex diminished 1+ in the right achilles tendon reflex. Sensory function: decreased sensation in left lower extremity. Motor Function: Coordination is normal. Muscle strength is decreased 4/5 (good) left lower extremity. Tone is normal. Gait is antalgic, unable to sit square in the chair. Examiner: Allison Davis, Nurse Practitioner (NP-C).

Physical Examination

Lumbo/Sacral::
Lumbar: moderate to severe pain in the bilateral lumbar

Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain. Positive for night sweats.

Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.

Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.

Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.

Neurology:
Negative for headaches, dizziness, insomnia, arm weakness. Positive for tingling, numbness, leg weakness.

paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints L>>R. Radiating Symptoms: severe lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the foot.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)

Treatment
1. LUMBAR POST-LAMINECTOMY
Notes: Pt.'s radicular leg pain is the area with the greatest pain and we will treat it today. Authorization has been preapproved.

Procedures
Sedation::
Versed 7 mg BLAZEJEWICZ (RN),SYLVIA 9/10/2014 11:56:25 AM > . Synera two patches applied lumbar region 30 minutes prior to procedure BLAZEJEWICZ (RN),SYLVIA 9/10/2014 12:00:18 PM > . Location left deltoid. Sedation Level 3/5 (OAA/S).
Supplies/Services::
Skin Prep Betadine x 3. Needles 25 gauge x 5 inch spinal needle. Local Anesthetic Lidocaine 1% 5 cc (preservative free). Steroid Celestone 12 mg+4 mg (preservative free). Omnipaque 1 cc. Other Procedure Tray, Epiduragram, Conscious Sedation.
Transforaminal Steroid Injection, Lumbar::
Level Right L4 nerve root, Bilateral L5 nerve root, Left S1 nerve root. Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The appropriate levels were identified using fluoroscopic imaging. The injection site was anesthetized as noted above. A 25 gauge Quincke spinal needle as noted above was directed to the 6 o'clock position of the pedicle using a line of site approach with the C-arm rotated in an oblique view and advanced to the mid-point of the neural foramen. Needle position was confirmed using both AP and oblique views with lateral views used as needed. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected as noted above to confirm needle placement. No evidence of intravascular or intrathecal placement was observed. The steroid noted above was injected in equal doses at each site. The needle was flushed with the local anesthetic noted above and removed intact. The skin was then cleansed and a sterile dressing applied to the injection sites. Additional level performed at no extra charge at left L4/L5. Fluoroscopy Time 24 sec. Complications None, the patient tolerated the procedure well and no complications were encountered.
Epiduragram::
Procedure Note : An epiduragram was performed using fluoroscopic guidance with the following results:. Omnipaque dye 1 cc injected into the epidural space. Bony structure intact. Pressure required normal. Pain on injection moderate. Filling defects a moderate amount of filling defects superiorly inferiorly on the

left. Contrast flow moderate obstruction to flow, superiorly, on the left. IMPRESSION moderate epidural inflammation, moderate obstruction to contrast flow within the epidural space.

Recovery and Discharge:

Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition. Discharge The patient was instructed to avoid driving for 24 hours, discharge instructions were given to the patient, patient was discharged with vital signs stable Pt escorted to driver with written discharge instructions BLAZEJEWICZ (RN),SYLVIA 9/10/2014 12:46:26 PM > .

Follow Up

2 Months, for Allison Davis, NP-C, Injection Eval to see if patient requires further injections

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 09/24/2014 at 09:02 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(63)

14

PATRICIA PATE (DOB: **w/ DAVIS (NP-C), ALLISON F 09/10/2014 @ 11:00 AM**

ADDRESS:
H

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** Last Friday

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) YES (NO)

Please list any medications changes (including dosage):

COMPLAINT:

Location: [redacted] Lower back, legs
Started: _____
How: lifting
Quality: Dull Sharp Ache Burn Throb Ting Shoot
Severity: _____ / 10 VAS overall

Timing: AM PM Constant Intermittent
Recent MRI, XRAYS, EMG/NCS studies: _____
What makes your pain better: _____
What makes your pain worse: _____
Recent ER/Urgent Care Visit: _____

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	O No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	O No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats all Day	● Yes	O No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	O No				arthritis	O Yes	● No
RECENT weight gain	O Yes	O No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	~~O Yes~~	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	● Yes	O No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	O Yes	● No
RECENT constipation	O Yes	● No				arm weakness	O Yes	● No
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: [signature] Date: _____

FOR OFFICE USE ONLY!!!!!!!

Driver: _____ Blood Thinner: No

Pre-OP Vital Signs: BP 135/98 P 104 Sat 96 T 97.9 Ht ____ Wt 183

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P____ Sat____ T____ **Pain Level:** _____ **Staff Initials:** _____

Document Scanned Initials: _____

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PATE, PATRICIA

TRIDENT
PAIN CENTER

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

09/22/2014

J. Edward Nolan, MD

Current Medications

Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Roxicodone 5 mg tablet 1 tab(s) every 6 hours
Unknown OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Unknown Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Unknown Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Unknown Effexor 50 mg tablet 1 tab(s) 2 times a day
Unknown Claritin-D
Unknown Ambien
Unknown omeprazole
Unknown quinine
Unknown Paxil
Unknown atorvastatin 10 mg tablet once a day
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Reason for Appointment

1. Low back pain
2. Leg pain

History of Present Illness

Anticoagulants::
Comments: Yes, Xarelto, on.
Driver::
Present in office: Yes.
Description of pain::
Location: low back, leg. Onset of pain: work injury. Date of Onset: 12/2011. Nature: dull, sharp, aching, burning, shooting. Severity: 5/10 overall. Timing: constant. Helping factors: rest, pain medications. Aggravating factors: sitting, standing, bending.

Vital Signs

Ht 5'5", BP Initial 125/80, HR Initial 90, Temp Initial 97.6, PO2 Initial 97, Pain Initial 5/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Examiner: Allison Davis, Nurse Practitioner (NP-C).

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the knee.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

65

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
2 night stay @ Trident Hospital for blood clots 9/16-9/18/14

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia. Positive for tingling, numbness, arm weakness, leg weakness.

2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, 30 day(s), 30, Refills 0
Start oxycodone tablet, immediate release, 10 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 10/2/14, 60, Refills 0
Notes: Pt has recently been hospitalized for blood clots in the lungs. Will now be on Xarelto for the next 3-6 months. Percocet has been d/c'd however she is not getting as much relief from the Oxycodone IR 5 mg therefore we will ask her to start doubling what she has to 10 mg and provide her with a new prescription at this time. Also pt will not be eligible for injections for the next 3-6 month period.

2. LONG-TERM USE MEDS NEC
Notes: Urine drug analysis performed in house today to verify compliance with current drug therapy.

3. THERAPEUTIC DRUG MONITOR
Notes: DHEC database reviewed and is appropriate.

Labs
Lab: UDS Testing	
Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	37.4MG/DL/POS

RIVERS,NANETTA 9/22/2014 10:06:21 AM > specimen collected in house only ADKINS(MLT),GINA 9/22/2014 11:11:40 AM > IN HOUSE UDS GADSON,CHERIKA S 9/22/2014 11:40:44 AM > , In office screen was appropriate

Follow Up
4 Weeks, for Allison Davis, NP-C, Medication refill

Electronically signed by JOSEPH NOLAN , MD on 10/06/2014 at 03:45 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA DC

Progress Note: J. Edward Nolan, MD 09/22/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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PATRICIA PATE w/ DAVIS (NP-C), ALLISON F 09/22/2014 @ 9:30 AM

16 ADH

ADDRESS:

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES NO If no, last day of work? _____

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

_____

Are you a Diabetic? (circle one) YES NO

Please list any medications changes (including dosage):
Roxicodone 5mg q4hr. Atorvastatin 10mg
Xarelto 15mg twice daily

COMPLAINT:

Location: Lower back.
Started: _____
How: _____
Quality: Dull Sharp Ache Burn Throb Ting Shoot
Severity: 5 / 10 VAS overall

Timing: AM PM Constant Intermittent
Recent MRI XRAYS, EMG/NCS studies: CT Scan
What makes your pain better: Rest, Meds.
What makes your pain worse: Sitting, Standing, bending, Activities
Recent ER/Urgent Care Visit: Yes
Last wed 2 night Stay @ Trident for blood clots

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**	
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes O No
RECENT weight loss	O Yes	● No				arthritis	O Yes ● No
RECENT weight gain	O Yes	● No					
Gastroenterology			**Genitourinary**			**Neurology**	
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes ● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes ● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	● Yes O No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	O Yes O No
RECENT constipation	O Yes	● No				arm weakness	● Yes O No
RECENT diarrhea	O Yes	● No				leg weakness	● Yes O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Patricia A. Pate Date: 9/22/14

FOR OFFICE USE ONLY!!!!!!!

Driver: Yes Blood Thinner: ADH Yes Xarelto

Pre-OP Vital Signs: BP 125/80 P 90 Sat 97 T 97.6 Ht ____ Wt ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P____ Sat ____ T ____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

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TRIDENT
PAIN CENTER

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

10/03/2014

J. Edward Nolan, MD

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Taking oxycodone 10 mg tablet, immediate release 1 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Roxicodone 5 mg tablet 1 tab(s) every 6 hours
Unknown Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Unknown Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Unknown Effexor 50 mg tablet 1 tab(s) 2 times a day
Unknown Claritin-D
Unknown Ambien
Unknown omeprazole
Unknown quinine
Unknown Paxil
Unknown atorvastatin 10 mg tablet once a day
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
Comments: Yes Xarelto, on.
Driver::
Present in office: Yes.
Description of pain::
Location: low back. Onset of pain: lifting injury. Date of Onset: 2011. Nature: dull, sharp, aching, burning, shooting. Severity: 6/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: sitting, standing, bending.

Vital Signs

Ht 5'6", BP Initial 127/83, HR Initial 96, Temp Initial 97.4, PO2 Initial 98, Pain Initial 6/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Examiner: Allison Davis, Nurse Practitioner (NP-C).

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the bilateral S1 nerve distribution into the buttocks.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
2 night stay @ Trident Hospital for blood clots 9/16-9/18/14

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, GERD, ulcers, recent blood in stool, recent constipation, recent diarrhea.
Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Positive for muscle pain, joint pain, joint pain, arthritis.
Neurology:
Negative for headaches, dizziness.
Positive for tingling, numbness, insomnia, arm weakness, leg weakness.

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q 12 hours, 20 day(s), 40, Refills 0
Notes: Counseled patient on their current medication regimen and discussed how they are tolerating it. Pt continues to complain of significant pain to the low back and buttocks primarily with radiating symptoms. She states the increase of OxyContin to BID has helped but she is ultimately unable to perform her job duties as required. Due to her inability to receive needed injection therapy until 02/2015 due to pulmonary embolisms we recommend she be placed out of work at this time and a letter will be drafted to this affect. I will continue to monitor her work status at each visit. Medication management and trigger point injections will be her treatment options at this time.

Follow Up
Keep previous appointment

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 10/23/2014 at 09:08 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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PATRICIA PATE (DOB: **v/ DAVIS (NP-C), ALLISON F 10/03/2014 @ 3:30 PM**

ADDRESS:

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

11

Are you currently working? (circle one) YES NO **If no, last day of work?** _____

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

_____

Are you a Diabetic? (circle one) YES (NO)

Please list any medications changes (including dosage):

_____ _____ _____

_____ _____ _____

COMPLAINT: low

Location: Back

Started: 2011

How: lifting

Quality: Dull Sharp Ache Burn Throb Ting Shoot

Severity: 6 / 10 VAS overall

Timing: AM PM (Constant) Intermittent

Recent MRI, XRAYS, EMG/NCS studies: NB

What makes your pain better: _____

What makes your pain worse: _____

Recent ER/Urgent Care Visit: NO

REVIEW OF SYSTEMS:

If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional

RECENT fever	O Yes	● No
RECENT fatigue	O Yes	● No
night sweats all the time	● Yes	O No
RECENT weight loss	O Yes	● No
RECENT weight gain	O Yes	● No

Dermatology

RECENT skin rash	O Yes	O No
RECENT skin sores	O Yes	O No
skin cancer	O Yes	O No

Musculoskeletal

muscle pain	● Yes	O No
joint pain	● Yes	O No
joint stiffness	● Yes	O No
arthritis	O Yes	O No

Gastroenterology

GERD	O Yes	● No
abdominal pain	O Yes	● No
ulcers	O Yes	O No
RECENT blood in stool	O Yes	● No
RECENT constipation	O Yes	● No
RECENT diarrhea	O Yes	● No

Genitourinary

urinary tract infections	O Yes	● No
bladder problems	O Yes	● No
kidney disease	O Yes	● No
prostate problems	O Yes	● No

Neurology

headaches	O Yes	O No
dizziness	O Yes	O No
tingling/numbness	● Yes	O No
insomnia	● Yes	O No
arm weakness	● Yes	O No
leg weakness	● Yes	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: _____ Date: _____

FOR OFFICE USE ONLY!!!!!!!

Driver: Yes Blood Thinner: Yes Xarelto 2x

Pre-OP Vital Signs: BP 127/83 P 96 Sat 98 T 97.4 Ht ____ Wt ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

OC Vital Signs: BP ____/____ P ____ Sat ____ T ____ Pain Level: ____ Staff Initials: ____

Document Scanned Initials: ____

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TRIDENT
PAIN CENTER

PATE, PATRICIA

60

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

10/17/2014

Allison Davis, NP-C

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking oxycodone 10 mg tablet, immediate release 1 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Roxicodone 5 mg tablet 1 tab(s) every 6 hours
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Discontinued Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Discontinued Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Discontinued Effexor 50 mg tablet 1 tab(s) 2 times a day
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 12/2011. Nature: sharp, aching. Severity: 6/10 overall. Timing: constant. Helping factors: back brace, rest, TENs, pain medication. Aggravating factors: activity.

Vital Signs

BP Initial 117/79, HR Initial 93, Temp Initial 97.6, PO2 Initial 96, Pain Initial 6/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints L>>R. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the foot.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies

penicillin: WELPS

Hospitalization/Major Diagnostic Procedure

2 night stay @ Trident Hospital for blood clots 9/16-9/18/14

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness, leg weakness.

Treatment

1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q 12 hours, DO NOT FILL UNTIL 11/27/14, 60, Refills 0
Continue oxycodone tablet, immediate release, 10 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 10/25/14, 90, Refills 0
Start Physical Therapy, eval and treat treat for low back and leg pain, as directed, 15 visits
Notes: Counseled patient on their current medication regimen and discussed how they are tolerating it. Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed. Will also start pt in PT to help with pain relief, particularly during this period of time that she must remain on a blood thinner.

2. LONG-TERM USE MEDS NEC
Notes: DHEC database reviewed and is appropriate.

3. THERAPEUTIC DRUG MONITOR
Notes: Urine drug analysis performed in house today to verify compliance with current drug therapy.

Labs

Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	POS
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	83.4MG/DL/POS

MCGUINESS,KELLI 10/17/2014 8:41:31 AM > SPECIMEN COLLECTED. SENT TO IN HOUSE ADKINS(MLT),GINA 10/17/2014 9:41:22 AM > IN HOUSE UDS GADSON,CHERIKA S 10/17/2014 2:30:56 PM > , In office screen was appropriate

Follow Up

4 Weeks from 10/25/14, for Allison Davis, NP-C, Medication refill

A. Nelson MD

Electronically signed by JOSEPH NOLAN , MD on 11/04/2014 at 02:59 PM EST

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA Progress Note: Allison Davis, NP-C 10/17/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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15 KH

PATRICIA PATE w/ DAVIS (NP-C), ALLISON F 10/17/2014 @ 8:30 AM

ADDRESS: [redacted]

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** 9-15-14

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) YES (NO)

Please list any medications changes (including dosage):

COMPLAINT: L

Location: back

Started: 12-15-11

How: lifting

Quality: Dull Sharp Ache Burn Throb Ting Shoot Numb L/G

Severity: 6 / 10 VAS overall

Timing: AM PM (Constant) Intermittent

Recent MRI, XRAYS, EMG/NCS studies: _____

What makes your pain better: brace, rest, tens, meds

What makes your pain worse: activity

Recent ER/Urgent Care Visit: _____

REVIEW OF SYSTEMS:

If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	O Yes	● No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	O Yes	● No
RECENT constipation	O Yes	● No				arm weakness	O Yes	● No
RECENT diarrhea	O Yes	● No				leg weakness	O Yes	● No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: [signature] Date: _____

FOR OFFICE USE ONLY!!!!!!!

Driver: _____ Blood Thinner: _____

Pre-OP Vital Signs: BP 117/79 P 93 Sat 96 T 97.6 Ht ____ Wt ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P____ Sat ____ T ____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

(15)

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking oxycodone 10 mg tablet, immediate release 1 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Roxicodone 5 mg tablet 1 tab(s) every 6 hours
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Not-Taking/PRN Physical Therapy, eval and treat treat for low back and leg pain as directed
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of

Reason for Appointment

1. Low back pain
2. Leg pain

History of Present Illness

Anticoagulants::
Comments: Xarelto. on.
Driver::
Present in office: No.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 12/2011. Nature: dull, sharp, aching, burning, shooting. Severity: 6/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: activity.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the foot.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. THERAPEUTIC DRUG MONITOR - V58.83
3. LONG-TERM USE MEDS NEC - V58.69

Treatment

1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q

Charleston.
Work Status: Not Working.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies

penicillin: WELPS

Hospitalization/Major Diagnostic Procedure

2 night stay @ Trident Hospital for blood clots 9/16-9/18/14

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, arm weakness, insomnia. Positive for leg weakness.

12 hours, DO NOT FILL UNTIL 11/25, 60, Refills 0
Continue oxycodone tablet, immediate release, 10 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 11/23, 90, Refills 0
Continue Tizanidine Hydrochloride tablet, 4 mg, 2 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 2
Notes: Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed. Pt is requesting to return to Percocet however we have not received her liver function results. She will obtain these before her next appt.

2. THERAPEUTIC DRUG MONITOR
Notes: DHEC database reviewed and is appropriate. Urine drug analysis performed in house today to verify compliance with current drug therapy.

Labs

Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	68.0MG/DL/POS

RIVERS,NANETTA 11/20/2014 2:18:33 PM > specimen collected in house only ADKINS(MLT),GINA 11/20/2014 5:52:54 PM > IN HOUSE UDS GADSON,CHERIKA S 11/21/2014 2:31:35 PM > , In office screen was appropriate

Follow Up

4 Weeks from 11/23, Medication refill, for Kristen Giet, PA-C

K. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 12/16/2014 at 02:38 PM EST

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA **Progress Note: Kristen Giet, PA 11/20/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

78

PATRICIA PATE (DOB:) w/ GIET, KRISTEN (PA-C) R 11/20/2014 @ 2:00 PM

ADDRESS: 11
H

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** 9-15-2014

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) YES (NO)

Please list any medications changes (including dosage):

COMPLAINT:

Location: lower back and legs
Started: 12-11
How: lifting
Quality: (Dull) (Sharp) (Ache) Burn Throb Ting (Shoot)
Severity: 6 / 10 VAS overall

Timing: AM PM (Constant) Intermittent
Recent MRI, XRAYS, EMG/NCS studies:
What makes your pain better: pain meds
What makes your pain worse:
Recent ER/Urgent Care Visit:

REVIEW OF SYSTEMS:

If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	O Yes	● No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	O Yes	● No
RECENT constipation	O Yes	● No				arm weakness	O Yes	● No
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Patricia A. Pate Date: 11-20-14

FOR OFFICE USE ONLY!!!!!!!

Driver: No Blood Thinner: Yes Xarelto, on

Pre-OP Vital Signs: BP ____/____ P____ Sat____ T____ Ht____ Wt____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

DC Vital Signs: BP ____/____ P____ Sat____ T____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

TRIDENT
PAIN CENTER

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER NC

11/24/2014

J. Edward Nolan, MD

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking oxycodone 10 mg tablet, immediate release 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Roxicodone 5 mg tablet 1 tab(s) every 6 hours
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Discontinued Physical Therapy, eval and treat treat for low back and leg pain as directed
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: Yes.
Description of pain::
Location: low back. Onset of pain: lifting injury. Date of Onset: 12/15/11. Nature: dull, sharp, aching, burning, throbbing, tingling, shooting. Severity: 6/10 overall. Timing: constant. Helping factors: injections by this clinic, pain medications, rest. Aggravating factors: activity.

Vital Signs

BP Initial 115/82, HR Initial 88, Temp Initial 98.1, PO2 Initial 95, Pain Initial 6/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the foot.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)

Treatment

Recent place of employment: College of Charleston.
Work Status: Not Working.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
2 night stay @ Trident Hospital for blood clots 9/16-9/18/14

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, tingling, numbness. Positive for arm weakness, leg weakness.

1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q 12 hours, DO NOT FILL UNTIL 11/25, 60, Refills 0
Stop oxycodone tablet, immediate release, 10 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 11/23, 90
Start Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 0
Notes: Pt returns today for us to switch her last prescription from Oxycodone to Percocet. This was discussed at last visit however we had not yet received her liver blood work. We have now received some of the labs but not liver enzymes. Pt is scheduled to see Dr. Rose on 12/03/14 and will provide us with a prescription note that releases her to take Acetaminophen type products. We will go ahead and make the switch today however we will not be able to continue this without that note. Pt verbalizes understanding. She is also here today to discuss her work restrictions. She continues to remain out of work per our last letter requesting 2 months out. She reports improvement in ability to cope with pain since she has been out of work. She has provided an accommodation request from her employer which we will complete and send back. At this point, we recommend pt to plan for return to work after 12/03/14 at 4 hours per day for 2 weeks with accommodations which will be available per her paperwork brought to be filled out today and then we will re-evaluate her work status 2 weeks after that.

Follow Up
Keep previous appointment

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 12/11/2014 at 03:53 PM EST

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

12/10 last FMLA date

15 KM

PATRICIA PATE (DOB: **w/ DAVIS (NP-C), ALLISON F 11/24/2014 @ 2:30 PM**

ADDRESS:

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** 9-15-14

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) YES (NO)

Please list any medications changes (including dosage):

No Changes

COMPLAINT:

Location: Lower Back
Started: 12-15-11
How: Lifting
Quality: (Dull Sharp Ache Burn Throb Ting Shoot)
Severity: 6 / 10 VAS overall

Timing: AM PM (Constant) Intermittent
Recent MRI, XRAYS, EMG/NCS studies:
What makes your pain better: Injection meds. Rest
What makes your pain worse: ~~Rest~~ Being Active
Recent ER/Urgent Care Visit: NO

REVIEW OF SYSTEMS:

If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	~~O No~~
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	O Yes	O No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	O Yes	● No
RECENT constipation	O Yes	● No				arm weakness	● Yes	O No
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No

8 6

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Patricia P. Pate Date:

FOR OFFICE USE ONLY!!!!!!!

Driver: UPD Blood Thinner: Xeralto, ON

Pre-OP Vital Signs: BP 115/82 P 88 Sat 95 T 98.1 Ht ____ Wt ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P____ Sat ____ T ____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

(82)

TRIDENT PAIN CENTER
FOR ALL • QUALITY OF LIFE

57-G Medical Plaza Dr.
Charleston, SC
106

N. Hwy 52
ncks Corner, SC
61

Medical Park Dr.,
207-A
lterboro, SC
88

ming Soon
1 Old Georgetown Rd.
Pleasant, SC
64

ne
-797-3636

-797-3637

b
entpaincenter.com

WORK RESTRICTIONS:

Date: 11/24/14

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☒ The patient may return to work on 12/4/14, **light duty** with the following restrictions: 4 hours per day for 2 weeks

- ☒ No lifting greater than 15 lbs
- ☒ No bending, squatting, or crawling
- ☒ No pushing/pulling heavy objects

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office 12/19/14. We will update you in regards to the patient's work status at that time. Thank you for your consideration.

Sincerely,

J. Edward Nolan, MD
Medical Director

(63)

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER NC

12/11/2014

Allison Davis, NP-C

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Roxicodone 5 mg tablet 1 tab(s) every 6 hours
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
Comments: ON XARELTO.
Driver::
Present in office: No.
Description of pain::
Location: low back. Onset of pain: lifting. Date of Onset: 12/15/11. Nature: sharp, aching, tingling. Severity: 6/10 overall. Timing: constant. Helping factors: injections by this clinic. Aggravating factors: up and down, walking, sitting.

Vital Signs

Wt 186, Ht 5'6, BP Initial 117/79, HR Initial 71, Temp Initial 97.3, PO2 Initial 98, Pain Initial 6/10, D/C BP 116/85, D/C HR 91, D/C PO2 99, D/C Pain 6/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints palpable paraspinous myospasms present. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the bilateral L5 nerve distribution and S1 nerve distribution to the foot.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. MUSCLE SPASMS - 728.85

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(84)

Work Status: Part Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies

penicillin: WELPS

Hospitalization/Major Diagnostic Procedure

2 night stay @ Trident Hospital for blood clots 9/16-9/18/14

Review of Systems

Constitutional:

Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.

Gastroenterology:

Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:

Negative for recent skin rash, recent skin sores, skin cancer.

Genitourinary:

Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.

Musculoskeletal:

Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.

Neurology:

Negative for headaches, dizziness, insomnia, arm weakness. Positive for tingling, numbness, leg weakness.

Treatment

1. MUSCLE SPASMS

Notes: Will treat myospasm today with trigger point injections.

Procedures

Supplies/Services::

Skin Prep Alcohol swab. Needles 27 gauge x 1.25 inch needle. Local Anesthetic Lidocaine 1% 10 cc.

Trigger Point Injection - Diagnosis: Myofascial Pain/Muscle Spasms:

Location Bilateral Lumbar Paravertebral. Procedure note Informed consent was obtained from patient. The myofascial trigger points were identified by palpation. The skin was prepped as noted above. The needle noted above was advanced into the deep musculature at each site. Aspiration was negative for heme, parasthesias, and air. The appropriate medicine as noted above was injected at each site in equally divided doses. The needles were flushed and withdrawn intact from the skin. The skin was cleaned and a sterile dressing applied as needed. Complications None, the patient tolerated the procedure well and no complications were encountered. Procedure performed by Allison Davis, NP-C.

Recovery and Discharge:

Recovery The patient was monitored for side effects and to ensure alert, awake, and in oriented condition. Discharge discharge instructions were given to the patient, patient was discharged with vital signs stable.

Follow Up

Keep previous appointment

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 01/06/2015 at 03:21 PM EST

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139

Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA] **Progress Note: Allison Davis, NP-C 12/11/2014**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(66)

15 min

PATRICIA PATE (DOB:) w/ DAVIS (NP-C), ALLISON F 12/11/2014 @ 8:45 AM

ADDRESS: T

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES NO **If no, last day of work?** part time

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) YES NO

Please list any medications changes (including dosage):

No changes

COMPLAINT:

Location: Lower Back
Started: 12-15-14
How: Lifting
Quality: Dull Sharp Ache Burn Throb Ting Shoot
Severity: 6 / 10 VAS overall

Timing: AM PM Constant Intermittent
Recent MRI, XRAYS, EMG/NCS studies:
What makes your pain better: injection
What makes your pain worse: up & down, walking sitting.
Recent ER/Urgent Care Visit:

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			Dermatology			Musculoskeletal		
RECENT fever	O Yes	O No	RECENT skin rash	O Yes	O No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	O No	RECENT skin sores	O Yes	O No	joint pain	● Yes	O No
night sweats	O Yes	O No	skin cancer	O Yes	O No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	O No				arthritis	O Yes	O No
RECENT weight gain	O Yes	O No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	O No	urinary tract infections	O Yes	O No	headaches	O Yes	O No
abdominal pain	O Yes	O No	bladder problems	O Yes	O No	dizziness	O Yes	O No
ulcers	O Yes	O No	kidney disease	O Yes	O No	tingling/numbness	● Yes	O No
RECENT blood in stool	O Yes	O No	prostate problems	O Yes	O No	insomnia	O Yes	O No
RECENT constipation	O Yes	O No				arm weakness	O Yes	O No
RECENT diarrhea	O Yes	O No				leg weakness	● Yes	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Date:

FOR OFFICE USE ONLY!!!!!!!

Driver: Ø Blood Thinner: On Xarelto

Pre-OP Vital Signs: BP 117/79 P 71 Sat 98 T 97.3 Ht ____ Wt 186

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P ____ Sat ____ T ____ Pai

Document Scanned Initials:

Name:
Arrival Time: 8:05

Please circle if the following has change
Insurance **Address** **Phone Numb**

(67)

TRIDENT
PAIN CENTER

PATE, PATRICIA

Account Number: 0

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER NC

12/19/2014

Kristen Giet, PA

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking pioglitazone 15 mg tablet 1 tab(s) once a day
Taking Bydureon 2 once a week
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of

Reason for Appointment

1. Low back pain
2. Buttocks pain
3. Leg pain

History of Present Illness

Anticoagulants::
Comments: On Xarelto.
Driver::
Present in office: No.
Description of pain::
Location: low back. Onset of pain: lifting. Date of Onset: 12/15/11. Nature: dull, sharp, aching, burning, throbbing, tingling, shooting. Severity: 6/10 overall. Timing: constant. Helping factors: rest, injection. Aggravating factors: activity.

Vital Signs

Ht 5'6", BP Initial 121/84, HR Initial 94, Temp Initial 97.1, PO2 Initial 98, Pain Initial 6/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine . -Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the bilateral L5 nerve distribution and S1 nerve distribution to the foot, L>>R.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69

Charleston.
Work Status: Part Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
No Hospitalization History.

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, arm weakness. Positive for tingling, numbness, insomnia, leg weakness.

3. THERAPEUTIC DRUG MONITOR - V58.83

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q 12 hours, DO NOT FILL UNTIL 12/23, 60, Refills 0
Continue Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 12/23, 90, Refills 0
Notes: Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed.

2. THERAPEUTIC DRUG MONITOR
Notes: DHEC database reviewed and is appropriate. Urinary drug screen performed today to assess patient's compliance in taking prescribed medications as well as to assess for the use of non prescribed prescription medications and illicit substances.

Labs
Lab: UDS Testing
Seagraves,Lindsay 12/19/2014 2:32:40 PM > Collected specimen Millennium only

Follow Up
12/22, discuss work restrictions, Dr Nolan, 4 Weeks from 12/23, Medication refill, for Kristen Giet, PA-C

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 01/07/2015 at 04:10 PM EST

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

11
LNS

PATRICIA PATE (DOB: **GIET, KRISTEN (PA-C) R 12/19/2014 @ 2:15 PM**

ADDRESS: :T

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES NO **If no, last day of work?** 4 hrs

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) YES NO ?

Please list any medications changes (including dosage): Pioglitazone 15mg Bydureon Zuspan

COMPLAINT:

Location: L back, buttocks, leg
Started: 12/15/11
How: lifting
Quality: Dull Sharp Ache Burn Throb Ting Shoot
Severity: 6 / 10 VAS overall

Timing: AM PM Constant Intermittent
Recent MRI, XRAYS, EMG/NCS studies: NO
What makes your pain better: rest, inj
What makes your pain worse: everything
Recent ER/Urgent Care Visit: NO

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	● Yes	O No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	● Yes	O No
RECENT constipation	O Yes	● No				arm weakness	O Yes	● No
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: _____ Date: _____

FOR OFFICE USE ONLY!!!!!!!

Driver: NO Blood Thinner: Xarelto

Pre-OP Vital Signs: BP 121/84 P 94 Sat 98 T 97.1 Ht ____ Wt ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P____ Sat ____ T ____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

90

TRIDENT PAIN CENTER
-G Medical Plaza Dr.
harleston, SC
06

N. Hwy 52
cks Corner, SC
31

Medical Park Dr.,
207-A
erboro, SC
38

ing Soon
Old Georgetown Rd.
Pleasant, SC
34

ie
797-3636

797-3637

ntpaincenter.com

WORK EXCUSE:

Date: 12/19/14

To Whom It May Concern:

Please excuse Patricia Pate for any absence related to:

☐ He/She had an **appointment** at Trident Pain Center today.

☐ He/She was required to pick up **prescription(s)** from our office today.

☐ He/She was required to act as **responsible party/driver** for a patient today secondary to sedation. (It is our policy the driver must remain on the premises for the duration of the appointment.)

☒ Other: Dr Nolan was not available today to discuss work restrictions. Will need return appt on 12/22 to discuss work status

Thank you for your consideration.

Sincerely,

J.EDWARD NOLAN, MD

(91)

PATE, PATRICIA

TRIDENT
PAIN CENTER

Home: 843-509-6704
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER NC

12/22/2014

J. Edward Nolan, MD

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking pioglitazone 15 mg tablet 1 tab(s) once a day
Taking Bydureon 2 once a week
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of

Reason for Appointment

1. Low back pain
2. Leg pain

History of Present Illness

Driver::
Present in office: No.
Anticoagulants::
AGGRENOX: Xarelto-on.
Description of pain::
Location: lower back, legs. Onset of pain: liftung. Date of Onset: 12/15/11. Nature: dull, sharp, aching, throbbing. Severity: 6/10 overall. Timing: constant. Helping factors: injections by this clinic, pain medications. Aggravating factors: sitting, standing, walking, bending, anything.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Sensory function: Sensation is grossly intact bilateral lower extremities. Motor Function: Coordination is normal. Muscle strength is decreased 3/5 (fair) left lower extremity. Tone is normal. Gait is antalgic. Examiner: Rebecca Muirhead, Family Nurse Practitioner (FNP-BC).

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine . Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the bilateral L5 nerve distribution and S1 nerve distribution to the foot, L>>R.

Assessments

Charleston.
Work Status: Part Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, arm weakness. Positive for insomnia, leg weakness.

1. LUMBAR FACET ARTHROPATHY - 721.3 (Primary)
2. LUMBAR POST-LAMINECTOMY - 722.83

Treatment
1. LUMBAR POST-LAMINECTOMY
Notes: Pt.'s low back pain and leg pain are the areas with the greatest pain and we will treat them upon RTC.

2. Others
Notes: Patient was instructed to work four hours a day x four days a week with restictions. No bending, squatting or crawling, no lifting greater than 15 pounds, and no pushing or pulling heavy objects.
Action Started- AUTHORIZATION

Procedures
Caudal Epidural Steroid Injection::
Procedure note plan to perform on return to clinic after authorization.

Follow Up
Block only, for Dr. Nolan,after authorization

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 01/06/2015 at 09:23 AM EST

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

WWR Research / consider a PLA/ current

PATRICIA PATE (DOB: **w/ NOLAN, JOSEPH E 12/22/2014 @ 8:15 AM**

ADDRESS:

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) ~~YES~~ NO **If no, last day of work?** part time

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) (YES) NO

Please list any medications changes (including dosage):

COMPLAINT:

Location: Lower Back down Legs
Started: 12-15-11
How: lifting
Quality: Dull Sharp Ache Burn Throb Ting Shoot
Severity: 6 / 10 VAS overall

Timing: AM PM Constant Intermittent
Recent MRI, XRAYS, EMG/NCS studies:
What makes your pain better: Injection pain meds
What makes your pain worse: sitting, standing, walking, bending anything
Recent ER/Urgent Care Visit:

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			Dermatology			Musculoskeletal		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	~~● Yes~~	O No
RECENT weight loss	O Yes	● No				arthritis	~~● Yes~~	~~● No~~
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	O Yes	● No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	O No	insomnia	~~● Yes~~	O No
RECENT constipation	O Yes	● No				arm weakness	O Yes	~~● No~~
RECENT diarrhea	O Yes	● No				leg weakness	~~● Yes~~	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Date:

FOR OFFICE USE ONLY!!!!!!!

Driver: ϕ Blood Thinner: ϕ

Pre-OP Vital Signs: BP ____/____ P____ Sat____ T____ Ht____ Wt____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

DC Vital Signs: BP ____/____ P____ Sat____ T____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials:____

TRIDENT PAIN CENTER
FOR ALL • QUALITY OF LIFE

67-G Medical Plaza Dr.
Charleston, SC
406

8 N. Hwy 52
ncks Corner, SC
461

2 Medical Park Dr.,
207-A
lterboro, SC
488

ming Soon
41 Old Georgetown Rd.
. Pleasant, SC
464

one
3-797-3636

x
3-797-3637

eb
lentpaincenter.com

WORK RESTRICTIONS:

Date: 12/22/14

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☑ The patient may return to work on 12/23/14, **light duty** with the following restrictions:

- ☑ No lifting greater than 15 lbs
- ☑ No bending, squatting, or crawling
- ☑ No pushing/pulling heavy objects

4 hours a day for 4 days a week.

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office 1/20/15. We will update you in regards to the patient's work status at that time. Thank you for your consideration.

Sincerely,

J. Edward Nolan, MD / Heather Bond

J. Edward Nolan, MD
Medical Director

(95)

Current Medications

Unknown OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Unknown Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Unknown Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Unknown LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Unknown TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Unknown Xarelto
Unknown atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Unknown Claritin-D
Unknown Ambien
Unknown omeprazole
Unknown quinine
Unknown Paxil
Unknown pioglitazone 15 mg tablet 1 tab(s) once a day
Unknown Bydureon 2 once a week
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol
Diabetes

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
Comments: Yes, Xarelto, On.
Driver::
Present in office: Yes.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 12/15/2011. Nature: dull, sharp, aching, burning, tingling, shooting. Severity: 5/10 overall. Timing: intermittent. Helping factors: rest, pain medications, injections by this clinic. Aggravating factors: standing, sitting, lifting.

Vital Signs

Wt 185, Ht 5'6", BP Initial 133/75, HR Initial 91, Temp Initial 98.3, PO2 Initial 97, Pain Initial 5/10, BP Proc 130/90, HR Proc 86, PO2 Proc 100, D/C BP 120/88, D/C HR 83, D/C PO2 99, D/C Pain 3/10.

Examination

General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments

1. LUMBAR DISC DISPLACEMENT - 722.10 (Primary)
2. THERAPEUTIC DRUG MONITOR - V58.83
3. LONG-TERM USE MEDS NEC - V58.69
4. DMII WO CMP NT ST UNCNTR - 250.00, Risk: Low

Treatment

1. LUMBAR DISC DISPLACEMENT
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q 12 hours, DO NOT FILL UNTIL 1/22/15, 60, Refills 0
Continue Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 1/22/15, 90, Refills 0
Notes: Pt.'s low back pain and leg pain are the areas with the greatest pain and we will treat them today.

2. THERAPEUTIC DRUG MONITOR

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Recent place of employment: College of Charleston.
Work Status: Part Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies

penicillin: WELPS

Hospitalization/Major Diagnostic Procedure

Patient denies recent hospitalization

Review of Systems

Constitutional:

Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.

Gastroenterology:

Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:

Negative for recent skin rash, recent skin sores, skin cancer.

Genitourinary:

Negative for urinary tract infections, bladder problems, kidney disease.

Musculoskeletal:

Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.

Neurology:

Negative for headaches, dizziness, insomnia, arm weakness. Positive for tingling, numbness, leg weakness.

Notes: Urinary drug screen performed today to assess patient's compliance in taking prescribed medications as well as to assess for the use of non prescribed prescription medications and illicit substances that will help determine the appropriate future pain management medication options.

3. LONG-TERM USE MEDS NEC

Notes: Counseled patient on their current medication regimen and discussed how they are tolerating it. Patient denies any significant side effects that need to be addressed.

Procedures

Sedation::

Versed 7 mg MILLER (LPN),BRITTANY 1/21/2015 2:49:40 PM > . Location left deltoid. Sedation Level 3/5 (OAA/S).

Supplies/Services::

Skin Prep Betadine x 3. Needles 22 gauge x 3.5 inch spinal needle. Local Anesthetic Lidocaine 1% 5 cc (preservative free). Steroid Celestone 9 mg (preservative free). Omnipaque 1 cc. Wydase 3 cc. Other Procedure Tray, Epiduragram, Conscious Sedation.

Caudal Epidural Steroid Injection::

Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The sacrum and sacral hiatus were identified using fluoroscopic imaging. The injection site overlying the sacrococcygeal ligament was anesthetized as noted above. A 22 gauge, 3.5 inch spinal needle was advanced to the caudal epidural space using fluoroscopic guidance with AP views and lateral views were used as needed. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected as noted above to confirm needle placement in the caudal epidural space. No evidence of intravascular or intrathecal placement was observed. A solution containing the appropriate medication as noted above was injected in divided doses. The needle was flushed and withdrawn intact. The skin was cleansed and sterile dressing applied to the injection site. Fluoroscopy Time: 2 SEC. Complications None, the patient tolerated the procedure well and no complications were encountered.

Epiduragram::

Procedure Note : An epiduragram was performed using fluoroscopic guidance with the following results:. Omnipaque dye 1 cc injected into the epidural space. Bony structure intact. Pressure required normal. Pain on injection moderate. Filling defects a few filling defects superiorly. Contrast flow moderate obstruction to flow, superiorly. IMPRESSION moderate epidural inflammation, moderate obstruction to contrast flow within the epidural space.

Recovery and Discharge:

Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition. Discharge The patient was instructed to avoid driving for 24 hours, discharge instructions were given to the patient, patient was discharged with vital signs stable Pt escorted to driver with written discharge instructions

WEST (RN),BRITTNEY 1/21/2015 4:02:28 PM > .

Labs

Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	POS
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	145.0MG/DL/POS

RIVERS,NANETTA 1/21/2015 2:32:52 PM > specimen collected in house only ADKINS(MLT),GINA 1/21/2015 4:32:36 PM > IN HOUSE UDS GADSON,CHERIKA S 1/22/2015 9:29:26 AM > , In office screen was appropriate

Lab: Blood glucose level tested today in office as steroid injections can increase blood glucose levels = 78

RIVERS,NANETTA 1/21/2015 2:33:43 PM >

Follow Up

4 Weeks, Medication refill, for Kristen Giet, PA-C

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 02/06/2015 at 09:10 AM EST

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

OxyContin, Percocet, F

PATRICIA PATE (DOB: **v/ NOLAN, JOSEPH E 01/21/2015 @ 2:05 PM**

5 (NDI)

ADDRESS: [redacted] T
0

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704 Hm: 554-4305

Are you currently working? (circle one) (YES) NO **If no, last day of work?** half days 4 day a week

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) (YES) NO borderline 178 @ 2:30p

Please list any medications changes (including dosage):

COMPLAINT:

Location: Lower Back

Started: 12-15-11

How: Lifting

Quality: Dull Sharp Ache Burn Throb Ting Shoot

Severity: 5 / 10 VAS overall

Timing: AM PM Constant (Intermittent)

Recent MRI, XRAYS, EMG/NCS studies: _____

What makes your pain better: Rest Meds Injections

What makes your pain worse: Standing Sitting Lifting Weight

Recent ER/Urgent Care Visit: _____

REVIEW OF SYSTEMS:

If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**			
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	O No	muscle pain	● Yes	O No	
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	O No	joint pain	● Yes	O No	
night sweats	O Yes	● No	skin cancer	O Yes	O No	joint stiffness	● Yes	O No	
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No	
RECENT weight gain	O Yes	● No							
Gastroenterology			**Genitourinary**			**Neurology**			
GERD	O Yes	● No	urinary tract infections	O Yes	O No	headaches	O Yes	● No	
abdominal pain	O Yes	● No	bladder problems	O Yes	O No	dizziness	O Yes	● No	
ulcers	O Yes	● No	kidney disease	O Yes	O No	tingling/numbness	● Yes	O No	at times
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	O No	insomnia	O Yes	● No	
RECENT constipation	O Yes	● No				arm weakness	O Yes	● No	
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No	

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: _____ Date: _____

FOR OFFICE USE ONLY!!!!!!!

Driver: Yes Blood Thinner: Yes, Xarelto

Pre-OP Vital Signs: BP 133/75 P 91 Sat 97 T 98.3 Ht ____ Wt 185

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P____ Sat ____ T ____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

(99)

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking pioglitazone 15 mg tablet 1 tab(s) once a day
Taking Bydureon 2 once a week

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol
Diabetes

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
None: Patient is taking Xarelto.
Driver::
Present in office: No.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 12/15/2011. Nature: sharp, aching, tingling, shooting. Severity: 6/10 overall. Timing: constant. Helping factors: rest, medication. Aggravating factors: being active.

Vital Signs

Wt 191, Ht 5'6", BP Initial 118/79, HR Initial 96, Temp Initial 97.5, PO2 Initial 97, Pain Initial 6/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints, L>>R. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the knee.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)

Treatment

1. LUMBAR POST-LAMINECTOMY

Work Status: Part Time.
Injured at work: Yes.
Marital Status: Married.
Children: none.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, recent blood in stool, ulcers, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness, leg weakness.

Notes: Patient in office today to discuss work restrictions. She reports that she is working 4 hours per day, 4 days a week. During that time she is doing primarily sedentary work. She reports that is not getting any easier. We will have pt continue working at current restrictions, pt given written document today to take to her employer.

Follow Up
3 Months from 1/21, Eval patients needs for further treatment, for Dr. Nolan

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 02/05/2015 at 10:43 AM EST

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

PATRICIA PATE (DOB: [redacted]) w/ GIET, KRISTEN (PA-C) R 01/27/2015 @ 8:15 AM

ADDRESS: [redacted]

PRIMARY PH#: 843-509-6704
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) (YES) NO **If no, last day of work?** 4 days 4hr a day.

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) (YES) NO border line

Please list any medications changes (including dosage):

COMPLAINT:

Location: Lower back
Started: 12-5-11
How: lifting
Quality: Dull (Sharp) Ache Burn Throb (Ting) Shoot
Severity: 9 / 10 VAS overall

Timing: AM PM Constant Intermittent
Recent MRI, XRAYS, EMG/NCS studies:
What makes your pain better: rest meds
What makes your pain worse: being active
Recent ER/Urgent Care Visit:

REVIEW OF SYSTEMS:

If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**	
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes O No
RECENT weight loss	O Yes	● No				arthritis	O Yes ● No
RECENT weight gain	O Yes	● No					
Gastroenterology			**Genitourinary**			**Neurology**	
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes O No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes O No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	O Yes O No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	O Yes O No
RECENT constipation	O Yes	● No				arm weakness	O Yes O No
RECENT diarrhea	O Yes	● No				leg weakness	O Yes O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Date:

FOR OFFICE USE ONLY!!!!!!!

Driver: Blood Thinner:

Pre-OP Vital Signs: BP ____/____ P____ Sat____ T____ Ht____ Wt____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

DC Vital Signs: BP ____/____ P____ Sat____ T____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials:

TRIDENT PAIN CENTER
FOR ALL • QUALITY OF LIFE

67-G Medical Plaza Dr.
Charleston, SC
406

8 N. Hwy 52
oncks Corner, SC
461

2 Medical Park Dr.,
e 207-A
alterboro, SC
488

ming Soon
41 Old Georgetown Rd.
. Pleasant, SC
464

one
3-797-3636

x
3-797-3637

:b
entpaincenter.com

WORK RESTRICTIONS:

Date: 1/27/15

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☒ The patient may return to work on 1/27/15, **light duty** with the following restrictions:

- ☒ No lifting greater than 15 lbs
- ☒ No bending, squatting, or crawling
- ☒ No pushing/pulling heavy objects

4 hours per day for 4 days per week

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office April 21, 2015. We will update you in regards to the patient's work status at that time. Thank you for your consideration.

Sincerely,

J. Edward Nolan MD | kbretm

J. Edward Nolan, MD
Medical Director

(103)

TRIDENT
PAIN CENTER

Home: 843-554-4305
Guarantor: PATE, PATRICIA A Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
PCP: DONALD T HANNA, MD Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER NC

02/18/2015

Kristen Giet, PA

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking pioglitazone 15 mg tablet 1 tab(s) once a day
Taking Bydureon 2 once a week

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol
Diabetes

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
Comments: Patient is taking Xarelto.
Driver::
Present in office: No.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 12/15/2011. Nature: sharp, aching, burning. Severity: 5/10 overall. Timing: constant. Helping factors: pain medications, rest. Aggravating factors: activity, getting up and down, standing any length of time.

Vital Signs

Ht 5'6", BP Initial 129/86, HR Initial 90, Temp Initial 97.3, PO2 Initial 97, Pain Initial 5/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints palpable paraspinous myospasms present.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. MUSCLE SPASMS - 728.85

Work Status: Not Working since January 29, 2015.
Injured at work: Yes.
Marital Status: Married.
Children: none.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain. Positive for night sweats.

Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent diarrhea, recent constipation.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia. Positive for arm weakness, leg weakness.

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q 12 hours, DO NOT FILL UNTIL 2/21, 60, Refills 0
Continue Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 2/21, 90, Refills 0
Notes: Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed.

2. THERAPEUTIC DRUG MONITOR
Notes: DHEC database reviewed and is appropriate. Urine drug analysis performed in house today to verify compliance with current drug therapy.

3. MUSCLE SPASMS
Continue Tizanidine Hydrochloride tablet, 4 mg, 2 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 2
Notes: Will treat myospasm on return to clinic with trigger point injections after authorization.

4. Others
Action Started- W/COMP

Procedures
Trigger Point Injection - Diagnosis: Myofascial Pain/Muscle Spasms:
Location Bilateral Lumbar Paravertebral. Procedure note plan to perform on return to clinic after authorization.
Recovery and Discharge:
Recovery Discharge

Labs
Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	POS
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	183.3MG/DL/POS

GRISSETT,SHAKIMA L 2/18/2015 2:20:46 PM > in house lab only ADKINS(MLT),GINA 2/18/2015 2:58:14 PM > IN HOUSE UDS GADSON,CHERIKA S 2/20/2015 9:23:53 AM > , In office screen was appropriate

Follow Up
4 Weeks from 2/21, Medication refill, for Kristen Giet, PA-C

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 02/26/2015 at 11:14 AM EST

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA A Progress Note: Kristen Giet, PA 02/18/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

106

PATRICIA A PATE (DOB: **w/ GIET, KRISTEN (PA-C) R 02/18/2015 @ 2:30 PM**

ADDRESS:

PRIMARY PH#: 843-554-4305
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** Jan 29, 2015

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) (YES) NO borderline

Please list any medications changes (including dosage):

COMPLAINT:

Location: Lower Back
Started: 12-15-~~14~~ 2011
How: hiking
Quality: Dull (Sharp) (Ache) (Burn) Throb Ting Shoot
Severity: 5 / 10 VAS overall

Timing: AM PM Constant Intermittent
Recent MRI, XRAYS, EMG/NCS studies:
What makes your pain better:
What makes your pain worse:
Recent ER/Urgent Care Visit:

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	● Yes	O No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	O Yes	● No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	O Yes	● No
RECENT constipation	O Yes	● No				arm weakness	● Yes	O No sometime
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No sometime

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Patricia A Pate Date: Feb. 18, 2015

FOR OFFICE USE ONLY!!!!!!!

Driver: _____ Blood Thinner: _____

Pre-OP Vital Signs: **BP** ____/____ **P**____ **Sat**____ **T**____ **Ht**____ **Wt**____

BP ____/____ **P**____ **Sat**____ **BP** ____/____ **P**____ **Sat**____

BP ____/____ **P**____ **Sat**____ **BP** ____/____ **P**____ **Sat**____

DC Vital Signs: **BP** ____/____ **P**____ **Sat**____ **T**____ **Pain Level:**____ **Staff Initials:**____

Document Scanned Initials:____

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking pioglitazone 15 mg tablet 1 tab(s) once a day
Taking Bydureon 2 once a week
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol
Diabetes

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
Comments: Yes, Xarelto On.
Driver::
Present in office: No.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 12/15/2011. Nature: dull, aching, burning, shooting. Severity: 6/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: activity.

Vital Signs

Ht 5'6", BP Initial 141/88, HR Initial 93, Temp Initial 97.6, PO2 Initial 96, Pain Initial 6/10, D/C BP 131/88, D/C HR 88, D/C PO2 99, D/C Pain 3/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints palpable paraspinous myospasms present.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. MUSCLE SPASMS - 728.85

Recent place of employment: College of Charleston.
Work Status: Not Working since January 29, 2015.
Injured at work: Yes.
Marital Status: Married.
Children: none.
no Smoking, 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Positive for GERD, abdominal pain, ulcers, recent blood in stool, constipation, recent diarrhea.
Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, muscle pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, arm weakness, leg weakness. Positive for tingling, numbness, insomnia.

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q 12 hours, DO NOT FILL UNTIL 3/22/15, 60, Refills 0
Continue Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 3/22/15, 90, Refills 0
Notes: Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed.

2. THERAPEUTIC DRUG MONITOR
Notes: DHEC database reviewed and is appropriate Urine drug analysis performed in house today to verify compliance with current drug therapy.

Procedures
Supplies/Services::
Skin Prep Alcohol swab. Needles 27 gauge x 1.25 inch needle. Local Anesthetic Lidocaine 1% 10 cc.
Trigger Point Injection - Diagnosis: Myofascial Pain/Muscle Spasms:
Location Bilateral Lumbar Paravertebral. Procedure note Informed consent was obtained from patient. The myofascial trigger points were identified by palpation. The skin was prepped as noted above. The needle noted above was advanced into the deep musculature at each site. Aspiration was negative for heme, parasthesias, and air. The appropriate medicine as noted above was injected at each site in equally divided doses. The needles were flushed and withdrawn intact from the skin. The skin was cleaned and a sterile dressing applied as needed. Complications None, the patient tolerated the procedure well and no complications were encountered.
Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition. Discharge discharge instructions were given to the patient, patient was discharged with vital signs stable.

Labs
Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	103.2MG/DL/POS

RIVERS,NANETTA 3/20/2015 12:18:08 PM > specimen collected in house only ADKINS(MLT),GINA 3/20/2015 5:16:22 PM > IN HOUSE UDS DAVIS (NP-C),ALLISON F

3/23/2015 11:39:13 AM > , In office screen was appropriate

Follow Up
4 Weeks, Medication refill



Electronically signed by JOSEPH NOLAN , MD on 04/03/2015 at 10:52 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA A o Progress Note: Kristen Giet, PA 03/20/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(110)

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PATRICIA A PATE (...) w/ GIET, KRISTEN (PA-C) R 03/20/2015 @ 11:45 AM

ADDRESS:

PRIMARY PH#: 843-554-4305
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** Jan 15, 2015

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) (YES) NO

Please list any medications changes (including dosage):

COMPLAINT:

Location: Lower Back
Started: Dec. 2011
How: Lifting
Quality (Dull) Sharp (Ache) (Burn) Throb Ting (Shoot)
Severity: 6 / 10 VAS overall

Timing: AM PM (Constant) Intermittent
Recent MRI, XRAYS, EMG/NCS studies:
What makes your pain better: Pain meds
What makes your pain worse: activity
Recent ER/Urgent Care Visit:

REVIEW OF SYSTEMS:

If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			Dermatology			Musculoskeletal		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						

Gastroenterology			Genitourinary			Neurology		
GERD	● Yes	O No	urinary tract infections	O Yes	● No	headaches	O Yes	O No
abdominal pain	● Yes	O No	bladder problems	O Yes	● No	dizziness	O Yes	O No
ulcers	● Yes	O No	kidney disease	O Yes	● No	tingling/numbness	O Yes	O No
RECENT blood in stool	● Yes	O No	prostate problems	O Yes	● No	insomnia	O Yes	O No
RECENT constipation	● Yes	O No				arm weakness	O Yes	O No
RECENT diarrhea	● Yes	O No				leg weakness	O Yes	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Patricia A Pate Date: 3/20/15

FOR OFFICE USE ONLY!!!!!!!

Driver: No Blood Thinner: Yes, Xarelto

Pre-OP Vital Signs: BP 141/88 P 93 Sat 96 T 97.6 Ht ____ Wt ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P ____ Sat ____ T ____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

(11)

TRIDENT
PAIN CENTER

Home: 843-554-4305
Guarantor: PATE, PATRICIA A Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
PCP: DONALD T HANNA, MD Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER NC

04/21/2015

J. Edward Nolan, MD

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking pioglitazone 15 mg tablet 1 tab(s) once a day
Taking Bydureon 2 once a week
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol
Diabetes

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.

Reason for Appointment

1. Low back pain
2. Buttocks pain
3. Leg pain

History of Present Illness

Anticoagulants::
Comments: On Xarelto.
Driver::
Present in office: No.
Description of pain::
Location: lower back, buttocks, leg. Onset of pain: lifting injury. Date of Onset: 12/2011. Nature: dull, sharp, aching, burning, throbbing, tingling, shooting. Severity: 5/10 overall. Timing: constant. Helping factors: pain medications, rest. Aggravating factors: bending, sitting, standing, everything.

Vital Signs

Ht 5'6", Wt 188 lbs, BMI 30.34, BP Initial 120/83 mm Hg, HR Initial 88, Temp Initial 96.3, PO2 Initial 99, Pain Initial 5/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Sensory function: Sensation is grossly intact bilateral lower extremities. Motor Function: Coordination is normal. Muscle strength is grossly intact bilateral lower extremities. Tone is normal. Gait is antalgic. Examiner: Rebecca Muirhead, Family Nurse Practitioner (FNP-BC).

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints, with

Recent place of employment: College of Charleston.
Work Status: Not Working since January 29, 2015.
Injured at work: Yes.
Marital Status: Married.
Children: none.
no Smoking, 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, arm weakness. Positive for insomnia, leg weakness, tingling, numbness.

palpable paraspinous myospasms present. Radiating Symptoms: moderate lumbar radiculitis pain with ROM with pain in the bilateral L4 nerve distribution to the knee.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. MUSCLE SPASMS - 728.85

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q 12 hours, 30 days, 60, Refills 0
Continue Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, TID PRN PAIN, 30 days, 90, Refills 0
Continue Tizanidine Hydrochloride tablet, 4 mg, 2 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 2
Notes: Pt.'s low back pain and leg pain are the areas with the greatest pain and we will treat them upon RTC. I have reviewed the pt's past medical, surgical and social history with the pt and we have made any changes noted above. I have reviewed the pt's most recent imaging with the patient and I have utilized this information in development of the treatment plan today. Prescription has been escribed today.

2. LONG-TERM USE MEDS NEC
Notes: Counseled patient on their current medication regimen and discussed how they are tolerating it. Patient denies any significant side effects that need to be addressed.

3. THERAPEUTIC DRUG MONITOR
Notes: Urinary drug screen performed today to assess patient's compliance in taking prescribed medications as well as to assess for the use of non prescribed prescription medications and illicit substances that will help determine the appropriate future pain management medication options. DHEC checked and is appropriate.

4. MUSCLE SPASMS
Notes: Muscle spasms significant and will treat upon RTC with TPIs once approval is gained.

5. Others
Action Started- AUTHORIZATION

Procedures
Trigger Point Injection - Diagnosis: Myofascial Pain/Muscle Spasms:
Location Bilateral Lumbar Paravertebral. Procedure note plan to perform on return to clinic.

Labs
Lab: UDS Testing

Benzodiazepines	NEG

Percocet, Oxycontin, Tizanidine

11
LWS

PATRICIA A PATE (DOB: / NOLAN, JOSEPH E 04/21/2015 @ 2:15 PM

ADDRESS: ..... T

PRIMARY PH#: 843-554-4305
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** Jan. 2015

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

N/A

Are you a Diabetic? (circle one) (YES) NO

Please list any medications changes (including dosage):

COMPLAINT:

Location: Lower Back, buttocks, leg
Started: 12-2011
How: Lifting
Quality: Dull Sharp Ache Burn Throb Ting Shoot
Severity: 5 / 10 VAS overall

Timing: AM PM (Constant) Intermittent
Recent MRI, XRAYS, EMG/NCS studies: NO
What makes your pain better: meds Rest
What makes your pain worse: Bending Sitting Standing Everything
Recent ER/Urgent Care Visit: NO

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	O Yes	O No at times
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	● Yes	O No
RECENT constipation	O Yes	● No				arm weakness	O Yes	● No
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No

** Please fill out the information listed above in its entirety as we take this information into consideration for your current and future treatment.

Signature: Patricia A. Pate Date:

FOR OFFICE USE ONLY!!!!!!!

Driver: NO Blood Thinner: Xarelto

Pre-OP Vital Signs: BP 120/83 P 88 Sat 99 T 96.3 Ht ____ Wt 188

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

BP ____/____ P ____ Sat ____ BP ____/____ P ____ Sat ____

DC Vital Signs: BP ____/____ P ____ Sat ____ T ____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

TRIDENT PAIN CENTER
FOR ALL • QUALITY OF LIFE

7-G Medical Plaza Dr.
Charleston, SC
06

N. Hwy 52
cks Corner, SC
61

Medical Park Dr.,
e 207-A
terboro, SC
88

ne
-797-3636

-797-3637

b
entpaincenter.com

WORK RESTRICTIONS:

Date: 4/21/15

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☑ The patient may return to work on 4/23/15, **light duty** with the following restrictions:

- ☑ No lifting greater than 10 lbs
- ☐ No bending, squatting, or crawling
- ☑ No pushing/pulling heavy objects

<4hrs per day
4 days per week

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office 6/2/2015. We will update you in regards to the patient's work status at that time. Thank you for your consideration.

Sincerely,

J. Edward Nolan, MD
Medical Director

115

TRIDENT
PAIN CENTER

Home: 843-554-4305
Guarantor: PATE, PATRICIA A Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
PCP: DONALD T HANNA, MD Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER NC

05/04/2015

Kristen Giet, PA

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking pioglitazone 15 mg tablet 1 tab(s) once a day
Taking Bydureon 2 once a week
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol
Diabetes

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.

Reason for Appointment

1. Low back pain

History of Present Illness

Anticoagulants::
Comments: Patient is taking Xarelto.
Driver::
Present in office: No.
Description of pain::
Location: lower back, buttocks, leg. Onset of pain: lifting injury. Date of Onset: 12/2011. Nature: aching. Severity: 5/10 overall. Timing: constant. Helping factors: pain meds, rest. Aggravating factors: standing, bending.

Vital Signs

Initial Vital Signs taken by: Shakima, Ht 5'6", Wt 189 lbs, BMI 30.50, BP Initial 120/83 mm Hg, HR Initial 86, Temp Initial 96.6, PO2 Initial 99, Pain Initial 5/10, Discharge Vital Signs taken by: Shakima, D/C BP 129/77, D/C HR 83, D/C PO2 100, D/C Pain 3/10.

Examination

General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. MUSCLE SPASMS - 728.85

Treatment

1. MUSCLE SPASMS
Notes: Will treat myospasm today with trigger point injections.

Procedures

Supplies/Services::
Skin Prep Alcohol swab. Needles 27 gauge x 1.25 inch needle. Local Anesthetic Lidocaine 1% 10 cc.
Trigger Point Injection - Diagnosis: Myofascial Pain/Muscle Spasms:
Location Bilateral Lumbar Paravertebral. Procedure note Informed consent was obtained from patient. The myofascial trigger points were identified by palpation. The skin was prepped as noted

Recent place of employment: College of Charleston.
Work Status: Not Working since January 29, 2015.
Injured at work: Yes.
Marital Status: Married.
Children: none.
no Smoking, 1/2 pack per day for 15 years, Quit 2003.
no Alcohol, denies alcohol use.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, tingling, numbness, arm weakness. Positive for insomnia, leg weakness.

above. The needle noted above was advanced into the deep musculature at each site. Aspiration was negative for heme, parasthesias, and air. The appropriate medicine as noted above was injected at each site in equally divided doses. The needles were flushed and withdrawn intact from the skin. The skin was cleaned and a sterile dressing applied as needed. Complications None, the patient tolerated the procedure well and no complications were encountered.
Recovery and Discharge:
Recovery The patient was monitored for side effects and to ensure alert, awake, and in oriented condition. Discharge discharge instructions were given to the patient, patient was discharged with vital signs stable.

Follow Up
Keep previous appointment

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 05/19/2015 at 12:22 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

PATRICIA A PATE (DOB: **w/ GIET, KRISTEN (PA-C) R 05/04/2015 @ 9:15 AM**

ADDRESS: [redacted]T

PRIMARY PH#: 843-554-4305
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** Jan. 2015

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

_____

Are you a Diabetic? (circle one) (YES) **NO**

Please list any medications changes (including dosage):

_____ _____ _____
_____ _____ _____

COMPLAINT:

Location: Lower Back
Started: 12-15-11
How: Lifting
Quality: Dull Sharp Ache Burn Throb Ting Shoot
Severity: 5 / 10 VAS overall

Timing: AM PM Constant Intermittent
Recent MRI, XRAYS, EMG/NCS studies: _____
What makes your pain better: _____
What makes your pain worse: _____
Recent ER/Urgent Care Visit: _____

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	O Yes	● No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	● Yes	O No
RECENT constipation	O Yes	● No				arm weakness	O Yes	● No
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Patricia A Pate Date: _____

FOR OFFICE USE ONLY!!!!!!!

Driver: _____ Blood Thinner: _____

Pre-OP Vital Signs: BP ____/____ P____ Sat____ T____ Ht____ Wt____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

DC Vital Signs: BP ____/____ P____ Sat____ T____ **Pain Level:** _____ **Staff Initials:** _____

Document Scanned Initials: _____

(118)

TRIDENT
PAIN CENTER

[illegible], SC-29410
Home: 843-554-4305
Guarantor: PATE, PATRICIA A Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
PCP: DONALD T HANNA, MD Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER NC

05/19/2015

Kristen Giet, PA

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking pioglitazone 15 mg tablet 1 tab(s) once a day
Taking Bydureon 2 once a week
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol
Diabetes

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.

Reason for Appointment

1. Low back pain

History of Present Illness

Driver::
Present in office: No.
Description of pain::
Location: lower back, buttocks, leg. Onset of pain: lifting injury. Date of Onset: 12/2011. Nature: sharp, aching, burning, throbbing, tingling, shooting. Severity: 5/10 overall. Timing: constant. Helping factors: injection, medication, rest. Aggravating factors: moving, bending, standing.
Anticoagulants::
Comments: ON XARELTO.

Vital Signs

Initial Vital Signs taken by: Shakima, Ht 5'6", Wt 191 lbs, BMI 30.82, BP Initial 100/68 mm Hg, HR Initial 86, Temp Initial 97.1, PO2 Initial 98, Pain Initial 5/10.

Examination

General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints, with palpable paraspinous myospasms present. Radiating Symptoms: moderate lumbar radiculitis pain with ROM with pain in the bilateral L4 , L5, S1 nerve distribution to the knee, intermittent numbness and tingling.

Assessments

Recent place of employment: College of Charleston.
Work Status: Not Working since January 29, 2015.
Injured at work: Yes.
Marital Status: Married.
Children: none.
Smoking: Former smoker, 1/2 pack per day for 15 years, Quit 2003.
Alcohol: denies alcohol use.

Allergies
penicillin: WELPS

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness. Positive for tingling, numbness, leg weakness.

1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. MUSCLE SPASMS - 728.85

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, q 12 hours, DO NOT FILL UNTIL 5/22, 60, Refills 0
Continue Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 5/22, 90, Refills 0
Clinical Notes: Discussed this patient with the attending physician and this treatment plan was decided upon.. Patient denies any significant side effects that need to be addressed.

2. MUSCLE SPASMS
Clinical Notes: Pt is unable to get injections with Dr Nolan due to currently being on Xarelto and not being able to d/c for any amount of time. We have done TPIs which do provide some relief. We will try and obtain auth for more than 1 treatment of TPIs so we can perform these monthly at her med refill appts.

3. Others
Action Started- AUTHORIZATION

Procedures
Trigger Point Injection - Diagnosis: Myofascial Pain/Muscle Spasms:
Location Bilateral Lumbar Paravertebral x3. Procedure note plan to perform on return to clinic after authorization.

Labs
Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	POS
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	179.4MG/DL/POS

GRISSETT,SHAKIMA L 5/19/2015 9:51:24 AM > in house lab only ADKINS(MLT),GINA 5/19/2015 2:52:12 PM > IN HOUSE UDS GADSON,CHERIKA S 5/19/2015 3:58:23 PM > , In office screen was appropriate

Follow Up
Next available appointment, TPI after authorization, 4 Weeks from 5/22, med refill; 8 weeks from 5/22 , Eval patients needs for further treatment/med refill, for Dr. Nolan



Electronically signed by JOSEPH NOLAN , MD on 05/20/2015 at 10:12 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Patient: PATE, PATRICIA A Progress Note: Kristen Giet, PA 05/19/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(121)

PATRICIA A PATE (DOB:) w/ GIET, KRISTEN (PA-C) R 05/19/2015 @ 9:30 AM

ADDRESS: 1

PRIMARY PH#: 843-554-4305
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** Jan, 2015

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) (YES) NO

Please list any medications changes (including dosage):

COMPLAINT:

Location: Lower Back
Started: 10-15-11
How: lifting
Quality: Dull (Sharp) (Ache) ~~Burn~~ ~~Throbbing~~ (Shoo) all at times
Severity: 5 / 10 VAS overall

Timing: AM PM Constant Intermittent
Recent MRI, XRAYS, EMG/NCS studies:
What makes your pain better: Injection + meds
What makes your pain worse: moving bending standing Heat being stressed
Recent ER/Urgent Care Visit:

REVIEW OF SYSTEMS:
If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	● Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	● Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	● Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	● No
RECENT weight gain	O Yes	● No						
Gastroenterology			**Genitourinary**			**Neurology**		
GERD	O Yes	● No	urinary tract infections	O Yes	● No	headaches	O Yes	● No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	dizziness	O Yes	● No
ulcers	O Yes	● No	kidney disease	O Yes	● No	tingling/numbness	● Yes	O No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	insomnia	O Yes	● No
RECENT constipation	O Yes	● No				arm weakness	O Yes	● No
RECENT diarrhea	O Yes	● No				leg weakness	● Yes	O No

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Patricia A. Pate Date: May 19, 2015

FOR OFFICE USE ONLY!!!!!!!

Driver: _____ Blood Thinner: _____

Pre-OP Vital Signs: BP ____/____ P____ Sat____ T____ Ht____ Wt____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

BP ____/____ P____ Sat____ BP ____/____ P____ Sat____

DC Vital Signs: BP ____/____ P____ Sat____ T____ **Pain Level:** ____ **Staff Initials:** ____

Document Scanned Initials: ____

(122)

PATE, PATRICIA A

TRIDENT
PAIN CENTER

110 [redacted]
Home: 843-554-4305
Guarantor: PATE, PATRICIA A Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
PCP: DONALD T HANNA, MD Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER NC

05/28/2015

Allison Davis, NP-C

Current Medications

Taking OxyContin 10 mg tablet, extended release 1 tab(s) q 12 hours
Taking Percocet-10/325 325 mg-10 mg tablet 1 tab(s) TID PRN PAIN
Taking Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Taking LUMBAR SUPPORT ORTHOTIC Horizon 627 LSO as directed
Taking TENS Unit & Monthly Supplies Pain Management Technologies E0730 / A4595 Use as directed
Taking Xarelto
Taking atorvastatin 10 mg tablet 1 tab(s) once a day (at bedtime)
Taking Claritin-D
Taking Ambien
Taking omeprazole
Taking quinine
Taking Paxil
Taking pioglitazone 15 mg tablet 1 tab(s) once a day
Taking Bydureon 2 once a week
Medication List reviewed and reconciled with the patient

Past Medical History

Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression
High cholesterol
Diabetes

Surgical History

Gallbladder 1985
Hysterectomy 1998
Back Surgery (lumbar fusion with rods) 2012

Family History

Father: alive
Mother: alive

Social History

Education: High School.
Occupation: Copy Center.

Reason for Appointment

1. Low back pain

History of Present Illness

Driver::
Present in office: No.
Anticoagulants::
Comments: on xarelto.
Description of pain::
Location: low back. Onset of pain: work injury. Date of Onset: 12/15/11. Nature: sharp, aching, tingling, shooting. Severity: 5/10 overall. Timing: constant. Helping factors: injections by this clinic, pain medications. Aggravating factors: bending, stooping, walking, activity.

Vital Signs

Initial Vital Signs taken by: kelli, Ht 5'6", Wt 188 lbs, BMI 30.34, BP Initial 115/81 mm Hg, HR Initial 84, Temp Initial 97.4, PO2 Initial 109, Discharge Vital Signs taken by: Kelli, D/C BP 125/81, D/C HR 88, D/C PO2 95, D/C Pain 6/10.

Examination

General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments

1. MUSCLE SPASMS - 728.85 (Primary)

Treatment

1. MUSCLE SPASMS
Clinical Notes: Will treat myospasm today with trigger point injections.

Procedures

Supplies/Services::
Skin Prep Alcohol swab. Needles 27 gauge x 1.25 inch needle. Local Anesthetic Lidocaine 1% 10 cc.
Trigger Point Injection - Diagnosis: Myofascial Pain/Muscle Spasms:
Location Bilateral Lumbar Paravertebral. Procedure note Informed consent was obtained from patient. The myofascial trigger

Recent place of employment: College of Charleston.
Work Status: Not Working since January 29, 2015.
Injured at work: Yes.
Marital Status: Married.
Children: none.
Alcohol: denies alcohol use.

Allergies

penicillin: WELPS

Hospitalization/Major Diagnostic Procedure

Patient denies recent hospitalization

Review of Systems

Constitutional:

Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.

Gastroenterology:

Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:

Negative for recent skin rash, recent skin sores, skin cancer.

Genitourinary:

Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.

Musculoskeletal:

Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.

Neurology:

Negative for headaches, dizziness, arm weakness. Positive for tingling, numbness, leg weakness, insomnia.

points were identified by palpation. The skin was prepped as noted above. The needle noted above was advanced into the deep musculature at each site. Aspiration was negative for heme, parasthesias, and air. The appropriate medicine as noted above was injected at each site in equally divided doses. The needles were flushed and withdrawn intact from the skin. The skin was cleaned and a sterile dressing applied as needed. Complications None, the patient tolerated the procedure well and no complications were encountered. Procedure performed by Allison Davis, NP-C.

Recovery and Discharge:

Recovery The patient was monitored for side effects and to ensure alert, awake, and in oriented condition. Discharge discharge instructions were given to the patient, patient was discharged with vital signs stable.

Follow Up

Keep previous appointment

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 06/03/2015 at 02:45 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER NC
9267 G MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

124

PATRICIA A PATE (DOB:) w/ DAVIS (NP-C), ALLISON F 05/28/2015 @ 10:45 AM

14 10m

ADDRESS: :T

PRIMARY PH#: 843-554-4305
SECONDARY PH#: 843-509-6704

Are you currently working? (circle one) YES (NO) **If no, last day of work?** Jan, 2015

Any changes in social/family history? (i.e. job status, marital status, recent deceased family members or new health problems)

Are you a Diabetic? (circle one) (YES) NO

Please list any medications changes (including dosage):

No change Ø Refills

COMPLAINT:

Location: Lower Back

Started: 12-15-11

How: Lifting

Quality: Dull Sharp Ache Burn Throb Tingle Shoot

Severity: 5 / 10 VAS overall

Timing: AM PM (Constant) Intermittent

Recent MRI, XRAYS, EMG/NCS studies:

What makes your pain better: Injection & meds

What makes your pain worse: Bending stand & walking active

Recent ER/Urgent Care Visit:

REVIEW OF SYSTEMS:

If you have experienced any of the following problems, please fill in the bubble completely (No check marks or cross marks)

Constitutional			**Dermatology**			**Musculoskeletal**		
RECENT fever	O Yes	● No	RECENT skin rash	O Yes	● No	muscle pain	Ø Yes	O No
RECENT fatigue	O Yes	● No	RECENT skin sores	O Yes	● No	joint pain	Ø Yes	O No
night sweats	O Yes	● No	skin cancer	O Yes	● No	joint stiffness	Ø Yes	O No
RECENT weight loss	O Yes	● No				arthritis	O Yes	Ø No
RECENT weight gain	O Yes	● No						
						Neurology		
Gastroenterology			**Genitourinary**			headaches	O Yes	Ø No
GERD	O Yes	O No	urinary tract infections	O Yes	● No	dizziness	O Yes	Ø No
abdominal pain	O Yes	● No	bladder problems	O Yes	● No	tingling/numbness	Ø Yes	O No
ulcers	O Yes	● No	kidney disease	O Yes	● No	insomnia	O Yes	● No
RECENT blood in stool	O Yes	● No	prostate problems	O Yes	● No	arm weakness	O Yes	Ø No
RECENT constipation	O Yes	● No				leg weakness	Ø Yes	O No
RECENT diarrhea	O Yes	● No						

** Please fill out the information listed above in its entirety, as we take this information into consideration for your current and future treatment.

Signature: Date:

FOR OFFICE USE ONLY!!!!!!!

Driver: ND 84

Blood Thinner: Ø Xarelto on

Pre-OP Vital Signs: BP 115, 81 P 47 Sat 100 T 97.4 Ht ___ Wt 188

BP ___/___ P ___ Sat ___ BP ___/___ P ___ Sat ___

BP ___/___ P ___ Sat ___ BP ___/___ P ___ Sat ___

DC Vital Signs: BP ___/___ P ___ Sat ___ T ___ **Pain Level:** ___ **Staff Initials:** ___

Document Scanned Initials: ___

(125)

TRIDENT
PAIN CENTER

WORK RESTRICTIONS:

Date: 6/19/15

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☑ The patient may return to work on 6/21/15, **light duty** with the following restrictions:

- ☑ No lifting greater than 10 lbs
- ☑ No bending, squatting, or crawling
- ☑ No pushing/pulling heavy objects

< 4 hours per day
4 days per week

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office in 3 months. We will update you in regards to the patient's work status at that time. Thank you for your consideration.

Sincerely,

J. Edward Nolan, MD
Medical Director

843.797.3636 . 843.797.3637 tridentpaincenter.com

North Charleston: 9267 Medical Plaza Drive, North Charleston, SC 29406
Moncks Corner: 108 North Hwy. 52, Moncks Corner, SC 29461
Walterboro: 302 Medical Park Drive, Ste. 207-A, Walterboro, SC 29488

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SOUTH CAROLINA
STATE ACCIDENT FUND

HARRY B. GREGORY, JR., Director

Dr. Edward Nolan
Trident Pain Center
9267 G Medical Plaza Dr
N Charleston, SC 29406

February 26, 2014

Re: Patricia Pate vs COLLEGE OF CHARLESTON
SF#: 2011-004217
WCC#: 1121370
D/A: 12/14/2011

Dr. Nolan,

Please answer the following questions on the above named patient. We need this information in order to properly process her claim.

You recently placed Ms. Pate at maximum medical improvement on 2/13/14.

Does Ms. Pate have an impairment rating for her injury on 12/14/2011? ☒YES ☐NO

If yes, please list 23% DRE cat IV

If yes, is it inclusive of or in addition to the 40% to the lumbar spine given to her by Dr Marzluff on 09/19/2012? ☒Inclusive Of ☐In Addition To

Thank you in advance for answering these questions. Feel free to contact this office with any questions or concerns you may have regarding this information.

Thanks and have a great day!

Jennifer Stone
Claims Adjuster
State Accident Fund
P.O. Box 102100
Columbia, SC 29221
Phone: 803-896-5913
Fax: 803-612-2715

2-10-14

This fax was sent with GFI FaxMaker fax server. For more information, visit: http://www.gfi.com

p.3 8437972837 Trident Pain Center
This fax was received by GFI FaxMaker fax server. For more information, visit: http://www.gfi.com

(1266)

TRIDENT REGIONAL MEDICAL CNTR
9330 MEDICAL PLAZA DRIVE
CHARLESTON, SC 29406

PHONE #: 843-847-4900
FAX #: 843-847-4553

Name: PATE,PATRICIA ANN

Acct: D00039935056 Loc: D.TORRAD
Exam Date: 07/11/2012 Status: REG CLI
Radiology No:
Unit No: D249254566

EXAMS:
003037895 SPINE LUMBAR AP LAT/SPO

EXAM REASON::
STENOSIS

HISTORY:
Lumbar stenosis postoperative.

Frontal laberal oblique views.

No previous plain films for comparison.

Intact left sided pedicle screws at the L4-L5 level and a spacer in the L4-5 disc space. Slight dextroscoliosis centered the region of L2-3. Lumbar vertebral bodies are normal height. Disc spaces are relatively well maintained including the L4-5 operated level where there is a spacer present. Slight grade 1 spondylolisthesis L4-L5 with elsewhere lumbar alignment is normal.

Impression
1. Slight grade 1 spondylolisthesis L4-5. Intact pedicle screws and a spacer. In good position. Remaining disc spaces well maintained elsewhere alignment is normal.

** Electronically Signed by M.D. Fredrick E. Cosco **
** on 07/11/2012 at 1346 **
Reported and signed by: Fredrick E. Cosco, M.D.

CC: DONALD T HANNA; JOSEPH MARZLUFF

Dictated Date/Time: 07/11/2012 (1346)
Technologist: GALLAGHER,KATHLEEN M

Transcribed Date/Time: 07/11/2012 (1346)
Prepared By: PHY.COSFR
Electronic Signature Date/Time: 07/11/2012 (1346)
Orig Print D/T: S: 07/11/2012 (1351)
BATCH NO: N/A

PAGE 1 Signed Report

SUMMERVILLE MEDICAL CENTER
295 MIDLAND PARKWAY
SUMMERVILLE, SC 29485

NAME: PATE,PATRICIA ANN
UNIT #: D249254566
Physician: JOSEPH MARZLUFF
REPORT: HISTORY PHYSICAL

ACCT #: D00039316660
ROOM #: D.633-A

Pt Location:D.T6FL

DATE OF ADMISSION: 05/15/2012

She is a [illegible].e who, in mid-December, did some heavy lifting, and with that had the onset of back pain and discomfort with associated dysesthesias of the legs. She has been treated with rest, analgesics, anti-inflammatories and 2 epidural steroids and has had some improvement. Continues to be symptomatic. The back pain is better but the dysesthesias are present. They are constant and actually worse when sitting rather than standing or walking. Subsequent workup has revealed stenosis with spondylolisthesis at L4-5 and she is now admitted for lumbar decompression and fusion at L4-5.

PAST MEDICAL HISTORY: A 10-point review of systems is otherwise negative. She has had an hysterectomy in the past.

PHYSICAL EXAMINATION: HEENT: Oropharynx clear.
CHEST: Clear to percussion and auscultation.
HEART: Regular rhythm without murmur.
ABDOMEN: Soft without masses or tenderness.
NEUROLOGICAL: Examination with decreased range of motion of the back in all directions. No motor or sensory deficit is noted.

IMPRESSION: Spondylolisthesis, L4-5.

PLAN: For lumbar fusion, L4-5.

JM/MedQ
OD: 05/10/2012 10:17 AM
DT: 05/10/2012 10:49 AM
Job #: 875376/513359113
Authenticated by JOSEPH MARZLUFF, MD On 05/17/2012 10:18:15 AM

Electronically Signed by JOSEPH MARZLUFF on 05/17/12 at 1119

Patient Name: PATE,PATRICIA ANN Account #: D00039316660

TRIDENT HEALTH SYSTEM

HISTORY & PHYSICAL PHYSICIAN REASSESSMENT

If History and Physical completed prior to admission:

☐ I have reviewed the H&P and have examined the patient and there are no interval changes.

☐ I have reviewed the H&P and have examined the patient and the following changes are noted:

Physician Signature

5/15/12 Date

0730 Time

PATE,PATRICIA ANN 12/22/60 51/F
DR MARZLUFF,JOSEPH ACCT: D00039316660
URN: 0136257 MR: D249254566

DOS: 05/15/12

HPS H&P Physician Reassessment Revision Date 10-5-11

NAME: PATE,PATRICIA ANN
UNIT #: D249254566
Physician: JOSEPH MARZLUFF
REPORT: HISTORY & PHYSICAL

ACCT #: D00039316660
Room #:
Pt Location:

DATE OF ADMISSION: 05/15/2012

She is a [redacted] who, in mid-December, did some heavy lifting, and with that had the onset of back pain and discomfort with associated dysesthesias of the legs. She has been treated with rest, analgesics, anti-inflammatories and 2 epidural steroids and has had some improvement. Continues to be symptomatic. The back pain is better but the dysesthesias are present. They are constant and actually worse when sitting rather than standing or walking. Subsequent workup has revealed stenosis with spondylolisthesis at L4-5 and she is now admitted for lumbar decompression and fusion at L4-5.

PAST MEDICAL HISTORY: A 10-point review of systems is otherwise negative. She has had an hysterectomy in the past.

PHYSICAL EXAMINATION: HEENT: Oropharynx clear.
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HEART: Regular rhythm without murmur.
ABDOMEN: Soft without masses or tenderness.
NEUROLOGICAL: Examination with decreased range of motion of the back in all directions. No motor or sensory deficit is noted.

IMPRESSION: Spondylolisthesis, L4-5.

PLAN: For lumbar fusion, L4-5.

JM/MedQ
DD: 05/10/2012 10:17 AM
DT: 05/10/2012 10:49 AM
Job #: 875376/513359113

5/14/12
0530

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NOTES

Date	Time	Neuro/Stroke Coordinator
5/12/12	0730	CC pain
		NPT Spondylolisthesis
		PH TLIF L4-5 5/15 POD2
		CC: 98.4 83 18 110/65
		Lungs CTA
		Heart RRR
		Abd soft NTND
		Talking PO voiding
		Wound Clean + dry.
		Ambulatory.
		Pt didn't take percocet yest. did OK
		until this AM severe pain took
		percocet dont hasn't been OOB to Chair
		Light Headed.
		L. Yoop
		Stat, dsk

PROGRESS NOTES

"PNS" Reviewed/Revised 4/29/11
Reorder # 0575600299 / SMART# 448396

PATIENT INFORMATION

PATE,PATRICIA ANN
DR MARZLUFF,JOSEPH
URN: D136257
ACCT: D0003931 6660
MR: D249254566
DOB: 05/15/12

NOTES

Date	Time	Neuro/Stroke Coordinator
5/16/12	0720	CC pain.
		HPI Spondylolisthesis
		PH TLIF L4-5 5/15 POD 1
		CC: 97.6 88 18 122/78
		Lungs CTA
		Heart RRR.
		Abd soft NTND
		Taking PO voiding
		Wound Clean x dry
		Ambulatory
		Unable to fully stop pain.
		Doesn't feel pain meds working well
		Plan Discharge.
		Lifecare
		Left calf calf sore —
		Leg = Lymph — definite

PROGRESS NOTES

"PNS" Reviewed/Revised 4/29/11
Reorder # 0875600299 / SMART# 448398

PATIENT INFORMATION

PATE,PATRICIA ANN 51
DR MARZLUFF,JOSEPH ACCT: D00039316660
ORN: D136257 MR: D249254566
DOS: 05/15/12

THS IMMEDIATE POST PROCEDURE PROGRESS NOTE

PRIMARY PHYSICIAN and ASSISTANTS:

Dr. Gold / D'Agostino

PROCEDURES PERFORMED and FINDINGS:

T Live L4-5

REF 7510200
INFUSE™ Bone Graft (rhBMP-2/ACS)
Small Kit 2.8 ml (sc)
M111101AAY
STERILE
USE BY 2014-11-01
Medtronic

ESTIMATED BLOOD LOSS: None or 5 CC

SPECIMENS REMOVED: None or

CONTRAST IF APPLICABLE: CC

POST PROCEDURE DIAGNOSIS:

Spondylosis L4-5

SIGNATURE:

DATE: 5/15/12

TIME: 11 am

PATIENT INFORMATION

DOS: 05/15/12
PATE, PATRICIA ANN
DR. MARZLUFF, JOSEPH
UPIN: D13625?
MR: D249254566

"PNS" Reviewed/Revised 042208 Reorder # 3400184023/ SMARTs

TRIDENT MEDICAL CENTER
9330 MEDICAL PLAZA DRIVE
CHARLESTON, SC 29406

NAME: PATE,PATRICIA ANN
UNIT #: D249254566
Report Name: OPERATIVE REPORT

ROOM #: D.633-A
ACCT #: D00039316660

DATE OF SURGERY: 05/15/2012

SURGEON: Joseph Marzluff, MD

ASSISTANT: _____.

PREOPERATIVE DIAGNOSIS: Spondylolisthesis at L4-5

POSTOPERATIVE DIAGNOSIS: Spondylolisthesis at L4-5.

PROCEDURE PERFORMED: Transforaminal interbody fusion L4-5 .

INDICATIONS FOR PROCEDURE: She is a with spondylolisthesis at L4-5.

FINDINGS: Spondylolisthesis and degenerative disk disease, transforaminal body fusion accomplished using the patient's own bone, expandible PEAK cage, _____rods and screws, bone morphogenic protein.

DESCRIPTION OF OPERATION: The patient was brought to the operating room and after general endotracheal anesthesia had been obtained the patient was placed in the prone position on the Heffington seat and the back prepped and draped in the usual fashion. A vertical incision was made from two spinous processes above to spinous processes below the above stated level. This was carried down sharply to the lumbodorsal fascia was opened on the side of the fusion. The paraspinous muscles were stripped of the spinous processes, lamina, facets, and transverse processes at the appropriate level. The microscope was brought in the operative field and the remainder of the operation done with the use of the operative microscope. Using a Leksell rongeur the facet was removed to completely posterolaterally decompress the nerve root and visualize the disc space. With minimal retraction on the superior and inferior nerve root, the disc space was sharply entered and discectomy performed with ring Raney and Scoville curets as well as pituitary forceps. Decortication was accomplished using curettes and a high-speed air drill. The patient's previously taken bone was wrapped in bone matrix protein and packed in the anterior portion of the disc space and appropriate sized bone spacer was also then packed into the disc space. This was done with the disc space distracted and with removal of distraction with excellent fixation of the construct. In posterior aspect, the pedicles were then identified by direct vision and by the standard fashion and a probe was placed within the pedicles and their position verified by x-rays. Appropriate sized screws where then placed without difficulty. The screws were connected to the rod and fixation accomplished. The posterior aspect of the transverse processes were decorticated and Ollier graft was accomplished using bone matrix protein plus the patient's own bone and this was augmented if necessary with crushed

cortical cancellous bone. Hemostasis was obtained with electrocoagulation and the wound closed in the usual fashion with interrupted sutures of #0 Vicryl in the fascia, 2-0 Vicryl in the subcutaneous and subcuticular and staples in the skin. After the wound had been adequately closed, x-ray was used to verify the lateral aspect of the pedicles at L4 and L5 on the right side. Beginning about 2-3 cm lateral to the most lateral edge of the pedicle, a Jamshidi needle was placed under x-ray control to the lateral aspect of the pedicle and its position verified by AP and lateral radiographs. The Jamshidi was then extended into the pedicle and position again verified by AP and lateral radiographs. A K-wire was then placed through the Jamshidi into the vertebral body and the Jamshidi needle was removed. Subsequent progressively enlarged dilators were then used over both K-wire's until a radiolucent dilator of about 1.5 cm was introduced at both levels. The inner dilators were removed. A percutaneous screw was then placed in the standard fashion. The K-wires were removed as well as the needle drivers. The posterior aspect of the screws could easily be visualized and again their position verified radiographically. The pivot actuator was then used to place a rod between the two screws and then caps were placed and the rods tightened down in the standard fashion. The installation hardware was easily removed. X-rays again verified excellent location of the construct at L4-5 on the right side.

JN/MedQ
DD: 05/15/2012 11:05 AM
DT: 05/15/2012 11:46 AM
Job #: 890799/513986229
Authenticated by JOSEPH MARZLUFF, MD On 05/17/2012 10:18:20 AM

Electronically Signed by JOSEPH MARZLUFF on 05/17/12 at 1119

Patient Name: PATE,PATRICIA ANN Account #: D00039316660

PATE, PATRICIA

ID:D136357

09-MAY-2012 15:13:45

HCA SC

female

Room:

Loc:14

Vent. rate	74	BPM
PR interval	156	ms
QRS duration	86	ms
QT/QTc	398/441	ms
P-R-T axes	22 73	48

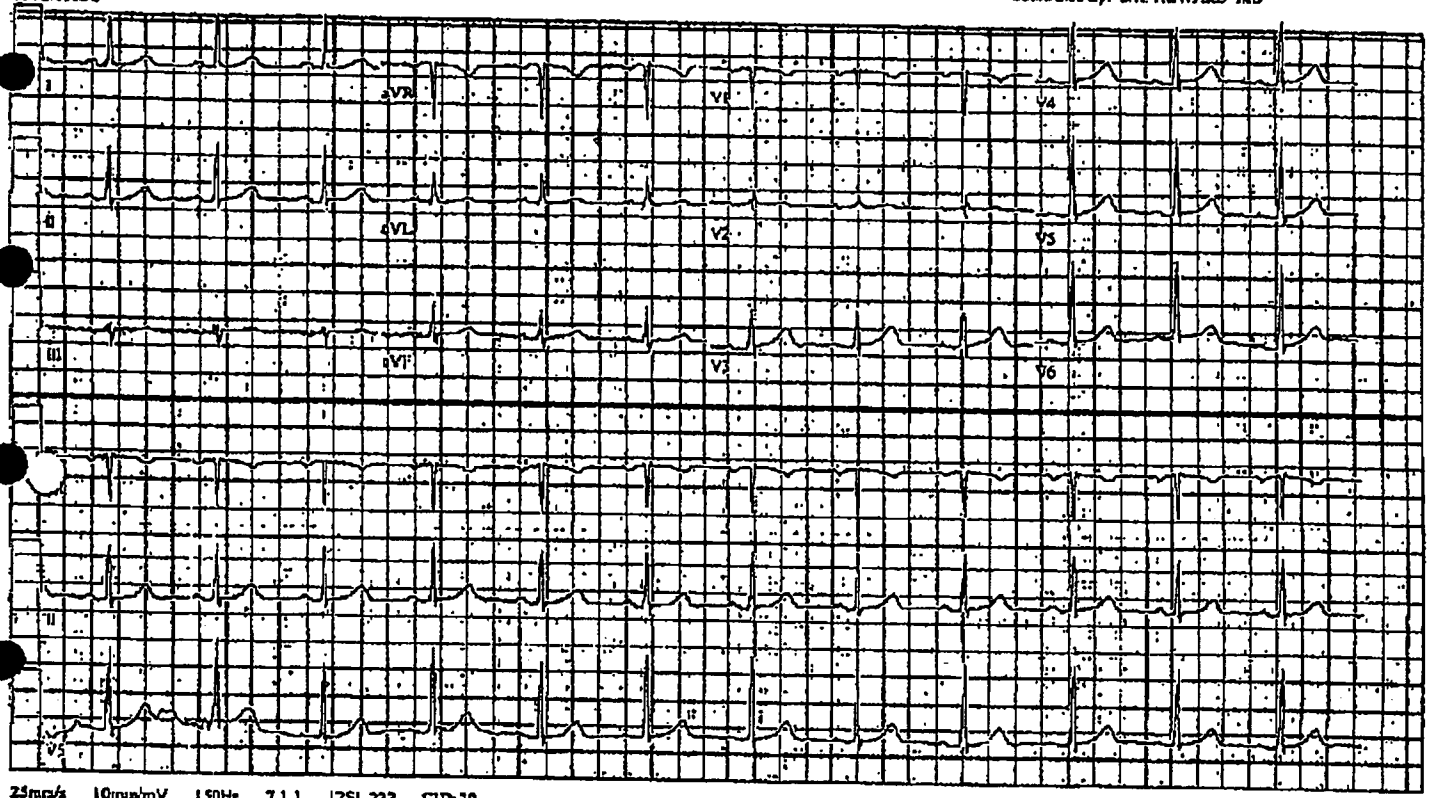
Normal sinus rhythm
Counter Clockwise rotation
No previous ECGs available

Technician: ZHL8443
Test Ind:5/15/12

TMC:TACC

Referred by: JOSEPH MARZLUFF

Confirmed By: L.K. HOWARD MD



25mm/s 10mm/mV 150Hz 7.1.1 12SL237 CID:30

SID: D249254566 EID:2000 EDT: 16:46 09-MAY-2012 ORDER: E05090892 ACCOUNT: D00039450834

Page 1 of 1

Patient:PATE, PATRICIA ANN MRN:D249254566 Encounter:D00039316660 Page 1 of 1

(136)

TRIDENT REGIONAL MEDICAL CNTR
9330 MEDICAL PLAZA DRIVE
CHARLESTON, SC 29406

PHONE #: 843-847-4900
FAX #: 843-847-4563

Name: PATE,PATRICIA ANN

Acct: D00039450834 Loc: D.TWAT
Exam Date: 05/09/2012 Status: REG CLI
Radiology No:
Unit No: D249254566

EXAMS:
003002110 CHEST AP/PA

EXAM REASON::
PREOP LUMBAR LAMINECTOMY AND FUSION

HISTORY:
Preoperative lumbar laminectomy and fusion

COMPARISON:
April 3, 2007 two-view chest study

TECHNIQUE:
A PA upright view of the chest was obtained at 1435 hours.

FINDINGS:
The cardiomediastinal silhouette is normal in appearance.

The lungs are symmetrically expanded, and are clear.

Osseous structures are unremarkable. Surgical clips in the right upper abdomen suggest prior cholecystectomy.

IMPRESSION:
Normal study..

** Electronically Signed by M.D. Rand Cuthbertson **
** on 05/09/2012 at 1546 **
Reported and signed by: Rand Cuthbertson, M.D.

CC: JOSEPH MARZLUFF

Dictated Date/Time: 05/09/2012 (1546)
Technologist: JILL N FLINT

Transcribed Date/Time: 05/09/2012 (1546)
Prepared By: PHY.CUTRA
Electronic Signature Date/Time: 05/09/2012 (1546)
Orig Print D/T: S: 05/09/2012 (1550)
BATCH NO: N/A

PAGE 1 Signed Report

(137)

EKG Report
Trident Special Testing
9330 Medical Plaza Dr
Charleston, SC 29406

Patient: PATE,PATRICIA ANN
Unit #: D249254566

Service Date: 05/09/12
Service Time: 1513

Test Reason : 5/15/12
Blood Pressure : ***/*** mmHG
Vent. Rate : 074 BPM Atrial Rate : 074 BPM
P-R Int : 156 ms QRS Dur : 066 ms
QT Int : 398 ms P-R-T Axes : 022 023 048 degrees
QTc Int : 441 ms

Normal sinus rhythm
Counter Clockwise rotation
No previous ECGs available

Referred By: JOSEPH MARZLUFF Overread By: L.K. HOWARD MD

Electronically Signed by L K HOWARD on 05/09/12 at 1646

Patient Name: PATE,PATRICIA ANN Account #: D00039450834

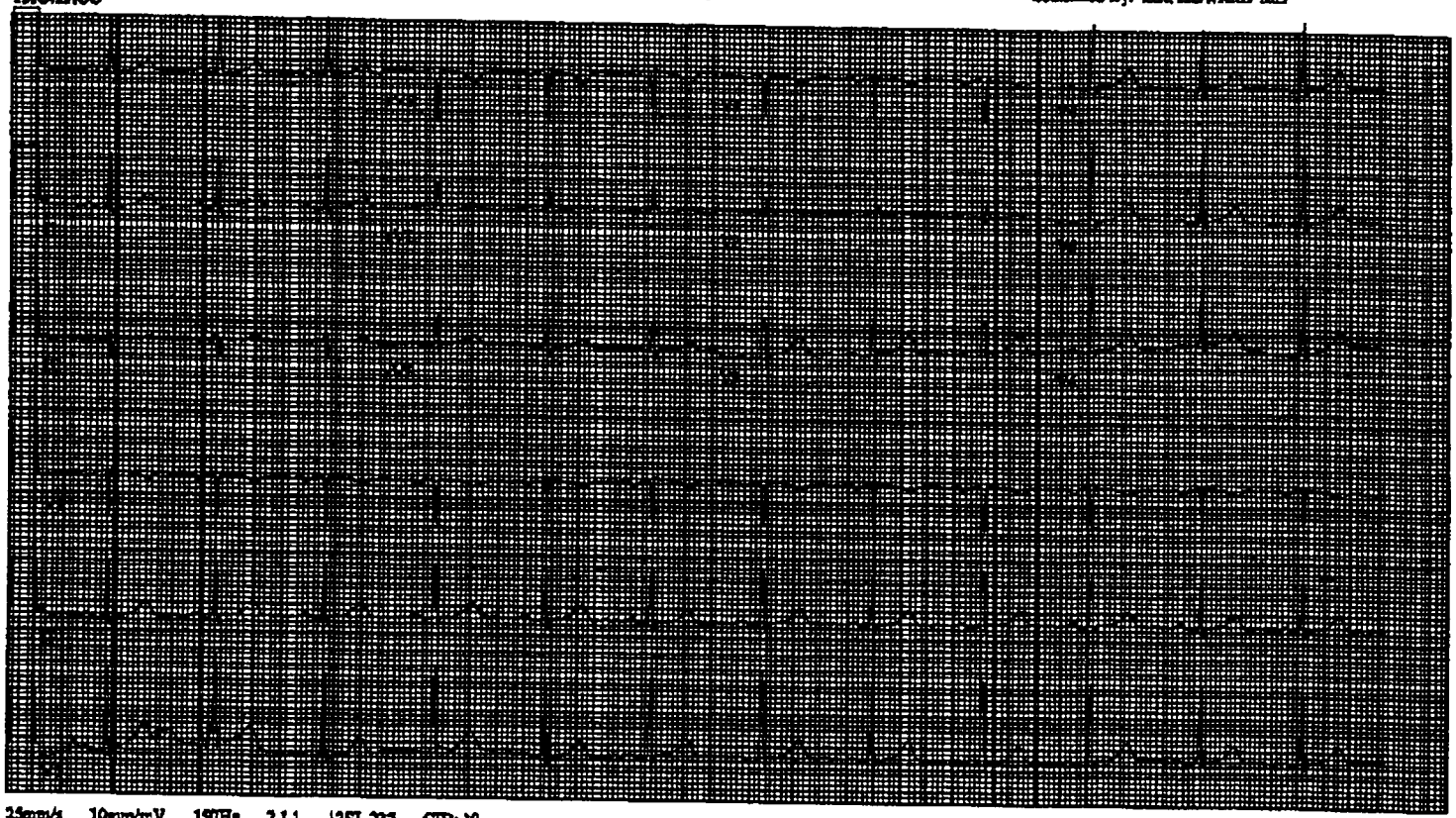
PATE, PATRICIA ID:D136257 09-MAY-2012 15:13:45 HCA EC-T-ACC ROUTINE RECORD

Vent. rate	74	BPM	Normal sinus rhythm
PR interval	156	ms	Counter Clockwise rotation
QRS duration	66	ms	No previous ECGs available
QT/QTc	398/441	ms	
P-R-T axes	22 23	48	

Room:
Loc:14

Technician: ZHL8443
Test ind:5/15/12

TMC-IACC Referred by: JOSEPH MANZLUPP Confirmed By: L.K. HOWARD MD



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 30

SID: D249254566 EID:2000 EDT: 15:46 09-MAY-2012 ORDER: HOSO0092 ACCOUNT: D00039450834

Page 1 of 1

Patient:PATE, PATRICIA ANN MRN:D249254566 Encounter:D00039450834 Page 1 of 1

(139)

JOSEPH M. MARZLUFF, M.D., FACS
JASON M. HIGHSMITH, M.D.
NEUROSURGERY
MIKE O. TYLER, JR.,, M.D.
DR. SABINO J. D'AGOSTINO

MR./MRS./MISS PATE (LAST) Paterica (FIRST) A. (MIDDLE INITIAL)

ADDRESS

☐ MALE ☑ FEMALE

SS# [redacted]

RACE W WT 170 HT 5'6"

HOME PHONE 843 554-4305

CELL PHONE 843 509 6704 PAGER

BIRTH DATE [redacted]

☐ SINGLE ☑ MARRIED ☐ DIVORCED ☐ WIDOWED

OCCUPATION Asst. Manager Copy Center

WORK PHONE 953-5924

NAME OF EMPLOYER College of Charleston

ADDRESS 81 St. Phillips St.

NAME OF SPOUSE/PARENT

SPOUSE'S SS#

DATE OF BIRTH

OCCUPATION

WORK PHONE

MEDICAL INSURANCE COMPANY

POLICY NUMBER

INSURANCE IN YOUR NAME OR SPOUSE'S?

OTHER INSURANCE

WERE YOU IN AN ACCIDENT? WAS THIS AN AUTO ACCIDENT?

WERE YOU INJURED ON THE JOB? Yes DATE OF INJURY? 12-14-11

DESCRIBE HOW IT HAPPENED lifting heavy box

WERE X-RAYS / MRI TAKEN OF INJURY OR PROBLEM? 1-25-12

WHEN AND WHERE? Tri County Rad. Associates

NAME OF YOUR REFERRING DOCTOR (Full Name and Number)
Dr. Donald Hanna
572-8201

PRIMARY CARE PHYSICIAN: Dr. Hanna

BLOOD THINNERS? ☐ YES ☑ NO

THIS INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR WRITTEN CONSENT.

DO YOU HAVE, OR EVER HAD:

	YES	NO
DIABETES	☐	☑
HIGH BLOOD PRESSURE	☐	☑
HEART TROUBLE	☐	☑
CANCER	☐	☑
KIDNEY TROUBLE	☐	☑
NERVOUS CONDITION	☐	☑
HEPATITIS	☐	☑
HIV POSITIVE	☐	☑

ALLERGIES? ☐ YES ☑ NO

List Allergies
Hydrocodone
Penicillin

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I HEREBY AUTHORIZE JOSEPH M. MARZLUFF, M.D. / MIKE O. TYLER, M.D. / JASON M. HIGHSMITH, M.D. / DR. SABINO J. D'AGOSTINO TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS, AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I UNDERSTAND FULLY THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE, OR ANY COLLECTION FEES, OR INTEREST ACQUIRED.

SIGNATURE [signature]

DATE 2-15-12

140

TriCounty Radiology Associates

(843) 529-0600
North Charleston
Summerville
West Ashley

PATIENT: Pate, Patricia
DOB:
MRN: 636406
PATIENT PHONE: 843-554-4305
PHYSICIAN: Donald Hanna, MD
DATE: 1/25/2012

EXAM: LUMBAR MRI WITH AND WITHOUT CONTRAST

COMPARISON STUDIES: None.

HISTORY: Back pain.

TECHNIQUE: Multiplanar multisequence images lumbar spine with and without 15 mL Magnevist IV contrast.

FINDINGS: *Alignment and bony structures:* L4-5 mild degenerative anterolisthesis and type I Modic change. L2-3 and L3-4 mild degenerative retrolistheses. Mid lumbar mild type I Modic changes anteriorly otherwise. *Conus medullaris:* Normal signal and caliber. *Findings by level:*

T12-L1 - L1-2: Normal.

L2-3: Mild disc bulge and facet hypertrophy. Mild exit narrowing. Left extraforaminal marginal annular enhancement.

L3-4: Mild disc bulge converts to shallow protrusion left intraforaminally. Facet hypertrophy with small right effusion. Mild exit narrowing with slight deflection L3s. Mild right recess narrowing. Left extraforaminal marginal annular enhancement.

L4-5: Shallow concentric disc osteophyte complex has superimposed shallow protrusion left intra to extraforaminally, with associated annular tear. Moderate facet hypertrophy. Ligamentum flavum thickening. Mild bilateral exit narrowing with deflection and flattening bilateral L4s. Moderate central narrowing. Mild recess crowding transiting L5s. Left extraforaminal marginal annular enhancement associated with the annular tear. Right extraforaminal annular enhancement extends right anterolaterally. Mild enhancement of ligamentum flavum at this level. Mild perifacet enhancement.

L5-S1: Mild disc bulge converts to shallow disc-osteophyte complex biforaminally to extraforaminally. Facet hypertrophy. Mild exit narrowing with crowding and mild deflection exiting L5s more prominent on the left.

IMPRESSION:
1. Diffuse spondylosis is mostly mild, with moderate central stenosis at L4-5. Based on the above findings, correlation for mild L3, left greater than right L4, and left greater than right L5 radiculopathies might be helpful. The L4-5 level has left intra to extraforaminal shallow protrusion and associated annular tear.
2. Mid to upper lumbar marginal annular enhancements compatible with annular tears, potential sources of non-radicular pain.

Troy Marlow, M.D.
TM / cm

141

Patient Name: Pate, Patricia
MRN: 636406
EXAM: LUMBAR MRI WITH AND WITHOUT CONTRAST

DD: 1/26/2012 / DT: 1/26/2012
JOB: 14444314

This document has been electronically reviewed and signed.

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PATE, PATRICIA
OFFICE NOTES

February 15, 2012: Patricia Pate was seen in the office today for evaluation of low-back pain and bilateral numbness and tingling in the legs. She is a mid-50-year-old female who, in mid-December, did some heavy lifting and, with that, had the onset of some back pain and discomfort and then associated dysesthesias of the legs. She has been treated with rest, analgesics and anti-inflammatories and has had some improvement, but continues to be symptomatic. The back pain is better, but the dysesthesias are present. They are constant and are actually worse with sitting rather than standing or walking.

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS: Documented in the chart and reviewed with the patient. Otherwise, noncontributory.

FAMILY & SOCIAL HISTORY: Documented in the chart and reviewed with the patient. Otherwise, noncontributory.

PHYSICAL EXAMINATION: Physical examination today reveals negative straight leg raising. No motor or sensory deficit is noted. No long tract signs are noted.

DIAGNOSTIC STUDIES: Magnetic resonance scan is reviewed. She has spondylolisthesis at L4-5 with moderate stenosis as a result.

IMPRESSION: Spondylolisthesis L4-5.

PLAN: We will get her back and try an epidural steroid or two, but certainly surgery is a possibility.

JMM:lsd

(143)

PATE, PATRICIA
OFFICE NOTES

February 15, 2012: Patricia Pate was seen in the office today for evaluation of low-back pain and bilateral numbness and tingling in the legs. She is a mid-50-year-old female who, in mid-December, did some heavy lifting and, with that, had the onset of some back pain and discomfort and then associated dysesthesias of the legs. She has been treated with rest, analgesics and anti-inflammatories and has had some improvement, but continues to be symptomatic. The back pain is better, but the dysesthesias are present. They are constant and are actually worse with sitting rather than standing or walking.

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS: Documented in the chart and reviewed with the patient. Otherwise, noncontributory.

FAMILY & SOCIAL HISTORY: Documented in the chart and reviewed with the patient. Otherwise, noncontributory.

PHYSICAL EXAMINATION: Physical examination today reveals negative straight leg raising. No motor or sensory deficit is noted. No long tract signs are noted.

DIAGNOSTIC STUDIES: Magnetic resonance scan is reviewed. She has spondylolisthesis at L4-5 with moderate stenosis as a result.

IMPRESSION: Spondylolisthesis L4-5.

PLAN: We will get her back and try an epidural steroid or two, but certainly surgery is a possibility.

JMM:lsd

144

PATE, PATRICIA
OFFICE NOTES

February 22, 2012: LES #1: The back was prepped with Betadine and infiltrated with 1% Xylocaine in the subcuticular and subcutaneous tissues. A #17-gauge Tuohy needle was introduced in the epidural space without difficulty and 80 mg of Depo-Medrol, 10 cc of 0.25% Marcaine, and 4 cc of normal saline were injected. The patient tolerated the procedure well.

JMM:lsd

PATE, PATRICIA
OFFICE NOTES

March 7, 2012: LES #2: The back was prepped with Betadine and infiltrated with 1% Xylocaine in the subcuticular and subcutaneous tissues. A #17-gauge Tuohy needle was introduced in the epidural space without difficulty and 80 mg of Depo-Medrol, 10 cc of 0.25% Marcaine, and 4 cc of normal saline were injected. The patient tolerated the procedure well.

She had no significant improvement with the first injection. If no better with this injection, surgery is the only thing I have left to offer.

JMM:lsd

146

PATE, PATERICA
OFFICE NOTES

April 4, 2012: Paterica Pate and her husband return to discuss options for treatment. She has had two epidurals without improvement. She has spondylolisthesis. Surgery is her best alternative. I have discussed the risks and benefits of surgery. They are aware of the risks of bleeding or infection, nerve damage with increased weakness or numbness in the leg, paralysis with loss of control in bowel or bladder function. They understand the possibility that the grafts could slip or break, as could the rods or screws.

She will think about things and be back in touch.

JMM:lsd

(147)

PATE, PATERICA
OFFICE NOTES

May 9, 2012: Paterica Pate comes in for pre-admission testing. We have previously discussed the risks and benefits of surgery with her and her husband. They have no further questions.

JMM:lsd

148

TRIDENT REGIONAL MEDICAL CNTR
9330 MEDICAL PLAZA DRIVE
CHARLESTON, SC 29406

PHONE #: 843-847-4900
FAX #: 843-847-4563

Name: PATE,PATRICIA ANN
Phys: MARZLUFF,JOSEPH
I
Acct: D00039450834 Loc: D.TPAT
Exam Date: 05/09/2012 Status: REG CLI
Radiology No:
Unit No: D249254566

JOSEPH MARZLUFF
9313 MEDICAL PLAZA DR, S-305
CHARLESTON, SC 29406

EXAMS:
003002110 CHEST AP/PA

EXAM REASON::
PREOP LUMBAR LAMINECTOMY A

HISTORY:
Preoperative lumbar laminectomy and fusion

COMPARISON:
April 3, 2007 two-view chest study

TECHNIQUE:
A PA upright view of the chest was obtained at 1435 hours.

FINDINGS:
The cardiomediastinal silhouette is normal in appearance.

The lungs are symmetrically expanded, and are clear.

Osseous structures are unremarkable. Surgical clips in the right upper abdomen suggest prior cholecystectomy.

IMPRESSION:
Normal study..

** Electronically Signed by M.D. Rand Cuthbertson **
** on 05/09/2012 at 1546 **
Reported and signed by: Rand Cuthbertson, M.D.

PATIENT NAME: PATE, PATRICIA ANN

DATE OF ADMISSION: 05/15/2012

She is a mid-50-year-old black female who, in mid-December, did some heavy lifting, and with that had the onset of back pain and discomfort with associated dysesthesias of the legs. She has been treated with rest, analgesics, anti-inflammatories and 2 epidural steroids and has had some improvement. Continues to be symptomatic. The back pain is better but the dysesthesias are present. They are constant and actually worse when sitting rather than standing or walking. Subsequent workup has revealed stenosis with spondylolisthesis at L4-5 and she is now admitted for lumbar decompression and fusion at L4-5.

PAST MEDICAL HISTORY: A 10-point review of systems is otherwise negative. She has had an hysterectomy in the past.

PHYSICAL EXAMINATION: HEENT: Oropharynx clear.
CHEST: Clear to percussion and auscultation.
HEART: Regular rhythm without murmur.
ABDOMEN: Soft without masses or tenderness.
NEUROLOGICAL: Examination with decreased range of motion of the back in all directions. No motor or sensory deficit is noted.

IMPRESSION: Spondylolisthesis, L4-5.

PLAN: For lumbar fusion, L4-5.

JM/MedQ
DD: 05/10/2012 10:17 AM
DT: 05/10/2012 10:49 AM
Job #: 875376/513359113

DATE SIGNED:_____

TIME SIGNED:_____

PATE, PATRICIA ANN
D249254566
D00039316660

Trident Health System
Summerville, South Carolina

SURGICAL HISTORY AND PHYSICAL

Copy For: Joseph Marzluff, MD

Page 1 of 2

150

JOSEPH MARZLUFF, MD

If H and P completed prior to admission:
I have reviewed the H and P and have examined the patient.
Interval Changes?
( ) No ( ) Yes - document changes on H and P

Physician Signature Date Time

PATE, PATRICIA ANN
D249254566
D00039316660

Copy For: Joseph Marzluff, MD

Trident Health System
Summerville, South Carolina

SURGICAL HISTORY AND PHYSICAL

PATIENT NAME: PATE, PATRICIA ANN

DATE OF SURGERY: 05/15/2012

SURGEON: Joseph Marzluff, MD

ASSISTANT: _____.

PREOPERATIVE DIAGNOSIS: Spondylolisthesis at L4-5

POSTOPERATIVE DIAGNOSIS: Spondylolisthesis at L4-5.

PROCEDURE PERFORMED: Transforaminal interbody fusion L4-5 .

INDICATIONS FOR PROCEDURE: She is a 51-year-old female with spondylolisthesis at L4-5.

FINDINGS: Spondylolisthesis and degenerative disk disease, transforaminal body fusion accomplished using the patient's own bone, expandible PEAK cage, rods and screws, bone morphogenic protein.

DESCRIPTION OF OPERATION: The patient was brought to the operating room and after general endotracheal anesthesia had been obtained the patient was placed in the prone position on the Heffington seat and the back prepped and draped in the usual fashion. A vertical incision was made from two spinous processes above to spinous processes below the above stated level. This was carried down sharply to the lumbodorsal fascia was opened on the side of the fusion. The paraspinous muscles were stripped of the spinous processes, lamina, facets, and transverse processes at the appropriate level. The microscope was brought in the operative field and the remainder of the operation done with the use of the operative microscope. Using a Leksell rongeur the facet was removed to completely posterolaterally decompress the nerve root and visualize the disc space. With minimal retraction on the superior and inferior nerve root, the disc space was sharply entered and discectomy performed with ring Rancy and Scoville curets as well as pituitary forceps. Decortication was accomplished using curettes and a high-speed air drill. The patient's previously taken bone was wrapped in bone matrix protein and packed in the anterior portion of the disc space and appropriate sized bone spacer was also then packed into the disc space. This was done with the disc space distracted and with removal of distraction with excellent fixation of the construct. In posterior aspect, the pedicles were then identified by direct vision and by the standard fashion and a probe was placed within the pedicles and their position verified by x-rays. Appropriate sized screws where then placed without difficulty. The screws were connected to the rod and fixation accomplished. The posterior aspect of the transverse

processes were decorticated and Ollier graft was accomplished using bone matrix protein plus the patient's own bone and this was augmented if necessary with crushed cortical cancellous bone. Hemostasis was obtained with electrocoagulation and the wound closed in the usual fashion with interrupted sutures of #0 Vicryl in the fascia, 2-0 Vicryl in the subcutaneous and subcuticular and staples in the skin. After the wound had been adequately closed, x-ray was used to verify the lateral aspect of the pedicles at L4 and L5 on the right side. Beginning about 2-3 cm lateral to the most lateral edge of the pedicle, a Jamshidi needle was placed under x-ray control to the lateral aspect of the pedicle and its position verified by AP and lateral radiographs. The Jamshidi was then extended into the pedicle and position again verified by AP and lateral radiographs. A K-wire was then placed through the Jamshidi into the vertebral body and the Jamshidi needle was removed. Subsequent progressively enlarged dilators were then used over both K-wire's until a radiolucent dilator of about 1.5 cm was introduced at both levels. The inner dilators were removed. A percutaneous screw was then placed in the standard fashion. The K-wires were removed as well as the needle drivers. The posterior aspect of the screws could easily be visualized and again their position verified radiographically. The pivot actuator was then used to place a rod between the two screws and then caps were placed and the rods tightened down in the standard fashion. The installation hardware was easily removed. X-rays again verified excellent location of the construct at L4-5 on the right side.

JM/MedQ
DD: 05/15/2012 11:05 AM
DT: 05/15/2012 11:46 AM
Job #: 890799/513986229

DATE SIGNED:_____

TIME SIGNED:_____

JOSEPH MARZLUFF, MD

PATE, PATRICIA ANN
D249254566
D00039316660
D.899

Copy For: Joseph Marzluff, MD

Trident Health System
Charleston, South Carolina

OPERATIVE REPORT

PATE, PATERICA
OFFICE NOTES

June 6, 2012: Ms. Pate is two weeks since lumbar fusion. She is doing well.

PHYSICAL EXAMINATION: Wound looks good. Staples were removed.

PLAN: Return in one month. X-rays at that time.

JMM:lsd

154

PATE, PATRICIA
OFFICE NOTES

July 11, 2012: Ms. Pate is six weeks since lumbar fusion. She is doing reasonably well. She is having some degree of back pain and some intermittent numbness in the feet, but certainly nothing spectacular.

PLAN: X-rays today and return in six weeks. Rehab at that time. JMM:lsd

TRIDENT REGIONAL MEDICAL CNTR
9330 MEDICAL PLAZA DRIVE
CHARLESTON, SC 29406

PHONE #: 843-847-4900
FAX #: 843-847-4563

Name: PATE,PATRICIA ANN
Phys: MARZLUFF,JOSEPH

Acct: D00039935056 Loc: D.TOPRAD
Exam Date: 07/11/2012 Status: REG CLI
Radiology No:
Unit No: D249254566

JOSEPH MARZLUFF
9313 MEDICAL PLAZA DR, S-305
CHARLESTON, SC 29406

EXAMS:
003037895 SPINE LUMBAR AP & LAT/SPO

EXAM REASON::
STENOSIS

HISTORY:
Lumbar stenosis postoperative.

Frontal lateral oblique views.

No previous plain films for comparison.

Intact left sided pedicle screws at the L4-L5 level and a spacer in the L4-5 disc space. Slight dextroscoliosis centered the region of L2-3. Lumbar vertebral bodies are normal height. Disc spaces are relatively well maintained including the L4-5 operated level where there is a spacer present. Slight grade 1 spondylolisthesis L4-L5 with elsewhere lumbar alignment is normal.

Impression
1. Slight grade 1 spondylolisthesis L4-5. Intact pedicle screws and a spacer. In good position. Remaining disc spaces well maintained elsewhere alignment is normal.

** Electronically Signed by M.D. Fredrick E. Cosco **
** on 07/11/2012 at 1346 **
Reported and signed by: Fredrick E. Cosco, M.D.

CC: DONALD T HANNA; JOSEPH MARZLUFF

Dictated Date/Time: 07/11/2012 (1346)
Technologist: GALLAGHER,KATHLEEN M
Transcribed Date/Time: 07/11/2012 (1346)
Prepared By: PHY.COSFR
Electronic Signature Date/Time: 07/11/2012 (1346)
Orig Print D/T: S: 07/11/2012 (1351)
BATCH NO: N/A

FROM: Raquel Fowler, LPN
Nurse Case Manager
Phone # 877-709-2667 Ext # 1017
Fax: 877-710-2667
E-mail address; rfowler@compendiumusa.net

CompEndium Services Inc.

We are the medical management company contracted by the State Accident Fund to medically manage the worker's compensation claims.

Urgent Request: Will need specific physical limitations to be addressed by Dr. Marzluff

Date: 08/22/12 **********ATTENTION Anna Fax # 843-553-1008 (PH: 843-553-7615)********

Injured worker : Patricia Pate DOI: 12/14/11 ; 6 SAF Claim # 2011-4217

This is a Worker's Compensation claim and I am the Nurse Case Manager assigned to the above captioned injured worker (IW), whom is currently being treated by you (**status post lumbar fusion, May 2012**).

If Mrs. Pate is NOT able to resume normal activities (FULL DUTY) then please indicate what she is specifically able OR NOT able to do (i.e. heavy lifting, desk etc.), as this would help with determining appropriate safe and suitable limits within the community, at home or at work. Please fill out indicating SPECIFIC physical limitations and then fax response back to Fax # 877-710-2667.

Postures:
- Stand (Hrs. at a time) 1 (2) 3 4 5 6 7 8 9 10
- Sit (Hrs. at a time) 1 (2) 3 4 5 6 7 8 9 10
- Walk (Hrs. at a time) (1) 2 3 4 5 6 7 8 9 10
- Drive (Reg. Vehicle) 1 (2) 3 4 5 6 7 8 9 10

Lift/Carry
- 1-10 lbs. None ___ Occasionally ___ Frequently ✓
- 11-20 lbs None ___ Occasionally ✓ Frequently ___
- 21-30 lbs. None ___ Occasionally ✓ Frequently ___
- 31-40 lbs. None ✓ Occasionally ___ Frequently ___
- 41-50 lbs. None ✓ Occasionally ___ Frequently ___

FAXED 8/22

Bend/Stoop None ___ Occasionally ✓ Frequently ___

Body Movements:

Climb None ___ Occasionally ✓ Frequently ___

Other Limitations: _____

NEXT APPOINTMENT DATE: _____

Physician Signature 8/22/12 **Date**

Thank you for your prompt attention to this matter. *CC: Employer: College of Charleston & Claims Adjuster at SAF*

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PATE, PATERICA
OFFICE NOTES

August 22, 2012: Paterica Pate returns. She continues to get progressively better at three months post-op.

PLAN: We will refer her to rehab. She will return to see me in one month for a final visit. I have told her that she can return to work any time she wants to, but she needs to be very careful. She will have a discussion with her employer about returning to work at limited duty status.

JMM:lsd

158

JOSEPH M. MARZLUFF, M.D.
MIKE O. TYLER, JR., M.D.
JASON M. HIGHSMITH, M.D.
DR. SABINO D'AGOSTINO
9313 MEDICAL PLAZA DR, SUITE 305
N. CHARLESTON, SC 29406
843-553-7615/(fax)843-553-1008

NAME: Patricia Pate DATE: 8-30-12

This patient was at the doctor's office on the date above.

✓ He/She may return to work/school: on Aug 31, 12
____ without restriction—using good judgement with the use of his/her back.
✓ light duty with no excessive bending, no lifting more than 30 pounds.

____ He/She may not return to work/school:
____ until his/her medical tests are completed.
____ until his/her physical therapy is completed.
____ until he/she has had ____ days of bed rest at home.
____ until his/her next appointment ____

_____ M.D.

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PATE, PATRICIA
OFFICE NOTES

September 19, 2012: Patricia Pate comes in for routine follow-up. She is now four months since lumbar fusion. She is doing reasonably well. She is continuing in physical therapy with strengthening. She is continuing home exercises. She has returned to work on a limited duty bases and seems to be tolerating that well. From my standpoint, she has reached maximum medical improvement. I would rate her as impaired by 40% of the spine for status post lumbar fusion and restriction of the back in all directions, as well as some chronic pain requiring limitation of activities and oral pain medications.

PLAN: Return as needed.

JMM:lsd

(160)

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: Patricia Pate
Physician's Name: Joseph M. Marziuff, MD
Practice/Clinic:
Preparer's Name:
Phone:

Employer's Name: College of Charleston
Insurance Carrier: State Accident Fund
SCWCC File No: 1121370

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: 12/14/2011

Date of first office visit: 2/15/2012 Date of last visit: 09/19/2012

Diagnosis or nature of injury or illness: Lumbar Fusion

Body part(s) injured: Back Body part(s) affected: Spine

Date of **Maximum Medical Improvement:** 9/19/0212

Based on the **AMA Guidelines**, the claimant has sustained a 40 **% medical impairment** to Spine injured body part(s) and a 36 **% medical impairment** to whole person other affected body part(s).

☐ The claimant is **able to return to work** without restriction.

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

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

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

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

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

Treating Physician

Date 11/7/12

/07

14B **Physician's Statement**

(161)

CHARLESTON PSYCHOLOGICAL ASSOCIATES, P.A.
WILLIAM G. KEE, PH.D.
LICENSED CLINICAL PSYCHOLOGIST
1341 Old Georgetown Road, Suite B Mount Pleasant, S.C. 29464
Post Office Box 21809 Charleston, S.C. 29413-1809

Initial Psychological Evaluation
Patricia Pate
September 22, 2014
12:30 – 02:15
Chart review: 08:00 - 09:00

Patricia Pate, a [redacted]e, was referred for evaluation by Dr. Nolan. Ms. Pate was interviewed and her history was reviewed. Ms. Pate completed the Beck Depression Inventory II, the Beck Anxiety Inventory, and the Pain Disability Questionnaire.

MEDICAL HISTORY: Ms. Pate presents with constant left-sided low back pain, left hip and leg pain following an on the job injury in December 2011. She reports she was helping to lift a heavy box and had the onset of pain. She reports initially seeing her family physician Dr. Hanna, who gave her muscle relaxants and put her on bed rest. She reports then seeing Dr. Marzluff for two epidural injections. In May 2012, Dr. Marzluff completed a lumbar fusion with implantation of cage, rods and screws. Ms. Pate reports it took her awhile to recover from this surgery and she was in physical therapy in August and September 2012. She reports there was pressure from her job and she was released back to work with restrictions. She reports continuing to work. She reports there has been conflict at work when she tries to stay within her restrictions with her supervisor. Dr. Marzluff notes indicate one incident of bowel incontinence in January 2013. Her Work Comp denied an MRI. In February 2013, the MRI was completed. She reports starting to see Dr. Nolan for pain management in August 2013. She was treated with medications and lumbar facet injections and SI joint injections. She reports the injections had been helpful for pain. She reports having back brace and having trouble getting this approved, also because she gained 35 pounds since her injury. She reports brief trial with the TENS unit, which was helpful, but Workmen's Compensation refused to pay for the TENS unit. Physical therapy has been ordered by Dr. Nolan, but has not been approved by Workmen's Compensation.

Ms. Pate denies any problems with back, hip, or leg pain prior to injury in December 2011.

At the time of the evaluation, Ms. Pate reports taking oxycodone 5 mg six a day, OxyContin 10 mg, Paxil 20 mg, Ambien 12.5 mg, L-methylfolate, vitamins, atorvastatin, quinine, omeprazole, Claritin, and Xarelto 20 mg. She reports taking her husband's Some for a few days when she ran out. Otherwise she denies illegal use of prescription medication. An FCE was completed at Select PT in March 2014. Dr. Nolan recommended that she be evaluated by Dr. Hanna for problems with blood flow and breathing in Septmeber. Ms. Pate saw Dr. Hanna on September 16th for an ultrasound of her veins. Chest x-rays and CT scan indicated some blood clots in her lung and she was hospitalized for three days. Since that time, she has been on Xarelto. She reports in December 2013, being seen by Dr. Morgan Stuart who said she was not a surgical candidate.

(162)

Ms. Pate reports other medical history of cholecystectomy, hysterectomy, allergies, GERD, high-cholesterol and 35-pound weight gain since the injury. She denies previous history of Workmen's Compensation or disability. She reports having bruxism and wearing a nightguard for the past five years. She reports formerly smoking cigarettes, but stopping in 2003. She reports having one alcoholic beverage a month. She denies lifetime history of problems with alcohol. She reports trying marijuana and speed when she was in high school, but denies other use of illegal substances. She currently does not exercise, but has tried exercising at home of walking, exercising in a pool and on stationary bike.

CURRENT ACTIVITIES AND PAIN LEVEL: At the time of the evaluation, Ms. Pate reports her pain to be 45 on a 100-point scale varying between 21 and 73 the preceding week. Ms. Pate reports being able to comfortably walk for 10 minutes, stand for 5 minutes and sit for 10 minutes. She was noted to get up after 30 minutes in the interview and then paced around the office. Sitting, she was noted to shift frequently in her chair. She reports going to bed between 10:00 and 11:00 clock at night, going to sleep at 11:30 with medications. She reports waking up two to three times at night in pain and sometimes worrying about her job and her ability to continue working. She reports getting up at 06:00 in the morning. She reports since her hospitalization, she has been put off work. She reports spending time at home doing some brief light household chores. She reports her husband had to takeover the housework and yard work. She reports going out to doctor's appointments, visit her parents and drive short distances. She reports prior to her hospitalization, she was continuing to work full time 08:30 to 05:00, five days a week at the Copy Center at the College of Charleston. She reports ongoing conflicts with her supervisor when she tried to stay within her work limitations of only standing for one hour at one time and only lifting 15 pounds.

SOCIAL/PSYCHIATRIC HISTORY: Ms. Pate reports growing up in Summerville, South Carolina with her parents and three siblings. She reports that her childhood was happy and denies incidents of physical or sexual abuse. She reports completing high school. She reports working at Copy Center at College of Charleston for three years prior to injury. She returned to work on light duty for a period of time, but is currently out of work. She has hired an attorney Max Sparwasser to represent her concerning her Workmen's Compensation claim. She reports prior to working at the College of Charleston, she worked at the print shop at the Citadel for 10 years. She reports that when she was hired at the College of Charleston she was clear with her employer that she was not trained in computers, but has learnt about this on the job. She reports there has been conflict that her supervisor has pushed her to do new jobs on the computer, for which she has had no training.

Ms. Pate reports having problems with anxiety and going to sleep because of worrying about work. She reports that in 2010, Dr. Hanna started her on Ambien. She reports following the accident, Dr. Hanna started her on Paxil as well as continuing the Ambien and changing from 10 mg to 12.5 mg. Ms. Pate reports seeing a counselor at College of Charleston for one month after the injury. She has currently been seeing a counselor at the college once or twice a month, Denise Mitchell for over a year. She reports finding this helpful in coping with her job situation and her pain. Ms. Pate does not have any children of her own. She reports being married once to her present husband Donald since 1987. She reports raising his two sons by previous marriage.

MENTAL STATUS: Ms. Pate denied delusions or hallucinations. She is oriented in all three spheres. She reports recent problems with memory and concentration secondary to pain, medications and sleep disturbance. She reports having a depressed mood on a daily basis. She was noted during the interview, to try to smile, but she had depressed affect. She was noted to avoid eye contact and look out the window when she started to cry about problems at work, her pain, and her fears and concerns about her ability to continue working. She reports feelings of hopelessness and helplessness. She reports crying spells a number of times a week. She denies suicidal ideation. She reports daily anxiety concerning her future, her pain, and her ability to work. She reports problems with anhedonia, social withdrawal, and changes in appetite. She is noted to sigh frequently. She denies problems with irritability. She reports reduction in libido, but continued sexual relations on a regular basis. She denies symptoms of panic attacks, phobia, mania or posttraumatic stress disorder.

TEST RESULTS: The Beck Depression Inventory II indicates a self-report depression score in the severe range. Such people report problems with hopelessness, sense of failure at work, anhedonia, difficulty with decision making, and low energy. They report problems with sleep disturbance, changes in appetite, problems with concentration, fatigue, and changes in libido. The Beck Anxiety Inventory indicates a self-report anxiety score in the severe range. Such people report difficulties relaxing, fears of negative events occurring, nervousness, fears of losing control, and numerous signs of autonomic nervous system arousal. The Pain Disability Questionnaire indicates a functional component score of 63 and a psychosocial component score of 43, yielding a full-scale score of 106. This places Ms. Pate in the severe range of disability secondary to her pain. Ms. Pate reports the pain interferes in her ability to work outside the home, has affected her income, affects basic movements such as walking, bending, lifting, traveling, sitting and standing. She reports pain causes her to be reliant on doctors and pain medications. She reports the pain interferes in recreational and social activities and affects her mood.

SUMMARY: Results of testing and interview indicate Ms. Pate to report a problem with persistent low back pain, left hip and leg pain. She also has problems with moderate to severe depression and anxiety. She could benefit from eight sessions of individual psychotherapy to work on cognitive and behavioral techniques for management of depression, anxiety, stress, and pain. She could benefit from training with progressive muscle relaxation, guided imagery, and self-hypnosis. She could benefit from training with correct body mechanics and posture and sleep hygiene. She may benefit from a trial of sedating antidepressant at night to help improve her sleep pattern and mood. She should continue with her regular sessions with Denise Mitchell. She may benefit from referral to stretching, strengthening and aerobic exercise program such as aqua therapy.

DIAGNOSES:

296.22	Major depressive disorder, single episode, moderate.
300.02	Generalized anxiety disorder.
316.00	Psychological factors affecting medical condition, moderate.

William Given Kee, Ph.D.
Licensed Clinical Psychologist.

WGK/SB

165

JEAN R. HUTCHINSON, M.ED., CRC, CVE
Vocational Consultant

715 N. Godfrey Park Place
Charleston, S.C. 29407

(843)766-1418
Fax(843)763-0501

EMPLOYABILITY EVALUATION

PERSONAL DATA:

Name: Patricia Ann Pate
Date of Birth: [redacted]
Marital Status: Married
Height: 5'6"
Weight: 180 pounds
Date of Injury: December 14, 2011
Date of Interview: June 26, 2015
Date of Report: June 27, 2015

EDUCATIONAL BACKGROUND:

Ms. Pate stated that she left school after the eleventh grade and later obtained her high school diploma. She stated that she has no computer skills other than emailing. Ms. Pate did not serve in the military. She has a driver's license, but noted increase pain when riding or driving longer distances.

WORK HISTORY:

Ms. Pate reported the following work experience: She first worked as a fast food worker and as a production worker at a factory for three years. Ms. Pate then worked for a construction company as a receptionist for five years. She next worked as a production worker for a printing company for ten years and as a production worker at the Citadel printing shop for ten years until it closed. Ms. Pate last worked for the College of Charleston in the copy center as a production worker and had worked in this capacity for approximately seven years when she was injured.

DESCRIPTION OF ACCIDENT/INJURY/CONDITION:

Ms. Pate was injured on December 14, 2011, while employed as a production worker in a college copy center. She stated that as she attempted to lift a large, heavy box, she felt immediate and significant pain in her lower back. Ms. Pate sought medical attention and has since undergone physical therapy, lumbar epidural steroid injections, bilateral lumbar paravertebral trigger point injections, lumbar facet injections, caudal epidural steroid injections, lumbar transforaminal steroid injections, bilateral sacro-iliac joint injections, transforaminal interbody fusion at L4-5 on May 15, 2012, use of a TENS unit and use of medications. Additionally, she noted that she developed bilateral blood clots in her lungs with shortness-of-breath and was hospitalized for several days in September, 2014, and is now taking blood thinner medication. Ms. Pate has diagnoses by x-ray (July 11, 2012) of slight grade 1 spondylolisthesis at L4-5; by MRI (January 25, 2012) of mild disc bulge and facet hypertrophy, mild exit narrowing, and left extraforaminal annual enhancement at L2-3, mild disc bulge converts to shallow protrusion left intraforaminally, facet hypertrophy with small right effusion, mild exit narrowing with slight deflection L3s, mild right recess narrowing, and left extraforaminal marginal annular enhancement at L3-4, shallow concentric disc osteophyte complex has superimposed shallow protrusion left intra to extraforaminally with associated annular tear, moderate facet hypertrophy, ligamentum flavum thickening, mild bilateral exit narrowing with deflection and flattening bilateral L4s, moderate central narrowing, mild recess crowding transiting L5s, left extraforaminal marginal annular enhancement associated with the annular tear, right extraforaminal annular enhancement extends right anterolaterally, mild enhancement of ligamentum flavum at this level, and mild perifacet enhancement at L4-5, and mild disc bulge converts to shallow disc osteophyte complex biforaminally to extraforaminally, facet hypertrophy, and mild exit narrowing with crowding and mild deflection exiting L5s more prominent on the left at L5-S1; SI joint pain, lumbar facet arthropathy, lumbar disc displacement, post-laminectomy syndrome, myofascial pain, muscle spasms, depression, somatic symptom disorder with predominant pain, and chronic pain. She has additional diagnoses of diabetes and high cholesterol.

At the present time, Ms. Pate states that she continues to have pain in the left side of her lower back that she described as "aching, burning, and stabbing"; in her left buttocks that she described as "stabbing"; in both thighs that she described as "aching with numbness"; and in her left foot that she described as "aching". She noted that her pain is constant though varying in intensity and any minimal increase in activity will cause an increase in pain. For limited

and temporary relief of pain, Ms. Pate stated that she uses a TENS unit, lies down, takes pain medications that make her sleepy, and significantly curtails her level of activity.

With regard to functional activities, Ms. Pate reported the following: She estimated that she can now walk for ten to twenty minutes slowly and with increasing pain. Ms. Pate stated that she now cannot run, jump, negotiate rough or uneven terrain, always maintain balance, climb stairs without pain, climb a ladder, stand for more than ten minutes, stoop on other than an occasional basis, bend from the waist, sit for other than short periods of time, or lift/carry more than eight to ten pounds.

With regard to activities of daily living, Ms. Pate stated that she now performs some light household chores by working a little at a time and by taking numerous breaks. She indicated difficulty sleeping despite her medications in that she cannot find a comfortable position, her pain often awakens her, and she "tosses and turns", resulting in fatigue and irritability. Ms. Pate reported that she remains independent in self care tasks, but requires more time to perform them and has difficulty bending down to put on her socks and shoes. She stated that she cannot perform yardwork and home maintenance tasks and can no longer enjoy her former hobbies of yardwork and working out at a gym.

DESCRIPTION OF USUAL OCCUPATIONS:

Most recently and for approximately seven years, Ms. Pate worked as a production worker in a college copy center. In this work, she made copies of documents for professors and students, collated copies, and supplied paper to copy machines. The Dictionary of Occupational Titles published by the United States Department of Labor defines this job as:

PHOTOCOPYING MACHINE OPERATOR (207.685-014)
"Tends duplicating machine to reproduce handwritten or typewritten matter: Places original copy on glass plate of machine. Places blank paper on loading tray. Sets control switch for number of copies. Presses button to start machine which transfers image of original copy onto blank paper by photographic and static electricity process. May clean and repair machine. May receive payment for duplicate copies. Important variables may be indicated by trade name of machine tended."

Other significant work experience for Ms. Pate has been as a production worker in a college

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printing shop. The Dictionary of Occupational Titles published by the United States Department of Labor defines this job as:

PHOTOCOPYING MACHINE OPERATOR (207.685-014)
See above definition.

COLLATOR OPERATOR (208.685-010)
"Tends machine that assembles pages of printed material in numerical sequence: Adjusts control that regulates stroke of paper pusher, according to size of paper. Places pages to be assembled in holding trays. Starts machine. Removes assembled pages from machine."

FOLDING MACHINE OPERATOR (208.685-014)
"Tends machine that folds advertising literature, forms, letters, and other paper sheets: Turns indicator knobs to adjust folding rulers, side guides, and stops, according to specified size and number of folds. Starts machine and feeds paper sheets between folding rollers. Removes folded sheets. May place folded sheets into envelopes preparatory to mailing."

Ms. Pate's past work experience is consistent with these definitions.

EVALUATION SUMMARY:

In determining employability, it is necessary to consider many factors. These factors include age, educational background, past work experience and transferable skills, and physical limitations and pain.

Ms. Pate is fifty-four years of age. Her age may affect her ability to adjust to a significant number of jobs in the national economy.

Ms. Pate has a high school diploma. Education at this level refers to abilities in reasoning, arithmetic, and language skills appropriate for semi-skilled to skilled work. She indicated that she has no computer skills, other than emailing.

Relevant past work experience for Ms. Pate has been as a production worker in a college copy center and in a printing shop. The Dictionary of Occupational Titles published by the United

States Department of Labor further defines these jobs as light, unskilled work. Light work requires standing and/or walking for at least six hours of an eight-hour day, sitting at least six hours of an eight-hour day, using hands or feet for pushing and pulling arm and leg controls, lifting of up to twenty pounds, and frequent lifting/carrying of up to ten pounds. Unskilled work is work which needs little or no judgement in the performance of simple duties that can be learned on the job in a short period of time.

Transferability of skills applies to work skills which a person has demonstrated in vocationally relevant past jobs that can be used to meet the requirements of other jobs. Transferability of skills is most probable and meaningful among jobs requiring similar skills, when similar tools and machine are utilized, and when similar processes and services are involved. As Ms. Pate has only performed unskilled work and as no acquired work skills can be attributed to unskilled work, she has no transferable skills.

Ms. Pate has significant physical limitations. On a "Work Restrictions" form dated June 19, 2015, Dr. J. Edward Nolan, her treating physician, indicates that she may return to work with restrictions to include no lifting greater than ten pounds, no bending, squatting, or crawling, no pushing/pulling heavy objects, and work for four hours, four days per week.

In an Independent Psychiatric Evaluation dated January 12, 2015, Dr. Dyana Lowndes-Rosen indicates that Ms. Pate is a victim fo chronic pain syndrome due to lumbar post-laminectomy syndrome and is maintained by her personal physician on an anti-depressant drug. Dr. Lowndes-Rosen is of the opinion that real physical pain is Ms. Pate's primary complaint and she is faced with chronic pain syndrome and is a pain management patient.

In considering these aforementioned factors, approaching advanced age, high school level of education, past work experience as a production worker in a college copy center and production worker in a college printing shop, lack of transferable skills, and significant physical limitations and ongoing pain of more than three years' duration, I am of the opinion that Ms. Pate is unable to perform the required job tasks of her former work as a production worker in a college copy center and is unable to return to any past employment. I am of the opinion that Ms. Pate is not able to engage in an eight-hour workday in a substantial number of jobs and cannot perform work tasks on a sustained basis. Her impairments and lack of transferable skills prevent her from making an adjustment to any work that exists in significant numbers in the national economy. It is therefore concluded that Ms. Pate is and

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remains unemployable. She is unable to compete on the open job market and is unable to perform substantial gainful work activity.

The conclusions rendered in this report are the opinions of this evaluator. This evaluation has been conducted on the basis of an in-depth interview with the client, a review of medical records and other case file information, and a vocational evaluation, with the assumption that the client's representations and the records are true and accurate. If more information becomes available at a later date, an addendum report or reconsideration may be forthcoming. Such additional information may or may not change the opinions rendered in this report. Further, the opinions rendered in this report are based upon a reasonable degree of vocational probability.

Jean R. Hutchinson
(Electronically signed)

Jean R. Hutchinson, M.Ed.
Certified Rehabilitation Counselor
Certified in Vocational Evaluation
June 27, 2015

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COLLEGE of CHARLESTON

OFFICE OF
HUMAN RESOURCES

MEMORANDUM

DATE: February 2, 2015

TO: Patricia Pate

FROM: Tammy L. McFadden, Benefits Counselor

SUBJECT: Extended Disability Leave Request

Mrs. Pate, your request for extended disability leave for 180 days has been approved with an effective date of January 29, 2015. The expiration of this request is July 28, 2015. If you return back to work prior to your expiration date, please inform me. In addition, you will need to provide a fitness of duty certification from your physician when you do return back to work to your supervisor and Human Resources. If you should have any questions or concerns, please feel free to contact me at (843) 953-5988 or via email at mcfaddentl@cofc.edu. Thank you.

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COLLEGE of CHARLESTON

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Human Relations and Minority Affairs

TO: Patty Pate, Assistant Manager, Copy Center

FROM: Kimberly Gertner, Director, Office of Human Relations and Minority Affairs

DATE: January 28, 2014

RE: Response to Request for Accommodation

CC: Cheryl Connor, Director, Copy Center

This correspondence is to notify you of the College of Charleston's response to your request for accommodation. As you may recall, on January 27, 2015, you provided your supervisor, Cheryl Connor, with a Work Restrictions document from your healthcare provider, J. Edward Nolan. The Work Restrictions document, provides, in pertinent part, that you are only able to work four (4) hours per day for four (4) days per week and that the restrictions apply until April 21, 2015.

Based upon the information you and your healthcare provider have submitted, and based upon information provided by your supervisor, the College of Charleston is unable to approve this request for accommodation.

While the Copy Center was able to temporarily permit you to work a reduced schedule during a time that is a slower period for the Center as students and faculty were not on campus, the Center is unable to continue this allowance. Your position as the Assistant Manager of the Copy Center plays an essential role in the successful operation of the Copy Center. As you are aware, this is a full-time position that is responsible for planning, coordinating and performing administrative activities related to the Center's successful operation. Not having someone to fill this role, full-time, detrimentally impacts the Copy Center's ability to effectively serve its clients and conduct business. For instance, the Copy Center is less able to provide responsive customer service, projects may be deferred, increased burden on management staff to readjust work flow or readjust priorities, increased overtime and overall decreased morale in the Center. Unfortunately, we are unable to grant your accommodation because it would be an undue hardship for the Copy Center.

While the College has looked into whether there are any other positions for which you are qualified, and that could accommodate your request, unfortunately, there are no available positions at this time. Please contact Tammy McFadden, Benefits Counselor, in the Office of Human Resources to explore whether there may be leave options available to you. If you have any questions, or need further assistance from the Office of Human Relations and Minority Affairs, please do not hesitate to contact us.

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South Carolina Workers' Compensation Commission
1333 Marion Street, Suite 500
P.O. Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5739

PRE-HEARING BRIEF
WCC FILE NO: 1121370

Patricia Pate	College of Charleston
Claimant's Name	Employer's Name
t	66 George Street
Address	Address
	Charleston, SC 29424
City State Zip	City State Zip
(843) 509-6704	State Accident Fund
Home Phone Work Phone	Carrier

Kirsten L. Barr — Preparer's Name
(843) 881-4228 — Phone #

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: $368.70 2. AWW: $553.02 Date of Injury: December 14, 2011

3. Type of injury and body part(s):

The Claimant chose to assist a recycling associate with lifting a box and claims to have experienced low back pain. She was subsequently diagnosed with degenerative changes in her lumbar spine (stenosis and spondylosis).

4. Facts in controversy:

The Claimant was treated for degenerative changes in her lumbar spine and was released at maximum medical improvement by Dr. Marzluff on September 12, 2012, at which time she returned to her regular, full time job as Assistant Manager of the copy center at the College of Charleston. The Claimant continued working in the position and earning her regular wages for over two years.

In September 2014, the Claimant was hospitalized for multiple pulmonary emboli, unrelated to her employment. As a result of the multiple pulmonary emboli and anticoagulant therapy, Dr. Nolan placed work restrictions on the Claimant, stating "[s]he has received benefit from injection therapy and with treatment she continued to perform her job duties;" however, "[i]n light of [her anticoagulant therapy] and our inability to resume injection therapy until her pulmonary embolisms are resolved, I recommend that she be placed out of work." (APA p.

257). Dr. Nolan also stated "[d]ue to her inability to receive needed injection therapy ...due to pulmonary embolisms we recommended she be placed out of work." (APA p. 70). The Claimant is currently out of work as a result of the complications of her personal health problems.

The Defendants contend that the Claimant's multiple pulmonary emboli in September 2014 constitute subsequent intervening injuries. Despite her back problem, the Claimant would be working her regular full time job, earning her regular wages but for the fact that she is currently undergoing anticoagulant therapy unrelated to her employment. Therefore, if the Claimant has any loss of wage-earning capacity, the proximate cause is her multiple pulmonary emboli and resulting treatment, which is not the responsibility of the College of Charleston or the State Accident Fund.

The Claimant also seeks benefits for depression. The record reveals that the Claimant's depression is related to her long-term irritable bowel syndrome and chronic diarrhea; her brother's battle with pancreatic cancer; and her own near fatal pulmonary emboli in September 2014. Regardless, the record contains no expert medical evidence stated to a reasonable degree of medical certainty that the Claimant requires treatment for depression to lessen the period of alleged disability.

5. Legal issues involved:

The Defendants seek to terminate temporary total disability pursuant to S.C. Code Ann. § 42-9-260 on the basis that the Claimant was released by the treating physician and returned to work in a full time position as assistant manager of the copy center for over two years. The Claimant is currently out of work due to a non-work-related problem (multiple pulmonary emboli).

The Defendants contend that the Claimant is not entitled to any benefits under S.C. Code Ann. §§ 42-9-10, 42-9-20, 42-9-30(21), or 42-15-60 pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007). The Claimant was working in her regular, full time position as assistant manager of the College copy center for over two years and; therefore her back injury was not disabling as a matter of law. Instead, the proximate cause of her disability is the multiple pulmonary emboli she suffered in September 2014, which

aggravated her pre-existing back condition according the Claimant's own treating physician. The Claimant's current subjective complaints are not relevant to the Claimant's causally-related loss of use of the back because of the subsequent intervening injury (pulmonary emboli) has resulted in increased pain and restrictions, as well as a change in recommended medical treatment.

The Claimant is not entitled to any medical benefits for depression as a matter of law pursuant to S.C. Code Ann. § 42-15-60 because the Claimant's depression is not causally-related to the December 14, 2011 accident and because there is no expert medical evidence stated to a reasonable degree of medical certainty that the Claimant requires treatment for depression to lessen her period of disability.

6. Unusual aspects:

None known or anticipated.

7. Witnesses (designate if expert*):

Julie Trexler, Cheryl Connor, Denny Mitchell, Edward Pope, Amy Orr and/or other representative of the College of Charleston

8. Exhibits:

See attached Notice of Submissions; Claimant's personnel file; Claimant's medical records; Claimant's discovery deposition; surveillance of the Claimant's activities

9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance)

See attached Notice of Submissions

10. Name, address, and specialty, if any, of the treating physician:

Dr. Joseph Nolan, Trident Pain Center

11. Impairment rating(s); body part(s); physician and date of opinion:

23% lumbar spine per Dr. Nolan on March 10, 2014

12. I am amending my Form 50/51 in the following manner: N/A

☒ **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: Max C. Sparwasser, Esq P.O. Box 2307, Mt. Pleasant, SC 29465 on the 2nd day of July 2015 by ☒ first class postage ☐ certified mail ☐ personal service.

Signature: Kristen L. Barr

Email: kbarr@trask-howell.com

Date of hearing: July 14, 2015 @ 1:00 p.m.

Time needed for hearing: One hour

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.

Carolina Family Medicine
100 Spring Hall Drive
Goose Creek, SC 29445
(843) 572-8201 – Phone
(843) 797-8491 – Fax

Donald T. Hanna, M.D.
Carey McNamara, PA-C
Denise Hosenfeld, FNP-C
Tara J. Hughes, PA-C

NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

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CHIEF COMPLAINT:
cpe

HISTORY OF PRESENT ILLNESS:
On 01/24/2011, Patricia Pate, le presented with:

-- stomach problems , which began years ago. Severity - improving. Aggravating Factors - eating and relieved by prilosec 40, probiotics otc. An associated sign and symptom is overall stable - no current symptoms (feels good). The patient denies the following: vomiting, fever, diarrhea, abdominal pain and constipation. There is parents with stomach problems (dad w/ blockage), mom w/ diverticulitis (bowel also removed) and brother w/ pancreatic cancer at 40. The patient has had Cholecystectomy and partial hysterectomy. had colonoscopy already and Was normal.

-- weight gain, which began months ago. It is relieved by nothing. Associated signs and symptoms are increased appetite (eating a lot more) and fatigue. used to work-out daily but not now.

-- here for cpe. Severity - stable. It is relieved by nothing. The patient has had partial hysterectomy.

-- back pain to the right lower back, which resulted lifting at work which began 4-5 days ago. Severity - uncontrolled. Timing - worse in morning. Aggravating factors: certain mvts. Relieving factors: none. isn't supposed to take nsaids b/c of stomach and has history of ulcer. typically sleeps on side - pain wakes her up at times.

-- asthma and allergies, which began years ago. Severity was described as was bad during pollen, now stable. It is aggravated by smoking and pollen and relieved by claritin d 24hr. Associated signs and symptoms are allergies and was with a cold but she is improving. The patient denies the following: stuffy nose and sinus pain. never tried asmanex and not needing advair. quit smoking 01 07, was smoking 1 2 ppd. no need for albuterol inhaler.

MEDICATIONS HISTORY:
Current Medications:
1. Omeprazole 40 mg, 1 PO QD
2. Carafate 1 g/10 mL, 2 tsp po qac and qhs
3. Loratadine 10 mg, 1 PO QD
4. Calcium 600 mg, 1 PO BID
5. Claritin-d 24 Hour 10 Mg-240 Mg, 1 PO QD

ALLERGIES: Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - none. Accidents - none. Operations: cholecystectomy-laparoscopic 1990 and hysterectomy - partial 2000. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - Cancer-Pancreatic. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4

cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none
SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS: B/P - 110/74, Sitting, Left arm, large cuff;

Pulse - 72, Respiration - 18, Temperature - 97

Weight: 178.00 lbs.

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort

CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - soft
GENITALIA - deferred
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - Normal affect
BREAST - Symmetric, no dimpling, retractions or discharge. No masses. No axillary or supraclavicular lymphadenopathy.

DIAGNOSTIC TEST RESULTS:

Urinalysis: small Leukocyte Esterase positive

ASSESSMENT:

1. Weight gain - New
2. Physical Exam - New
3. Allergic Rhinitis - Stable
4. Heartburn - Stable
5. Abdominal pain unspec - Improving

PLAN:
1. Weight gain - *TSH, Serum
2. Physical Exam - **VENIPUNCURE
3. Physical Exam - *Comprehensive Metabolic Panel (CMP)
4. Physical Exam - *CBC with Differential
5. Physical Exam - NMR LipoProfile
6. Physical Exam - *Urine Dip Stick

DIAGNOSTIC TESTS:
1. **VENIPUNCURE, V70.0

2. *Comprehensive Metabolic Panel (CMP), V70.0
3. *CBC with Differential, V70.0
4. NMR LipoProfile, V70.0
5. *Urine Dip Stick, V70.0
6. *TSH, Serum, 783.1

Special notes: pt to call if symptoms worsen or do not improve

DRUG RX:
1. Claritin-d 24 Hour 10 Mg-240 Mg, 1 PO QD
2. Flector Patch 1.3 %, apply patch to back bid
3. Flexeril 5 mg, 1 PO QHS

The following drugs were stopped:
1. Carafate 1 g/10 mL, No Longer Needed

Entered by: Carey McNamara, P.A.

~

Electronically signed by CAREY MCNAMARA, PA-C 1/24/2011 9:19:37

Carolina Family Medicine
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Goose Creek, SC 29445
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Donald T. Hanna, M.D.
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Denise Hosenfeld, FNP-C
Tara J. Hughes, PA-C

NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
left ankle sprain

HISTORY OF PRESENT ILLNESS:
On 04/14/2011, Patricia Pate, a e presented with:

-- left ankle pain to the left ankle, which resulted WALKING OFF ELEVATOR and which occurred on 04/08/2011 which began 6 days ago. Severity - no better/worse. Timing - constant. Aggravating factors: certain mvts. Relieving factors: none. was x-rayed at nason,s and told no fx.

MEDICATIONS HISTORY:
Current Medications:
1. Omeprazole 40 mg, 1 PO QD
2. Claritin-d 24 Hour 10 Mg-240 Mg, 1 PO QD
3. Flector Patch 1.3 %, apply patch to back bid
4. Flexeril 5 mg, 1 PO QHS
5. Calcium 600 mg, 1 PO BID
6. Lortab 7.5/500 500 mg-7.5 mg, 1 PO q6h prn pain

ALLERGIES: Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - none. Accidents - none. Operations: cholecystectomy-laparoscopic 1990 and hysterectomy - partial 2000. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - Cancer-Pancreatic. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

REVIEW OF SYSTEMS:
SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - See HPI
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS: B/P - 124/88, Sitting, Left arm, large cuff;

Pulse - 80, Respiration - 16, Temperature - 98.6

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
MUSCULOSKELETAL - tender left ankle and foot with marked ecchymoses and swelling
ABDOMEN - soft
GENITALIA - deferred
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - Normal affect
BREAST - Symmetric, no dimpling, retractions or discharge. No masses. No axillary or supraclavicular lymphadenopathy.

ASSESSMENT:

1. Pain In Joint Involving Shoulder Region - New
2. Pain In Joint Involving Ankle And Foot - New

PLAN:
1. Pain In Joint Involving Ankle And Foot - Ice pack
2. Pain In Joint Involving Ankle And Foot - X-Ray Left Ankle 3V
3. Pain In Joint Involving Ankle And Foot - X-Ray Left Foot

DIAGNOSTIC TESTS:
1. X-Ray Left Ankle 3V, 719.47
2. X-Ray Left Foot, 719.47

DRUG RX:
1. Anaprox-DS sodium 550 mg, 1 PO BID with food
2. Percocet 5/325 325 mg-5 mg, 1-2 po q 4-6 hrs prn pain

Entered by: DONALD T. HANNA, MD

Electronically signed by DONALD T. HANNA, MD 4/14/2011 16:41:58

Carolina Family Medicine
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Denise Hosenfeld, FNP-C NPI: 1861753204
Tara J. Hughes, PA-C NPI: 1255367322

F 51

CHIEF COMPLAINT:
recheck

HISTORY OF PRESENT ILLNESS:
On 04/27/2011, Patricia Pate, a e presented with:

-- left ankle pain to the left ankle, which resulted WALKING OFF ELEVATOR and which occurred on 04/08/2011 which began 19 days ago. Severity - no better/worse. Timing - constant. Aggravating factors: certain mvts. Relieving factors: none. negative x-rays x2.

MEDICATIONS HISTORY:
Current Medications:
1. Anaprox-DS sodium 550 mg, 1 PO BID with food
2. Omeprazole 40 mg, 1 PO QD
3. Percocet 5/325 325 Mg-5 Mg, 1-2 po q 4-6 hrs prn pain
4. Claritin-d 24 Hour 10 Mg-240 Mg, 1 PO QD
5. Flector Patch 1.3 %, apply patch to back bid
6. Flexeril 5 mg, 1 PO QHS
7. Calcium 600 mg, 1 PO BID
8. Lortab 7.5/500 500 mg-7.5 mg, 1 PO q6h prn pain

ALLERGIES: Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - none. Accidents - none. Operations: cholecystectomy-laparoscopic 1990 and hysterectomy - partial 2000. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - Cancer-Pancreatic. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

REVIEW OF SYSTEMS:
SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - See HPI
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS: B/P - 128/80, Sitting, Left arm, large cuff;

Pulse - 76, Respiration - 16, Temperature - 98.5

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
MUSCULOSKELETAL - tender left ankle and foot with marked ecchymoses and swelling
ABDOMEN - soft
GENITALIA - deferred
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - Normal affect

ASSESSMENT:

1. Pain In Joint Involving Ankle And Foot - Unchanged
2. Pain In Joint Involving Shoulder Region - Improving

PLAN:
1. Pain In Joint Involving Ankle And Foot - MRI W/CONTRAST left ankle and foot
2. Pain In Joint Involving Ankle And Foot - Return visit in 12 days

FOLLOWUP: Return visit in 12 days

Entered by: DONALD T. HANNA, MD

Electronically signed by DONALD T. HANNA, MD 4/27/2011 10:8:35

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Carey McNamara, PA-C NPI: 1689639672
Denise Hosenfeld, FNP-C NPI: 1861753204
Tara J. Hughes, PA-C NPI: 1255367322

CHIEF COMPLAINT:
diarrhea

HISTORY OF PRESENT ILLNESS:
On 12/06/2012, Patricia Pate, a presented with:

-- chr. stomach problems, and now 1 wk of diarrhea , which began years ago. Severity - recently worsened. Duration - 1 wk for diarrhea. Aggravating Factors - stress and relieved by levbid previously. Associated signs and symptoms are loose stools, bloating, stomach cramps at times, burping, watery diarrhea and chills. The patient denies the following: vomiting, constipation, sev. pain, bloody or tarry stools. There is parents with stomach problems (dad w/ blockage), mom w/ diverticulitis (bowel also removed) and brother w/ pancreatic cancer at 40. The patient has had Cholecystectomy and partial hysterectomy. had colonoscopy already and Was normal.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5 mg-325 mg Tab, 1-2 po q 4-6 hrs prn pain
4. Soma 350 mg Tab, 1 BID prn
5. omeprazole 40 mg capsule,delayed release, 1 DAILY
6. Claritin-D 24 Hour 10 mg-240 mg tablet,extended release, 1 DAILY
7. Qualaquin 324 mg capsule, 1 QHS
8. Ambien CR 12.5 mg tablet,extended release, 1 QHS
9. Cymbalta 60 mg capsule,delayed release, 2 DAILY
10. Levbid 0.375 mg tablet,extended release, 1-2 po bid prn

ALLERGIES: acetaminophen- Nausea/vomiting; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - none. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

REVIEW OF SYSTEMS:
GENERAL - Denies fever or chills
SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - See HPI
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 120/82 Sitting, Left arm, large cuff
Pulse - 72
Respiration - 16
Temperature - 97.8 degrees
Weight - 175.00 lbs.
Glucose -

BMI- Unable to Compute
Weight Change: 1.00 lbs. gained since 11/14/12

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - Bs pos, mild tenderness, bloated, mildly tympanitic
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - overall improved since last visit, calm affect and mood and tone

ASSESSMENT:

1. Diarrhea - New

PLAN:
1. Diarrhea - **VENIPUNCURE
2. Diarrhea - *CBC with Differential
3. Diarrhea - *STOOL CULTURE
4. Diarrhea - Stool O
5. Diarrhea - White Blood Cells, Stool
6. Diarrhea - Giardia lamblia, Dir Det. by EIA
7. Diarrhea - Request Clinical Summary

DIAGNOSTIC TESTS:
1. **VENIPUNCURE, 558.9
2. *CBC with Differential, 558.9
3. *STOOL CULTURE, 558.9
4. Stool O, 558.9
5. White Blood Cells, Stool, 558.9
6. Giardia lamblia, Dir Det. by EIA, 558.9

Special notes: pt to call if symptoms worsen or do not improve and and do not start Abx until gives cultures

DRUG RX:
1. Cipro 500 mg tablet, 1 po bid
2. Flagyl 500 mg tablet, 1 po tid

Entered by: JOHN W. CAMPBELL, MD

Electronically signed by JOHN W. CAMPBELL, MD 12/6/2012 15:4:38

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NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:
On 12/14/2012, Patricia Pate, a : presented with:

-- chr. stomach problems, and now 1 wk of diarrhea , which began years ago. Severity - recently worsened and not any better. Duration - 1 wk for diarrhea. Aggravating Factors - stress and relieved by levbid previously and no help abx. Associated signs and symptoms are loose stools, bloating, stomach cramps at times, burping, watery diarrhea and chills. The patient denies the following: vomiting, constipation, sev. pain, bloody or tarry stools. There is parents with stomach problems (dad w/ blockage), mom w/ diverticulitis (bowel also removed) and brother w/ pancreatic cancer at 40. The patient has had Cholecystectomy and partial hysterectomy. had colonoscopy already and Was normal. recent labs: E coli neg, O and P, pos few WBC, Giardia neg..

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5 mg-325 mg Tab, 1-2 po q 4-6 hrs prn pain
4. Soma 350 mg Tab, 1 BID prn
5. omeprazole 40 mg capsule,delayed release, 1 DAILY
6. Claritin-D 24 Hour 10 mg-240 mg tablet,extended release, 1 DAILY
7. Qualaquin 324 mg capsule, 1 QHS
8. Ambien CR 12.5 mg tablet,extended release, 1 QHS
9. Cymbalta 60 mg capsule,delayed release, 2 DAILY
10. Levbid 0.375 mg tablet,extended release, 1-2 po bid prn
11. Cipro 500 mg tablet, 1 po bid
12. Flagyl 500 mg tablet, 1 po tid

ALLERGIES: acetaminophen- Nausea/vomiting; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

REVIEW OF SYSTEMS:
GENERAL - Denies fever or chills
SKIN - No rash(es)
EYES - No blurry vision.
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - See HPI
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 110/70 Sitting, Left arm, large cuff
Pulse - 72
Respiration - 18
Temperature - 98.6 degrees

Weight - .00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -175.00 lbs. lost since 12/06/12

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - Bs pos, mild tenderness, bloated, mildly tympanitic
RECTAL - Deferred.
NEUROLOGICAL - No obvious motor or sensory deficits.

ASSESSMENT:

1. Diarrhea - Unchanged

PLAN:
1. Diarrhea - Request Clinical Summary
2. Diarrhea - Refer to Gastroenterology NEW, MARC D. [NEWM9267G000001] ph. 843/797-6800 fax 843/797-6825 2671 ELMS PLANTATION BLVD CHARLESTON, SC 29405

DRUG RX:
1. Lomotil 2.5-0.025 mg tablet, 1 po q day prn

The following drugs were stopped:
1. Cipro 500 mg tablet, Ineffective
2. Flagyl 500 mg tablet, Ineffective

Entered by: JOHN W. CAMPBELL, MD

~

Electronically signed by JOHN W. CAMPBELL, MD 12/14/2012 12:49:16

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NPI: 1689639072
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NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
diarrhea

HISTORY OF PRESENT ILLNESS:
On 01/23/2013, Patricia Pate, a 52 year old female presented with:

-- chronic stomach problems, now months of diarrhea , which began years ago. Severity - recently worsened and not any better. Duration - months ago. Aggravating Factors - stress and eating and relieved by no help w/ levbid or abx. Associated signs and symptoms are loose stools, bloating, stomach cramps at times, burping, watery diarrhea, chills, having diarrhea 22-24 x a day and fecal urgency. The patient denies the following: vomiting, constipation, sev. pain, bloody or tarry stools, fever and appetite loss. There is parents with stomach problems (dad w/ blockage), mom w/ diverticulitis (bowel also removed) and brother w/ pancreatic cancer at 40. The patient has had Cholecystectomy and partial hysterectomy. had colonoscopy already and Was normal. recent labs: E coli neg, O and P, pos few WBC, Giardia neg. Went to Nason 3-4 wks ago - ct scan normal. was seeing Dr. New - colonoscopy normal (pt said he wouldn't listen and doesn't want to go back to him).

-- stress, which began 3-4 years ago. Severity - improving. Aggravating factors include: work stressors, brother dying from pancreatic cancer and relieved by cymbalta, ambien. Associated signs and symptoms are was feeling better on cymbalta but is having severe diarrhea and bloating so wants to come off all meds until her stomach is better. cymbalta might be helping some w/ chronic back pain. having bad diarrhea (even before going on cymbalta) - is worse now.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5 mg-325 mg Tab, 1-2 po q 4-6 hrs prn pain
4. Soma 350 mg Tab, 1 BID prn
5. omeprazole 40 mg capsule,delayed release, 1 DAILY
6. Claritin-D 24 Hour 10 mg-240 mg tablet,extended release, 1 DAILY
7. Qualaquin 324 mg capsule, 1 QHS
8. Cymbalta 60 mg capsule,delayed release, 2 DAILY
9. Levbid 0.375 mg tablet,extended release, 1-2 po bid prn
10. Lomotil 2.5-0.025 mg tablet, 1 po q day prn
11. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS

ALLERGIES: acetaminophen- Nausea/vomiting; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual

Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none
SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - See HPI and diarrhea
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)
PSYCHIATRIC - See HPI

EXAMINATION:

VITAL SIGNS:
B/P - 120/80 Sitting, Left arm, regular cuff
Pulse - 80
Respiration - 18
Temperature - 98.5 degrees
Weight - .00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -175.00 lbs. lost since 12/14/12

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - significan abdominal tendnerness diffusely, BS pos, very bloated (abdomen distended), abdomen mildly tympanitic
RECTAL - Deferred.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - distressed mood and affect

DIAGNOSTIC TEST RESULTS:

CBC: wbc and gran slightly low

ASSESSMENT:

1. Depressive Disorder Nos - Unchanged
2. Diarrhea - Uncontrolled
3. Abdominal pain unspec - Unchanged

PLAN:
1. Diarrhea - **VENIPUNCURE
2. Diarrhea - *CBC with Differential
3. Diarrhea - *Comprehensive Metabolic Panel (CMP)
4. Diarrhea - Bowel Disorders Cascade
5. Diarrhea - Refer to Gastroenterology HOFFMAN,BRENDA[HOFF171AS000001] ph. 843/792-6982 fax 843/876-4717 171 ASHLEY AVE CHARLESTON, SC 29425

DIAGNOSTIC TESTS:
1. **VENIPUNCURE, 558.9
2. *CBC with Differential, 558.9
3. *Comprehensive Metabolic Panel (CMP), 558.9
4. Bowel Disorders Cascade, 558.9

Medications instructions: stop fish oil for right now and wean off cymbalta and maybe consider stopping omeprazole too and try align probiotics
Special notes: pt to call if symptoms worsen or do not improve

DRUG RX:

The following drugs were stopped:
1. Levbid 0.375 mg tablet,extended release, Ineffective

Entered by: CAREY MCNAMARA, PA-C

Electronically signed by CAREY MCNAMARA, PA-C 1/23/2013 16:58:16

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NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
cpe

HISTORY OF PRESENT ILLNESS:
On 01/28/2013, Patricia Pate, a 52 year old female presented with:

-- chronic stomach problems, now months of diarrhea , which began years ago. Severity - uncontrolled. Duration - months ago. Aggravating Factors - stress and eating and relieved by no help w/ levbid or abx, immodium slight help and just started align probiotics. Associated signs and symptoms are loose stools, bloating, stomach cramps at times, burping, watery diarrhea, chills, having diarrhea 22-24 x a day and fecal urgency. The patient denies the following: vomiting, constipation, sev. pain, bloody or tarry stools, fever and appetite loss. There is parents with stomach problems (dad w/ blockage), mom w/ diverticulitis (bowel also removed) and brother w/ pancreatic cancer at 40. The patient has had Cholecystectomy and partial hysterectomy. had colonoscopy already and Was normal. recent labs: E coli neg, O and P, pos few WBC, Giardia neg. Went to Nason 3-4 wks ago - ct scan normal. was seeing Dr. New - colonoscopy normal (pt said he wouldn't listen and doesn't want to go back to him).

-- here for cpe. Severity - stable. It is relieved by nothing. The patient denies the following: vaginal bleeding, vaginal discharge, pelvic pain. There is no family history of ovarian cancer and aunt and cousin w/ breast cancer. The patient has had partial hysterectomy. had hysterectomy due to benign growth. currently has chronic diarrhea and abdominal bloating that is being investigated and treated.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5 mg-325 mg Tab, 1-2 po q 4-6 hrs prn pain
4. Soma 350 mg Tab, 1 BID prn
5. omeprazole 40 mg capsule,delayed release, 1 DAILY
6. Claritin-D 24 Hour 10 mg-240 mg tablet,extended release, 1 DAILY
7. Qualaquin 324 mg capsule, 1 QHS
8. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS

ALLERGIES: acetaminophen- Nausea/vomiting; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 120/80 Sitting, Left arm, regular cuff
Pulse - 72
Respiration - 18
Temperature - 98.5 degrees
Weight - 175.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: 0.00 lbs. lost since 01/23/13

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
ENT - TM clear and external auditory canal clear, normal nasal mucosa, throat clear
NECK - Supple, No lymphadenopathy and No masses
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
MUSCULOSKELETAL - No spinal tenderness
ABDOMEN - abdomen bloated and diffusely tender - no masses palpated
GENITALIA - no ovarian masses but tender abdominal exam due to bloating, cervix surgically absent and vaginal mucosa slightly atrophic
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - sad mood and affect

DIAGNOSTIC TEST RESULTS:

Urinalysis: trace Leukocyte Esterase positive

ASSESSMENT:

1. MAMMOGRAM SCREENING - New
2. Depressive Disorder Nos - Unchanged
3. Diarrhea - Uncontrolled
4. Abdominal pain unspec - Uncontrolled
5. MAMMOGRAM SCREENING - Resolved
6. Hypercholesterolemia - Unchanged

PLAN:
1. Hypercholesterolemia - **VENIPUNCURE

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CHIEF COMPLAINT:
stress/anxiety

HISTORY OF PRESENT ILLNESS:
On 02/11/2013, Patricia Pate, a [redacted] presented with:

-- chronic stomach problems, now months of diarrhea , which began years ago. Severity - uncontrolled. Duration - months ago. Aggravating Factors - stress and eating and relieved by no help w/ levbid or abx, immodium slight help and just started align probiotics. Associated signs and symptoms are loose stools, bloating, stomach cramps at times, burping, watery diarrhea, chills, having diarrhea 22-24 x a day and fecal urgency. The patient denies the following: vomiting, constipation, sev. pain, bloody or tarry stools, fever and appetite loss. There is parents with stomach problems (dad w/ blockage), mom w/ diverticulitis (bowel also removed) and brother w/ pancreatic cancer at 40. The patient has had Cholecystectomy and partial hysterectomy. had colonoscopy already and Was normal. recent labs: E coli neg, O and P, pos few WBC, Giardia neg. Went to Nason 3-4 wks ago - ct scan normal. was seeing Dr. New - colonoscopy normal (pt said he wouldn't listen and doesn't want to go back to him).

-- stress, which began 3-4 years ago. Severity - worsening. Aggravating factors include: work stressors, brother dying from pancreatic cancer and relieved by cymbalta, ambien. Associated signs and symptoms are decreased memory, diarrhea, disturbed sleep, decreased concentration and mood swings. cymbalta might be helping some w/ chronic back pain. having bad diarrhea (even before going on cymbalta) - is worse now. brother died of pancreatic cancer in Oct.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5 mg-325 mg Tab, 1-2 po q 4-6 hrs prn pain
4. Soma 350 mg Tab, 1 BID prn
5. omeprazole 40 mg capsule,delayed release, 1 DAILY
6. Claritin-D 24 Hour 10 mg-240 mg tablet,extended release, 1 DAILY
7. Qualaquin 324 mg capsule, 1 QHS
8. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS

ALLERGIES: acetaminophen- Nausea/vomiting; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy- laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week.

Spouses Occupation - heating and air conditioning. Children - none

REVIEW OF SYSTEMS:
SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)
PSYCHIATRIC - See HPI

EXAMINATION:

VITAL SIGNS:
B/P - 114/80 Sitting, Left arm, large cuff
Pulse - 100
Respiration - 16
Temperature - 98.4 degrees
Weight - .00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -175.00 lbs. lost since 01/28/13

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
ENT - TM clear and external auditory canal clear, normal nasal mucosa, throat clear
NECK - Supple, No lymphadenopathy and No masses
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
MUSCULOSKELETAL - No spinal tenderness
ABDOMEN - abdomen bloated and diffusely tender - no masses palpated
GENITALIA - deferred
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - anxious, depressed, oriented to time, place, and person, no difficulties with speech or language, normal memory, tearful, blunted affect and crying

ASSESSMENT:

1. Anxiety - New
2. Depression - New
3. MAMMOGRAM SCREENING - New
4. Depressive Disorder Nos - Unchanged
5. Diarrhea - Unchanged
6. Abdominal pain unspec - Uncontrolled
7. Hypercholesterolemia - Unchanged

PLAN:
1. Depression - Return visit in 3 Weeks

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Tara J. Hughes, PA-C

NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
hdl results
recheck

HISTORY OF PRESENT ILLNESS:
On 02/25/2013, Patricia Pate, a [redacted] presented with:

-- stress, which began 3-4 years ago. Severity - improving slightly on paxil but still room for improvement. Aggravating factors include: work stressors, brother dying from pancreatic cancer and relieved by cymbalta helped w/ mood in past - currently on paxil with only some help. Associated signs and symptoms are decreased memory, diarrhea, disturbed sleep, decreased concentration and mood swings. cymbalta might be helping some w/ chronic back pain. had diarrhea (even before going on cymbalta) but this has improved. brother died of pancreatic cancer in Oct.

-- elevated chol and was diagnosed recent. Severity - mild. Patient is not on medication. galectin slightly elevated, omega 3 deficient, slight elevation in ldl. taking fish oil now. eating apples.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5 mg-325 mg Tab, 1-2 po q 4-6 hrs prn pain
4. Soma 350 mg Tab, 1 BID prn
5. omeprazole 40 mg capsule,delayed release, 1 DAILY
6. Claritin-D 24 Hour 10 mg-240 mg tablet,extended release, 1 DAILY
7. Qualaquin 324 mg capsule, 1 QHS
8. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS
9. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
10. Ativan 0.5 mg tablet, 1 PO BID prn

ALLERGIES: acetaminophen- Nausea/vomiting; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints

RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - See HPI
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 118/76 Sitting, Left arm, regular cuff
Pulse - 72 .
Respiration - 16
Temperature - 98.1 degrees
Weight - .00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -175.00 lbs. lost since 02/11/13

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - soft
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - anxious mood at times - affect much calmer and improved since last visit but still slightly stressed

ASSESSMENT:

1. Depression - New
2. MAMMOGRAM SCREENING - New
3. Abdominal pain unspec - Uncontrolled
4. Depressive Disorder Nos - Unchanged
5. Anxiety - Unchanged
6. Diarrhea - Improving
7. Hypercholesterolemia - Unchanged

PLAN:

DRUG RX:
1. Cymbalta 30 mg capsule,delayed release(DR/EC), 1 PO QD

Entered by: CAREY MCNAMARA, PA-C

Electronically signed by CAREY MCNAMARA, PA-C 2/25/2013 15:35:7

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Carey McNamara, PA-C
Denise Hosenfeld, FNP-C
Tara J. Hughes, PA-C

NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
recheck

HISTORY OF PRESENT ILLNESS:
On 05/21/2013, Patricia Pate, a 52 year old female presented with:

-- Abdominal pain , which began years ago. Severity - uncontrolled. Duration - months ago. Aggravating Factors - stress and eating and relieved by no help w/ levbid or abx, immodium slight help and just started align probiotics. Associated signs and symptoms are loose stools, bloating, stomach cramps at times, burping, watery diarrhea, chills, having diarrhea 22-24 x a day and fecal urgency. The patient denies the following: vomiting, constipation, sev. pain, bloody or tarry stools, fever and appetite loss. There is parents with stomach problems (dad w/ blockage), mom w/ diverticulitis (bowel also removed) and brother w/ pancreatic cancer at 40. The patient has had Cholecystectomy and partial hysterectomy. had colonoscopy already and Was normal. recent labs: E coli neg, O and P, pos few WBC, Giardia neg. Went to Nason 3-4 wks ago - ct scan normal. was seeing Dr. New - colonoscopy normal (pt said he wouldn't listen and doesn't want to go back to him).

-- elevated bp.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed.
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5 mg-325 mg Tab, 1-2 po q 4-6 hrs prn pain
4. Soma 350 mg Tab, 1 BID prn
5. omeprazole 40 mg capsule,delayed release, 1 DAILY
6. Claritin-D 24 Hour 10 mg-240 mg tablet,extended release, 1 DAILY
7. Ativan 0.5 mg tablet, 1 PO BID prn
8. Cymbalta 30 mg capsule,delayed release(DR/EC), 1 PO QD
9. Qualaquin 324 mg capsule, 1 QHS
10. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
11. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS

ALLERGIES: acetaminophen- Nausea/vomiting; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

REVIEW OF SYSTEMS:

SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - See HPI
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 122/80 Sitting, Left arm, regular cuff
Pulse - 60
Respiration - 16
Temperature - 98.6 degrees
Weight - 182.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: 7.00 lbs. gained since 02/25/13

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - no masses, normal bowel sounds and tenderness to palpation of LUQ RUQ
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - anxious mood at times - affect much calmer and improved since last visit but still slightly stressed

ASSESSMENT:

1. Ibs [irritable Bowel Syndrome] - New

PLAN:

DRUG RX:
1. Librax (with clidinium) 5-2.5 mg capsule, 1 PO TID

FOLLOWUP: Return visit in 3 Weeks

Entered by: DONALD T. HANNA, MD

Electronically signed by DONALD T. HANNA, MD 5/21/2013 12:7:53

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Denise Hosenfeld, FNP-C
Tara J. Hughes, PA-C

NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
3 week recheck

HISTORY OF PRESENT ILLNESS:
On 06/11/2013, Patricia Pate, a ed with:

-- Abdominal pain , which began years ago. Severity - uncontrolled. Duration - months ago. Aggravating Factors - stress and eating and relieved by no help w/ levbid or abx, immodium slight help and just started align probiotics. Associated signs and symptoms are loose stools, bloating, stomach cramps at times, burping, watery diarrhea, chills, having diarrhea 22-24 x a day and fecal urgency. The patient denies the following: vomiting, constipation, sev. pain, bloody or tarry stools, fever and appetite loss. There is parents with stomach problems (dad w/ blockage), mom w/ diverticulitis (bowel also removed) and brother w/ pancreatic cancer at 40. The patient has had Cholecystectomy and partial hysterectomy. had colonoscopy already and Was normal. recent labs: E coli neg, O and P, pos few WBC, Giardia neg. Went to Nason 3-4 wks ago - ct scan normal. was seeing Dr. New - colonoscopy normal (pt said he wouldn't listen and doesn't want to go back to him).

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5 mg-325 mg Tab, 1-2 po q 4-6 hrs prn pain
4. Soma 350 mg Tab, 1 BID prn
5. omeprazole 40 mg capsule,delayed release, 1 DAILY
6. Claritin-D 24 Hour 10 mg-240 mg tablet,extended release, 1 DAILY
7. Ativan 0.5 mg tablet, 1 PO BID prn
8. Qualaquin 324 mg capsule, 1 QHS
9. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
10. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS
11. Librax (with clidinium) 5-2.5 mg capsule, 1 PO TID

ALLERGIES: acetaminophen- Nausea/vomiting; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

REVIEW OF SYSTEMS:
SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints

RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - See HPI
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 110/80 Sitting, Left arm, regular cuff
Pulse - 68
Respiration - 18
Temperature - 98.0 degrees
Weight - .00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -182.00 lbs. lost since 05/21/13

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - no masses, normal bowel sounds and mild tenderness to palpation of LUQ RUQ
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - anxious mood at times - affect much calmer and improved since last visit but still slightly stressed

ASSESSMENT:

1. Ibs [irritable Bowel Syndrome] - Improving

PLAN:

DRUG RX:
1. Librax (with clidinium) 5-2.5 mg capsule, 1 PO TID
2. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD

Entered by: DONALD T. HANNA, MD

Electronically signed by DONALD T. HANNA, MD 6/11/2013 13:58:2

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NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
office visit

HISTORY OF PRESENT ILLNESS:
On 07/14/2014, Patricia Pate, a 53 year old female presented with:

-- elevated chol and was diagnosed recent. Severity - mild. Patient is not on medication. galectin slightly elevated, omega 3 deficient, slight elevation in ldl. taking fish oil now. eating apples.

-- discoloration of skin, which began 2 months ago. It is located on the both feet and sometimes lower legs. Severity was described as unchanged. It is relieved by nothing. Associated signs and symptoms are tingling in both feet and some swelling in lower legs. The patient denies the following: pain with walking.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Ativan 0.5 mg tablet, 1 PO BID prn
4. omeprazole 40 mg capsule,delayed release(DR/EC), 1 DAILY
5. Percocet 5-325 mg tablet, 1 po bid - tid
6. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
7. Claritin-D 24 Hour 10-240 mg tablet extended release 24 hr, 1 DAILY
8. Qualaquin 324 mg capsule, 1 QHS
9. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS
10. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD

ALLERGIES: acetaminophen- Nausea/vomiting; cymbalta- Diarrhea; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

SKIN - See HPI
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 120/80 Sitting, Left arm, large cuff
Pulse - 72
Respiration - 18
Temperature - 96.3 degrees Taken by Ear
Weight - 188.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: 6.00 lbs. gained since 02/05/14

CONSTITUTIONAL - In no distress.
SKIN - skin on lower legs pinkish due to blood circulation - very slightly diminished cap refill of toes
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - soft
GENITALIA - deferred
RECTAL - Deferred.
EXTREMITIES - normal filament test bottom of both feet
NEUROLOGICAL - No obvious motor or sensory deficits.

ASSESSMENT:

1. Edema /Bilateral peripheral - New
2. Hypercholesterolemia - Unchanged

PLAN:
1. Edema /Bilateral peripheral - Request Clinical Summary
2. Edema /Bilateral peripheral - ABI- In House
3. Edema /Bilateral peripheral - IN HOUSE- CIMT
4. Edema /Bilateral peripheral - Fasting Bloodwork only

FUTURE ORDERS:
1. Edema /Bilateral peripheral - **VENIPUNCURE - 07/16/14
2. Edema /Bilateral peripheral - *CBC with Differential - 07/16/14
3. Edema /Bilateral peripheral - *Comprehensive Metabolic Panel (CMP) - 07/16/14
4. Edema /Bilateral peripheral - *TSH, Serum - 07/16/14
5. Edema /Bilateral peripheral - *HDL- Follow Up Panel - 07/16/14
6. Edema /Bilateral peripheral - *Singulex - 07/16/14

DIAGNOSTIC TESTS:
1. ABI- In House, 782.3

Special notes: pt to call if symptoms worsen or do not improve

DRUG RX:
1. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS

FOLLOWUP: Fasting Bloodwork only

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NPI: 1689639072
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NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
discuss lab results

HISTORY OF PRESENT ILLNESS:
On 08/18/2014, Patricia Pate, a - :d with:

-- elevated chol and was diagnosed recent. Severity - mild. Patient is not on medication. galectin slightly elevated, omega 3 deficient, slight elevation in ldl. taking flaxseed oil.

-- prediabetes. Patient compliance: is not on meds. ha1c 5.7, leptin elevated.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Ativan 0.5 mg tablet, 1 PO BID prn
4. omeprazole 40 mg capsule,delayed release(DR/EC), 1 DAILY
5. Percocet 5-325 mg tablet, 1 po bid - tid
6. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
7. Qualaquin 324 mg capsule, 1 QHS
8. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
9. Claritin-D 24 Hour 10-240 mg tablet extended release 24 hr, 1 DAILY
10. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS
11. Vitamin B-12 5,000 mcg tablet, sublingual, 1 po qd
12. Aspir-81 81 mg tablet,delayed release (DR/EC), 1 PO QD

ALLERGIES: acetaminophen- Nausea/vomiting; cymbalta- Diarrhea; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain

NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 138/84 Sitting, Left arm, large cuff
Pulse - 76
Respiration - 16
Temperature - 97.6 degrees
Weight - 186.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -2.00 lbs. lost since 07/14/14

CONSTITUTIONAL - In no distress.
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - soft
GENITALIA - deferred
RECTAL - Deferred.
NEUROLOGICAL - No obvious motor or sensory deficits.

ASSESSMENT:

1. Edema /Bilateral peripheral - New
2. Hypercholesterolemia - Unchanged

PLAN:
1. Hypercholesterolemia - Request Clinical Summary
2. Hypercholesterolemia - IN HOUSE HDL DIETICIAN
3. Hypercholesterolemia - 2 HR GTT
4. Hypercholesterolemia - Return Fasting in 3 months

Special notes: pt to call if symptoms worsen or do not improve

DRUG RX:
1. L-Methylfolate 15 mg tablet, 1 po qd (either deplin or if generic then from breckinridge manufacturer)
2. Lipitor 10 mg tablet, 1 PO Qam

FOLLOWUP: 2 HR GTT and Return Fasting in 3 months

Entered by: CAREY MCNAMARA, PA-C

Electronically signed by CAREY MCNAMARA, PA-C 8/18/2014 11:10:41

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NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
SOB

HISTORY OF PRESENT ILLNESS:
On 09/16/2014, Patricia Pate, a [illegible] ented with:

-- SOB, which began 1 week ago. Severity was described as moderate. It is relieved by nothing. An associated sign and symptom is none. The patient denies the following: prod or non-prod cough, fever, wheezing, any sinus issues. did use husband's HHN with Duoned treatment last pm with no relief.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Ativan 0.5 mg tablet, 1 PO BID prn
4. omeprazole 40 mg capsule,delayed release(DR/EC), 1 DAILY
5. Percocet 5-325 mg tablet, 1 po bid - tid
6. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
7. Qualaquin 324 mg capsule, 1 QHS
8. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
9. Claritin-D 24 Hour 10-240 mg tablet extended release 24 hr, 1 DAILY
10. Vitamin B-12 5,000 mcg tablet, sublingual, 1 po qd
11. Lipitor 10 mg tablet, 1 PO Qam
12. L-Methylfolate 15 mg tablet, 1 po qd (either deplin or if generic then from breckinridge manufacturer)
13. Aspir-81 81 mg tablet,delayed release (DR/EC), 1 PO QD
14. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS-due 9/13/2014

ALLERGIES: acetaminophen- Nausea/vomiting; cymbalta- Diarrhea; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

REVIEW OF SYSTEMS:
SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - See HPI
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain

MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 116/80 Sitting, Left arm, regular cuff
Pulse - 86
Respiration - 17
Temperature - 98.0 degrees
Weight - .00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -186.00 lbs. lost since 08/18/14

CONSTITUTIONAL - looks as if she is out of breath
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
ENT - TM's intact, posterior pharynx is clear and TM's normal color with distinct land marks
NECK - supple
CHEST - upper lobles clear, lower lobes with bronchitic noises, effort was forced at times
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - BS(+), soft, nontender. No masses or organomegaly.
EXTREMITIES - No joint swelling or deformity, normal to light touch and pinprick, no clubbing, pulses 2+ bilat. and cap. refill wnl
NEUROLOGICAL - No obvious motor or sensory deficits.

ASSESSMENT:

1. Neoplasm Of Uncertain Behavior Of Trachea, Bronchus, And Lung - New
2. Shortness Of Breath - New
3. Other Nonspecific Abnormal Finding Of Lung Field - New

PLAN:
1. Shortness Of Breath - *Comprehensive Metabolic Panel (CMP)
2. Shortness Of Breath - B -type natriuretic peptide
3. Shortness Of Breath - **VENIPUNCURE
4. Shortness Of Breath - EKG
5. Shortness Of Breath - Pulse Oximetry
6. Shortness Of Breath - Spirometry w/Broncodilator
7. Shortness Of Breath - Request Clinical Summary
8. Shortness Of Breath - X-Ray Chest 2V
9. Other Nonspecific Abnormal Finding Of Lung Field - CT SCAN W/ CONTRAST
10. Other Nonspecific Abnormal Finding Of Lung Field - CT SCAN WO/ CONTRAST

Pt in for SOB that started 1 week ago. No other sxs except SOB. EKG was unremarkable and unchanged from last one in 2010. Spirometry shown moderate airway abstruction with upper airway obstruction. Did HHN with Duoneb treatmt with very little improvement on post spriometry. Started on Adviar diskus and sent for chest x-ray which showed mild asthma with bronchitis. Also noted was a clustered of nodules noted in the left upper lobe. Spoke with pt and placed on Z-pk also sending for CT scan with and without contrast in am. Pt told that if her SOB increased she is to go to ER. Will call pt with results once we have them. DH, FNP-C

DIAGNOSTIC TESTS:
1. EKG, 786.09
2. Pulse Oximetry, 786.09
3. X-Ray Chest 2V, 786.09
4. Spirometry w/Broncodilator, 786.09
5. **VENIPUNCURE, 786.09
6. *Comprehensive Metabolic Panel (CMP), 786.09
7. B -type natriuretic peptide, 786.09
8. CT SCAN W/ CONTRAST, 793.19
9. CT SCAN WO/ CONTRAST, 793.19

DRUG RX:
1. Advair Diskus 100-50 mcg/dose blister with device, 1 actuation bid Use as Directed
2. Zithromax Z-Pak 250 mg tablet, Use as Directed

Entered by: DENISE HOSENFELD, NP

-

Electronically signed by DENISE HOSENFELD, NP 9/24/2014 14:16:40

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Denise Hosenfeld, FNP-C
Tara J. Hughes, PA-C

NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
hospital f.u

HISTORY OF PRESENT ILLNESS:
On 09/22/2014, Patricia Pate, a 53 year old female presented with:

-- stress, which began 3-4 years ago. Severity - improving slightly on paxil but still room for improvement. Aggravating factors include: work stressors, brother dying from pancreatic cancer and relieved by paxil cr best tolerated, ambien 12.5 for sleep. Associated signs and symptoms are decreased memory, diarrhea, disturbed sleep, decreased concentration and mood swings. cymbalta might be helping some w/ chronic back pain and but cymbalta caused GI side effects. seeing pain management for back. brother died of pancreatic cancer - thinking of resigning from her job.

Also, multiple pulmonary embolisms, which began 1 wk ago. It was located on the lungs. Severity was described as improving slightly. It is relieved by lovenox and xarelto. An associated sign and symptom is shortness of breath (but improving some). Was admitted for 2 days to see if they could figure out why the patient had the multiple PE's but they didn't know.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Ativan 0.5 mg tablet, 1 PO BID prn
4. omeprazole 40 mg capsule,delayed release(DR/EC), 1 DAILY
5. Percocet 5-325 mg tablet, 1 po bid - tid
6. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
7. Qualaquin 324 mg capsule, 1 QHS
8. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
9. Claritin-D 24 Hour 10-240 mg tablet extended release 24 hr, 1 DAILY
10. Vitamin B-12 5,000 mcg tablet, sublingual, 1 po qd
11. Lipitor 10 mg tablet, 1 PO Qam
12. L-Methylfolate 15 mg tablet, 1 po qd (either deplin or if generic then from breckinridge manufacturer)
13. Aspir-81 81 mg tablet,delayed release (DR/EC), 1 PO QD
14. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS-due 9/13/2014
15. Advair Diskus 100-50 mcg/dose blister with device, 1 actuation bid Use as Directed
16. Zithromax Z-Pak 250 mg tablet, Use as Directed
17. Xarelto 20 mg tablet, 1 PO QD

ALLERGIES: acetaminophen- Nausea/vomiting; cymbalta- Diarrhea; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill.

Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none
SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 112/70 Sitting, Left arm, large cuff
Pulse - 84
Respiration - 17
Temperature - 98.6 degrees
Weight - 182.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -4.00 lbs. lost since 09/16/14

HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - clear to auscultation and percussion. Effort normal.
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - soft
EXTREMITIES - otherwise within normal limits
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - stressed and sad mood and affect and tone

ASSESSMENT:

1. Pulmonary embolism other - New
2. Anxiety - Unchanged

PLAN:
1. Pulmonary embolism other - Request Clinical Summary
2. Pulmonary embolism other - Refer to Hematology

Medications instructions: since cymbalta helped more than paxil but caused gi s.e. will see if pristiq helps
Special notes: pt to call if symptoms worsen or do not improve

DRUG RX:

The following drugs were stopped:
1. Ativan 0.5 mg tablet, No Longer Needed

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Tara J. Hughes, PA-C

NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
recheck

HISTORY OF PRESENT ILLNESS:
On 10/22/2014, Patricia Pate, resented with:

-- stress, which began 3-4 years ago. Severity - improving slightly on paxil but still room for improvement. Aggravating factors include: work stressors, brother dying from pancreatic cancer and relieved by paxil cr best tolerated, ambien 12.5 for sleep. Associated signs and symptoms are decreased memory, diarrhea, disturbed sleep, decreased concentration and mood swings. cymbalta might be helping some w/ chronic back pain and but cymbalta caused GI side effects. seeing pain management for back but can't do spinal injections while on blood thinners. brother died of pancreatic cancer - recently decided to resign from her job.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5-325 mg tablet, 1 po bid - tid
4. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
5. Qualaquin 324 mg capsule, 1 QHS
6. Claritin-D 24 Hour 10-240 mg tablet extended release 24 hr, 1 DAILY
7. Vitamin B-12 5,000 mcg tablet, sublingual, 1 po qd
8. Lipitor 10 mg tablet, 1 PO Qam
9. L-Methylfolate 15 mg tablet, 1 po qd (either deplin or if generic then from breckinridge manufacturer)
10. Aspir-81 81 mg tablet,delayed release (DR/EC), 1 PO QD
11. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS-due 9/13/2014
12. Advair Diskus 100-50 mcg/dose blister with device, 1 actuation bid Use as Directed
13. Xarelto 20 mg tablet, 1 PO QD
14. Pristiq 50 mg tablet extended release 24 hr, 1 PO QD
15. omeprazole 40 mg capsule,delayed release(DR/EC), 1 DAILY

ALLERGIES: acetaminophen- Nausea/vomiting; cymbalta- Diarrhea; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

~~SKIN - No rash(es)~~
EYES - No blurry vision.

ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 114/80 Sitting, Left arm, regular cuff
Pulse - 64
Respiration - 16
Temperature - 98.3 degrees
Weight - 188.00 lbs.
Height - 66 inches
Glucose -
BMI- 30.41
Weight Change: 6.00 lbs. gained since 09/22/14

HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - clear to auscultation and percussion. Effort normal.
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - soft
EXTREMITIES - otherwise within normal limits
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - overall improving - affect and mood improved

ASSESSMENT:

1. Shortness of breath - New
2. Vaccation against influenza - New
3. Pulmonary embolism other - Unchanged

PLAN:
1. Vaccation against influenza - *Admin Fee
2. Vaccation against influenza - flu vacc 3+ yrs old

DIAGNOSTIC TESTS:
1. *Admin Fee, V04.81
2. flu vacc 3+ yrs old, V04.81

Medications instructions: start advair bid
Special notes: pt to call if symptoms worsen or do not improve

DRUG RX:
1. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD

Entered by: CAREY MCNAMARA, PA-C

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NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
3 month recheck, check knot back of L leg hurts
results of 2 hr gtt

HISTORY OF PRESENT ILLNESS:
On 11/24/2014, Patricia Pate, [redacted] presented with:

-- stress, which began 3-4 years ago. Severity - improving. Aggravating factors include: work stressors, brother dying from pancreatic cancer and relieved by paxil cr best tolerated, ambien 12.5 for sleep and not working. An associated sign and symptom is overall feeling better since not working, mood pretty good on paxil, sleeping fine on ambien. cymbalta might be helping some w/ chronic back pain and but cymbalta caused GI side effects. seeing pain management for back but can't do spinal injections while on blood thinners. brother died of pancreatic cancer - recently decided to resign from her job.

-- prediabetes. Patient compliance: is not on meds. ha1c 5.7, leptin elevated. 2hrgtt 11/14 fbs 120, 30min 193, 1hr 215, 1.5hr 174, 2hr 145.

-- LLE pain to the left lower leg and behind left knee, which did not result from an injury which began 1 month ago. The patient characterized it as stabbing pain when standing up. Severity - worsening. Aggravating factors: weight bearing, standing, walking and bending knee. Relieving factors: nothing. on xarelto. History of multiple pulmonary embolisms.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5-325 mg tablet, 1 po bid - tid
4. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
5. Qualaquin 324 mg capsule, 1 QHS
6. Claritin-D 24 Hour 10-240 mg tablet extended release 24 hr, 1 DAILY
7. Vitamin B-12 5,000 mcg tablet, sublingual, 1 po qd
8. Lipitor 10 mg tablet, 1 PO Qam
9. L-Methylfolate 15 mg tablet, 1 po qd (either deplin or if generic then from breckinridge manufacturer)
10. Aspir-81 81 mg tablet,delayed release (DR/EC), 1 PO QD
11. Advair Diskus 100-50 mcg/dose blister with device, 1 actuation bid Use as Directed
12. Xarelto 20 mg tablet, 1 PO QD
13. omeprazole 40 mg capsule,delayed release(DR/EC), 1 DAILY
14. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
15. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS

ALLERGIES: acetaminophen- Nausea/vomiting; cymbalta- Diarrhea; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 110/68 Sitting, Left arm, large cuff
Pulse - 72
Respiration - 18
Temperature - 98.9 degrees
Weight - 188.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: 0.00 lbs. lost since 10/22/14

HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - clear to auscultation and percussion. Effort normal.
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - soft
EXTREMITIES - left post knee and calf tender on exam - very slight swelling LLE
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - overall improving - affect and mood improved

ASSESSMENT:

1. Pain In Joint Involving Lower Leg/Left - New
2. Impaired Fasting Glucose - New

PLAN:
1. Pain In Joint Involving Lower Leg/Left - Request Clinical Summary
2. Pain In Joint Involving Lower Leg/Left - Ultrasound: doppler left leg ASAP
3. Impaired Fasting Glucose - IN HOUSE BYDUREON DIABETIC EDUCATION
4. Impaired Fasting Glucose - Return Fasting in 3 months

DIAGNOSTIC TESTS:
1. Ultrasound: doppler left leg, ASAP, 719.46

Diet comments: eat 25 g carbs or less every 4 hrs
Lifestyle Comments: cardiovascular exercise minimun of 40 min daily
Special notes: pt to call if symptoms worsen or do not improve

DRUG RX:
1. Accu-Chek Compact Plus Care kit, use daily
2. Accu-Chek Compact Plus Test strip, use daily
3. Actos 15 mg tablet, 1 po qd
4. Bydureon 2 mg/0.65 mL pen injector, 1 injection weekly
5. Lancets, Super Thin misc, Use as Directed
6. spironolactone 50 mg tablet, 1-2 po qam prn swelling

FOLLOWUP: Return Fasting in 3 months

Entered by: CAREY MCNAMARA, PA-C

-

Electronically signed by CAREY MCNAMARA, PA-C 11/24/2014 9:6:45

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NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
1 mo reck/hdl results

HISTORY OF PRESENT ILLNESS:
On 12/22/2014, Patricia Pate, a ced with:

-- elevated chol and was diagnosed recent. Severity - mild. Patient taking lipitor. galectin slightly elevated, omega 3 deficient, slight elevation in ldl. taking flaxseed oil.

-- prediabetes. Patient compliance: is not on meds. Glucose levels were reported by the patient to be fbs 93-110. halc 5.7, leptin elevated. 2hrgtt 11/14 fbs 120, 30min 193, 1hr 215, 1.5hr 174, 2hr 145.

-- elevated bp. Patient is not on meds. Severity was described as borderline.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5-325 mg tablet, 1 po bid - tid
4. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
5. Qualaquin 324 mg capsule, 1 QHS
6. Claritin-D 24 Hour 10-240 mg tablet extended release 24 hr, 1 DAILY
7. Vitamin B-12 5,000 mcg tablet, sublingual, 1 po qd
8. L-Methylfolate 15 mg tablet, 1 po qd (either deplin or if generic then from breckinridge manufacturer)
9. Aspir-81 81 mg tablet,delayed release (DR/EC), 1 PO QD
10. Advair Diskus 100-50 mcg/dose blister with device, 1 actuation bid Use as Directed
11. Xarelto 20 mg tablet, 1 PO QD
12. omeprazole 40 mg capsule,delayed release(DR/EC), 1 DAILY
13. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
14. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS
15. Actos 15 mg tablet, 1 po qd
16. spironolactone 50 mg tablet, 1-2 po qam prn swelling
17. Bydureon 2 mg/0.65 mL pen injector, 1 injection weekly
18. Accu-Chek Compact Plus Care kit, use daily
19. Accu-Chek Compact Plus Test strip, use daily
20. Accu-Chek Multiclix Lancet misc, Use as Directed
21. Lipitor 10 mg tablet, 1 PO Qam

ALLERGIES: acetaminophen- Nausea/vomiting; cymbalta- Diarrhea; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 140/90 Sitting, Left arm, large cuff
Pulse - 98
Respiration - 16
Temperature - 98.4 degrees
Weight - 186.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -2.00 lbs. lost since 11/24/14

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - soft
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - Normal affect

ASSESSMENT:

1. Other Nonspecific Abnormal Function Study Of Cardiovascular System - New
2. Hypercholesterolemia - Unchanged
3. Impaired Fasting Glucose - Unchanged

PLAN:
Diet comments: eat 25 g carbs or less every 4 hrs
Medications instructions: increase fish oil to 2 a day and increase actos 15 to 2 pills a day and see if any issues with swelling (if not will refill at 30mg dose)
Lifestyle Comments: cardiovascular exercise minimun of 40 min daily
Special notes: pt to call if symptoms worsen or do not improve and check bp and keep a record

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NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
cpe

HISTORY OF PRESENT ILLNESS:
On 02/09/2015, Patricia Pate, a presented with:

-- stress, which began 3-4 years ago. Severity - improving. Aggravating factors include: work stressors, brother dying from pancreatic cancer and relieved by paxil cr best tolerated, ambien 12.5 for sleep and not working. An associated sign and symptom is overall feeling better since not working, mood pretty good on paxil, sleeping fine on ambien. cymbalta might be helping some w/ chronic back pain and but cymbalta caused GI side effects. seeing pain management for back but can't do spinal injections while on blood thinners. brother died of pancreatic cancer - recently decided to resign from her job.

-- elevated chol and was diagnosed recent. Severity - mild. Patient taking lipitor. galectin slightly elevated, omega 3 deficient, slight elevation in ldl. taking flaxseed oil.

-- prediabetes. Patient compliance: actos 30, bydureon weekly and taking one of spironolactone daily. Glucose levels were reported by the patient to be fbs 93-110. ha1c 5.7, leptin elevated. 2hrgtt 11/14 fbs 120, 30min 193, 1hr 215, 1.5hr 174, 2hr 145.

Also, multiple pulmonary embolisms, which began 09/14. It was located on the lungs. Severity was described as improving. It is relieved by xarelto 20mg qd (was on lovenox at first). The patient denied the following: current shortness of breath. Was admitted for 2 days to see if they could figure out why the patient had the multiple PE's but they didn't know and Seeing Dr. Rose (recommended staying on xarelto for at least a year and then will test her for certain blood disorders).

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5-325 mg tablet, 1 po bid - tid
4. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
5. Claritin-D 24 Hour 10-240 mg tablet extended release 24 hr, 1 DAILY
6. Vitamin B-12 5,000 mcg tablet, sublingual, 1 po qd
7. L-Methylfolate 15 mg tablet, 1 po qd (either deplin or if generic then from breckinridge manufacturer)
8. Aspir-81 81 mg tablet,delayed release (DR/EC), 1 PO QD
9. Advair Diskus 100-50 mcg/dose blister with device, 1 actuation bid Use as Directed
10. Xarelto 20 mg tablet, 1 PO QD
11. omeprazole 40 mg capsule,delayed release(DR/EC), 1 DAILY
12. spironolactone 50 mg tablet, 1-2 po qam prn swelling
13. Bydureon 2 mg/0.65 mL pen injector, 1 injection weekly
14. Accu-Chek Compact Plus Care kit, use daily
~~15. Accu-Chek Compact Plus Test strip, use daily~~
16. Accu-Chek Multiclix Lancet misc, Use as Directed

17. Lipitor 10 mg tablet, 1 PO Qam
18. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
19. Actos 15 mg tablet, 1 po qd
20. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS
21. Qualaquin 324 mg capsule, 1 QHS

ALLERGIES: acetaminophen- Nausea/vomiting; cymbalta- Diarrhea; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 130/72 Sitting, Left arm, large cuff
Pulse - 72
Respiration - 18
Temperature - 98.5 degrees
Weight - 185.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -1.00 lbs. lost since 12/22/14

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
ENT - TM clear and external auditory canal clear, normal nasal mucosa, throat clear
NECK - Supple, No lymphadenopathy and No masses
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.

MUSCULOSKELETAL - No spinal tenderness and multiple sensitive trigger points for fibromyalgia
ABDOMEN - soft, no masses, mild diffuse tenderness on exam (normal for pt)
GENITALIA - otherwise within normal limits, cervix surgically absent and no adnexal mass nor tenderness
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - Normal affect
BREAST - Symmetric, no dimpling, retractions or discharge. No masses. No axillary or supraclavicular lymphadenopathy.

ASSESSMENT:

1. Osteopenia - New
2. Physical exam - New
3. Impaired Fasting Glucose - Unchanged
4. Other Nonspecific Abnormal Function Study Of Cardiovascular System - Unchanged
5. Hypercholesterolemia - Unchanged
6. Depressive Disorder Nos - Unchanged
7. Pulmonary embolism other - Unchanged

PLAN:
1. Hypercholesterolemia - **VENIPUNCURE
2. Hypercholesterolemia - *CBC with Differential
3. Hypercholesterolemia - *B12 and Folate
4. Hypercholesterolemia - *Comprehensive Metabolic Panel
5. Hypercholesterolemia - *HDL- Follow Up
6. Hypercholesterolemia - *Singulex
7. Hypercholesterolemia - *T4, Free
8. Hypercholesterolemia - *T3, Free, Serum
9. Hypercholesterolemia - *TSH, Serum
10. Hypercholesterolemia - Return in 1 Month
11. Physical exam - *Urine Dip Stick

DIAGNOSTIC TESTS:
1. **VENIPUNCURE, 272.0
2. *CBC with Differential, 272.0
3. *B12 and Folate, 272.0
4. *Comprehensive Metabolic Panel, 272.0
5. *HDL- Follow Up, 272.0
6. *Singulex, 272.0
7. *T4, Free, 272.0
8. *T3, Free, Serum, 272.0
9. *TSH, Serum, 272.0
10. *Urine Dip Stick, V70.0

DRUG RX:
1. Actos 30 mg tablet, 1 po qd
2. Bydureon 2 mg/0.65 mL pen injector, 1 injection weekly
3. Xarelto 20 mg tablet, 1 PO QD

FOLLOWUP: Return in 1 Month

Entered by: CAREY MCNAMARA, PA-C

Electronically signed by CAREY MCNAMARA, PA-C 2/9/2015 9:24:11

Carolina Family Medicine
100 Spring Hall Drive
Goose Creek, SC 29445
(843) 572-8201 – Phone
(843) 797-8491 – Fax
Fed Tax ID #:

Donald T. Hanna, M.D.
Carey McNamara, PA-C
Denise Hosenfeld, FNP-C
Tara J. Hughes, PA-C

NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
cpe

HISTORY OF PRESENT ILLNESS:
On 02/09/2015, Patricia Pate, a presented with:

-- stress, which began 3-4 years ago. Severity - improving. Aggravating factors include: work stressors, brother dying from pancreatic cancer and relieved by paxil cr best tolerated, ambien 12.5 for sleep and not working. An associated sign and symptom is overall feeling better since not working, mood pretty good on paxil, sleeping fine on ambien. cymbalta might be helping some w/ chronic back pain and but cymbalta caused GI side effects. seeing pain management for back but can't do spinal injections while on blood thinners. brother died of pancreatic cancer - recently decided to resign from her job.

-- elevated chol and was diagnosed recent. Severity - mild. Patient taking lipitor. galectin slightly elevated, omega 3 deficient, slight elevation in ldl. taking flaxseed oil.

-- prediabetes. Patient compliance: actos 30, bydureon weekly and taking one of spironolactone daily. Glucose levels were reported by the patient to be fbs 93-110. ha1c 5.7, leptin elevated. 2hrgtt 11/14 fbs 120, 30min 193, 1hr 215, 1.5hr 174, 2hr 145.

Also, multiple pulmonary embolisms, which began 09/14. It was located on the lungs. Severity was described as improving. It is relieved by xarelto 20mg qd (was on lovenox at first). The patient denied the following: current shortness of breath. Was admitted for 2 days to see if they could figure out why the patient had the multiple PE's but they didn't know and Seeing Dr. Rose (recommended staying on xarelto for at least a year and then will test her for certain blood disorders).

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5-325 mg tablet, 1 po bid - tid
4. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
5. Claritin-D 24 Hour 10-240 mg tablet extended release 24 hr, 1 DAILY
6. Vitamin B-12 5,000 mcg tablet, sublingual, 1 po qd
7. L-Methylfolate 15 mg tablet, 1 po qd (either deplin or if generic then from breckinridge manufacturer)
8. Aspir-81 81 mg tablet,delayed release (DR/EC), 1 PO QD
9. Advair Diskus 100-50 mcg/dose blister with device, 1 actuation bid Use as Directed
10. Xarelto 20 mg tablet, 1 PO QD
11. omeprazole 40 mg capsule,delayed release(DR/EC), 1 DAILY
12. spironolactone 50 mg tablet, 1-2 po qam prn swelling
13. Bydureon 2 mg/0.65 mL pen injector, 1 injection weekly
14. Accu-Chek Compact Plus Care kit, use daily
15. ~~Accu-Chek Compact Plus Test strip, use daily~~
16. Accu-Chek Multiclix Lancet misc, Use as Directed

17. Lipitor 10 mg tablet, 1 PO Qam
18. Paxil CR 25 mg tablet extended release 24 hr, 1 PO QD
19. Actos 15 mg tablet, 1 po qd
20. Ambien CR 12.5 mg tablet,ext release multiphase, 1 QHS
21. Qualaquin 324 mg capsule, 1 QHS

ALLERGIES: acetaminophen- Nausea/vomiting; cymbalta- Diarrhea; Hydrocodone- Nausea; hydrocodone bit- Nausea/vomiting; Penicillin- Rash - diffuse

PAST HISTORY: Childhood Illnesses - No unusual illnesses. Chronic Illnesses - IBS type sx and hyperlipidemia. Accidents - none. Operations: cholecystectomy-laparoscopic 1990, hysterectomy - partial 2000 and back surgery 05/12. Procedures: colonoscopy 2009.

FAMILY HISTORY: Father - Diabetes-Type II (NIDDM) and Hypertension. Mother - Alive and Well; Brother 1 - pancreatic cancer at 39. Sister 1 - Alive and Well. Sister 2 - Alive and Well. Aunt (P) - Age 50, Cancer-Breast and died.

SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 4 cups coffee,5 glasses tea a day and no particular diet. Exercise - treadmill. Education completed - High school diploma. Seat Belt Use - Always. Occupation - production at print shop. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Hours Worked - 40 hours per week. Spouses Occupation - heating and air conditioning. Children - none

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EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 130/72 Sitting, Left arm, large cuff
Pulse - 72
Respiration - 18
Temperature - 98.5 degrees
Weight - 185.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: -1.00 lbs. lost since 12/22/14

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
ENT - TM clear and external auditory canal clear, normal nasal mucosa, throat clear
NECK - Supple, No lymphadenopathy and No masses
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.

MUSCULOSKELETAL - No spinal tenderness and multiple sensitive trigger points for fibromyalgia
ABDOMEN - soft, no masses, mild diffuse tenderness on exam (normal for pt)
GENITALIA - otherwise within normal limits, cervix surgically absent and no adnexal mass nor tenderness
RECTAL - Deferred.
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PSYCHIATRIC - Normal affect
BREAST - Symmetric, no dimpling, retractions or discharge. No masses. No axillary or supraclavicular lymphadenopathy.

ASSESSMENT:

1. Osteopenia - New
2. Physical exam - New
3. Impaired Fasting Glucose - Unchanged
4. Other Nonspecific Abnormal Function Study Of Cardiovascular System - Unchanged
5. Hypercholesterolemia - Unchanged
6. Depressive Disorder Nos - Unchanged
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PLAN:
1. Hypercholesterolemia - **VENIPUNCURE
2. Hypercholesterolemia - *CBC with Differential
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7. Hypercholesterolemia - *T4, Free
8. Hypercholesterolemia - *T3, Free, Serum
9. Hypercholesterolemia - *TSH, Serum
10. Hypercholesterolemia - Return in 1 Month.
11. Physical exam - *Urine Dip Stick

DIAGNOSTIC TESTS:
1. **VENIPUNCURE, 272.0
2. *CBC with Differential, 272.0
3. *B12 and Folate, 272.0
4. *Comprehensive Metabolic Panel, 272.0
5. *HDL- Follow Up, 272.0
6. *Singulex, 272.0
7. *T4, Free, 272.0
8. *T3, Free, Serum, 272.0
9. *TSH, Serum, 272.0
10. *Urine Dip Stick, V70.0

DRUG RX:
1. Actos 30 mg tablet, 1 po qd
2. Bydureon 2 mg/0.65 mL pen injector, 1 injection weekly
3. Xarelto 20 mg tablet, 1 PO QD

FOLLOWUP: Return in 1 Month

Entered by: CAREY MCNAMARA, PA-C

~

Electronically signed by CAREY MCNAMARA, PA-C 2/9/2015 9:24:11

Carolina Family Medicine
100 Spring Hall Drive
Goose Creek, SC 29445
(843) 572-8201 – Phone
(843) 797-8491 – Fax
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Donald T. Hanna, M.D.
Carey McNamara, PA-C
Denise Hosenfeld, FNP-C
Tara J. Hughes, PA-C

NPI: 1689639072
NPI: 1689639672
NPI: 1861753204
NPI: 1255367322

CHIEF COMPLAINT:
discuss hdl results

HISTORY OF PRESENT ILLNESS:
On 03/09/2015, Patricia Pate, a : presented with:

-- heart issues?. Severity - stable. An associated sign and symptom is significant shortness of breath in past but had mulitple PEs. The patient denies the following: chest pain, shortness of breath. saw Dr. Maran and exercise treadmill stress test (nuclear) and was normal.

-- elevated chol and was diagnosed recent. Severity - mild. Patient taking lipitor. galectin slightly elevated, omega 3 deficient, slight elevation in ldl. taking flaxseed oil.

-- prediabetes. Patient compliance: actos 30, bydureon weekly and taking one of spironolactone daily. Glucose levels were reported by the patient to be fbs 99-105. ha1c 5.7, leptin elevated. 2hrgtt 11/14 fbs 120, 30min 193, 1hr 215, 1.5hr 174, 2hr 145.

-- fatigue, which began months ago. Severity - uncontrolled. It is relieved by nothing. Associated signs and symptoms are increased appetite (eating a lot more), fatigue, feels tires when she wakes up in morning, class 4 airway and snores at times. just started walking on treadmill and this helps with energy. takes ambien every night to help her sleep.

MEDICATIONS HISTORY:
Current Medications:
1. Nasonex 50 mcg/Actuation Spray, as directed
2. Fish Oil 1,000 mg Cap, 2 DAILY
3. Percocet 5-325 mg tablet, 1 po bid - tid
4. OxyContin 10 mg tablet extended release 12 hr, 1 po qhs
5. Vitamin B-12 5,000 mcg tablet, sublingual, 1 po qd
6. Aspir-81 81 mg tablet,delayed release (DR/EC), 1 PO QD
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10. Accu-Chek Compact Plus Care kit, use daily
11. Accu-Chek Compact Plus Test strip, use daily
12. Accu-Chek Multiclix Lancet misc, Use as Directed
13. Lipitor 10 mg tablet, 1 PO Qam
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SOCIAL HISTORY: Alcohol Use - occasionally. Smoking - quit smoking 02/07. Diet - 2 cups of coffee. Exercise - treadmill.Education completed - High school diploma. Seat Belt Use - Always. Occupation - currently not working. Illicit Drug Use - denies use of street drugs. Sexual Activity - married. Residence - lives with husband. Place of Birth - South Carolina. Job Description - moderatly physical. Spouses Occupation - heating and air conditioning. Children - none

SKIN - No rash(es)
EYES - No blurry vision.
ENT - No sinus complaints
RESPIRATORY - No shortness of breath
CARDIOVASCULAR - No chest pain
GASTROINTESTINAL - No abdominal pain
MUSCULOSKELETAL - No joint pain
NEUROLOGICAL - No headache(s)

EXAMINATION:

VITAL SIGNS:
B/P - 110/70 Sitting, Left arm, large cuff
Pulse - 72
Respiration - 18
Temperature - 98.5 degrees
Weight - 187.00 lbs.
Glucose -
BMI- Unable to Compute
Weight Change: 2.00 lbs. gained since 02/09/15

CONSTITUTIONAL - In no distress.
SKIN - Warm to touch, dry and normal color
HEAD - Normal. No trauma.
EYE - PERRLA and EOMI
ENT - class 4 airway (drooping soft palate)
NECK - supple
CHEST - Clear to auscultation and Normal effort
CARDIAC - Regular rate and rhythm, without rubs, gallops, or murmurs.
ABDOMEN - soft
RECTAL - Deferred.
EXTREMITIES - No joint swelling or deformity.
NEUROLOGICAL - No obvious motor or sensory deficits.
PSYCHIATRIC - Normal affect

ASSESSMENT:

1. Fatigue - New
2. Impaired Fasting Glucose - Unchanged
3. Hypercholesterolemia - Unchanged
4. Depressive Disorder Nos - Unchanged

PLAN:
1. Fatigue - Request Clinical Summary
2. Fatigue - SLEEP STUDIES
3. Impaired Fasting Glucose - Return Visit in 3 Months
4. Impaired Fasting Glucose - Return for bloodwork

Diet comments: low carb diet
Medications instructions: increase fish oil
Special notes: pt to call if symptoms worsen or do not improve

FOLLOWUP: Return Visit in 3 Months and Return for bloodwork

Entered by: CAREY MCNAMARA, PA-C

Electronically signed by CAREY MCNAMARA, PA-C 3/9/2015 11:26:10

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

05/14/2013

J. Edward Nolan, MD

Current Medications
Percocet
carisoprodol
paroxetine
Paxil
omeprazole
Ambien
Qualaquin
Claritin-D

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
No Hospitalization History.

Review of Systems

Reason for Appointment
1. Low back pain
2. Leg pain
3. Buttocks pain

History of Present Illness
Driver::
Present in office: No.
Anticoagulants::
None: Patient denies anticoagulant use.
Description of pain::
Location: lower back, buttocks, bilateral legs. Onset of pain: work injury (lifting boxes). Date of Onset: 12/2011. Nature: sharp, dull, aching, throbbing, tingling. Severity: 8/10 overall. Timing: constant. Helping factors: lying down. Aggravating factors: bending, lifting, twisting, standing. Associated signs/symptoms 7 hours of sleep per night on average, pain affects physical activities 10/10, pain affects social activities 8/10, pain affects sexual activities 7/10. Pt states feeling discouraged and depressed.
Adjuvant therapies::
Physical Therapy: Yes, no pain relief. Psychological Counseling: yes, currently seeing: Sarah Gainey.
Legal/Work Compensation Issues::
Legal representation/status: Yes, attorney is Max Sparwasser Law.

Vital Signs
Wt 185, Ht 5'6", BP Initial 136/91, HR Initial 94, Temp Initial 97.5, PO2 Initial 99, Pain Initial 8/10.

Examination
General examination:
Appearance: Patient is mildly obese female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Deep tendon reflexes are intact bilateral lower extremities 2+. Sensory function: Sensation is grossly intact bilateral lower extremities. Motor Function: Coordination is normal. Muscle strength is grossly intact bilateral lower extremities. Tone is normal. Skin: patient has erythematous digits of the bilateral lower extremities,

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss. Positive for recent weight gain.
Gastroenterology:
Negative for ulcers, recent blood in stool, recent constipation. Positive for GERD, abdominal pain, recent diarrhea.
Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for joint problems, arthritis, history of fractures. Positive for muscle pain, walking problems.
Neurology:
Negative for history of seizures, stroke, memory loss, headaches, speech/language, dizziness.
Eyes:
Negative for glaucoma, problem with eyes, spots, floaters, cataracts.

Allergy:
Negative for hives/itching, frequent sneezing. Positive for seasonal allergies.
Cardiology:
Negative for chest pain, irregular heartbeats, heart attack/angina.
Endocrinology:
Negative for diabetes, recent decreased appetite, recent increased appetite, thyroid problems.
ENT:
Negative for nose problems, hearing problems, mouth problems.
Hematology/Lymph:
Negative for anemia, bleeding/bruising, history of blood transfusion.
Psychology:
Negative for any psychiatric condition, alcohol abuse, drug abuse, panic attacks. Positive for depression.
Respiratory:
Negative for shortness of breath, lung problems, chronic cough, wheezing.

capillary refill +.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the bilateral S1 nerve distribution nerve distribution to the feet.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)

Treatment
1. LUMBAR POST-LAMINECTOMY
Pt.'s low back pain and leg pain are the areas with the greatest pain and we will treat them on return to clinic.

2. Others
We will take over writing pt Percocet on next appointment, this is when she is due for refill.

Procedures
Transforaminal Steroid Injection, Lumbar::
Level Bilateral L5 nerve root and S1 nerve root.
Procedure note Plan to perform on return to clinic when patient has a driver.

Follow Up
Next available appointment, Block only, for Dr. Nolan



Electronically signed by JOSEPH NOLAN , MD on 05/29/2013 at 08:34 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

05/15/2013

J. Edward Nolan, MD

Current Medications
Qualaquin
Ambien
omeprazole
Paxil
paroxetine
carisoprodol
Percocet
Claritin-D

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
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Family History
Father: alive
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Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Denies Past Hospitalization

Review of Systems

Reason for Appointment
1. Low back pain
2. Leg pain
3. Buttocks pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: Yes, Donald.
Description of pain::
Location: low back, legs, buttocks. Onset of pain: work injury. Date of Onset: 12/2011. Nature: dull, sharp, aching, tingling, throbbing. Severity: 7/10 overall. Timing: constant. Helping factors: rest, lying down. Aggravating factors: movement.

Vital Signs
BP Initial 149/86, HR Initial 91, Temp Initial 98, PO2 Initial 99, Pain Initial 7/10, BP Proc 144/87, HR Proc 86, PO2 Proc 99, D/C BP 135/87, D/C HR 82, D/C PO2 95, D/C Pain 6/10.

Examination
General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83

Treatment
1. LUMBAR POST-LAMINECTOMY
Pt.'s low back pain and leg pain are the areas with the greatest pain and we will treat them today.

2. THERAPEUTIC DRUG MONITOR
Patient is currently taking Percocet, will perform random UDS to verify compliance with pain medications.

Procedures
Sedation::

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, -, recent diarrhea.
Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for muscle pain, joint pain, joint stiffness, arthritis.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness, leg weakness. Positive for tingling, numbness.

Versed 5 mg, MILLER (LPN),BRITTANY 5/15/2013 4:22:20 PM > .
Synera 2, patches applied, lumbar region, 30 minutes prior to procedure, MILLER (LPN),BRITTANY 5/15/2013 4:32:20 PM > .
Location left, deltoid.
Sedation Level 3/5 (OAA/S).

Supplies/Services::
Skin Prep Betadine x 3.
Needles 25 gauge x 5 inch spinal needle.
Local Anesthetic Lidocaine 1% 5 cc (preservative free).
Steroid Celestone 9 mg (preservative free).
Omnipaque 1 cc.
Other Procedure Tray Epiduragram Conscious Sedation.

Transforaminal Steroid Injection, Lumbar::
Level Bilateral L5 nerve root and S1 nerve root.
Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The appropriate levels were identified using fluoroscopic imaging. The injection site was anesthetized as noted above. A 25 gauge Quincke spinal needle as noted above was directed to the 6 o'clock position of the pedicle using a line of site approach with the C-arm rotated in an oblique view and advanced to the mid-point of the neural foramen. Needle position was confirmed using both AP and oblique views with lateral views used as needed. Aspiration was negative for CSF, heme, and air, No paresthesias were elicited during needle placement. Radiopaque dye was injected as noted above to confirm needle placement. No evidence of intravascular or intrathecal placement was observed. The steroid noted above was injected in equal doses at each site. The needle was flushed with the local anesthetic noted above and removed intact. The skin was then cleansed and a sterile dressing applied to the injection sites.
Fluoroscopy Time 24 SEC.
Complications None, the patient tolerated the procedure well and no complications were encountered.

Epiduragram::
Procedure Note An epiduragram was performed using fluoroscopic imaging with the following results:.
Omnipaque dye 1 cc injected into the epidural space.
Bony structure intact.
Pressure required normal.
Pain on injection moderate.
Filling defects a moderate amount of filling defects superiorly.
Contrast flow moderate obstruction to flow inferiorly.
IMPRESSION moderate epidural inflammation moderate obstruction to contrast flow within the epidural space.

Electrical Stimulation/Modalities::
Application of Modalities Pt. refused ice.

Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition.
Discharge The patient was instructed to avoid driving for 24 hours

discharge instructions were given to the patient, patient was discharged with vital signs stable.

Labs

Lab: UDS Testing	6 PANEL UDS+THC DIP
THC	NEG
Cocaine	NEG
Opiates	NEG
Amphetamines	NEG
Methamphetamine	NEG
Benzodiazepines	NEG
Oxycodone	POS

West,Brittney 5/15/2013 5:40:42 PM >

Procedure Codes

80104 DRUG SCRN 1+ CLASS NONCHROMO

Follow Up

2 Weeks, for Allison Davis, NP-C, Injection Eval to see if patient requires further injections



Electronically signed by JOSEPH NOLAN , MD on 05/29/2013 at 02:22 PM EDT

Sign off status: Completed

TRIDENT PAIN CENTER
9267 G MEDICAL PLAZA DR
N CHARLESTON, SC 29406-9139
Tel: 843-797-3636
Fax: 843-797-3637

TRIDENT
PAIN CENTER

PATE, PATRICIA

[illegible] 0
[illegible], [illegible] 0
Home: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

06/03/2013

Allison Davis, NP-C

Current Medications
Ambien
Qualaquin
Percocet-5/325
Claritin-D
Percocet
carisoprodol
paroxetine
Paxil
omeprazole

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
No Hospitalization History.

Reason for Appointment
1. Low back pain
2. Buttocks pain
3. Leg pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: Yes.
Description of pain::
Location: lower back, legs, buttocks. Onset of pain: work injury. Date of Onset: 12/2011. Nature: burning, aching, numbness. Severity: 7/10 overall. Timing: constant. Helping factors: rest, lying down. Aggravating factors: sitting.
Pain relief from previous injection::
Date: 05/15/13. Injection: Lumbar, transforaminal epidural injection. Pain relief: significant (>80%) initial pain relief, of leg pain. Duration of relief: the pain has slowly returned since the last injection.

Vital Signs
Wt 188, Ht 5'6, BP Initial 118/75, HR Initial 90, Temp Initial 96.6, PO2 Initial 99, Pain Initial 6/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the bilateral S1 nerve distribution nerve distribution to the feet.

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss. Positive for recent weight gain.
Gastroenterology:
Negative for ulcers, recent blood in stool, recent constipation. Positive for GERD, abdominal pain, recent diarrhea.
Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for joint pain, joint stiffness, arthritis. Positive for muscle pain.
Neurology:
Negative for headaches, dizziness, arm weakness, leg weakness. Positive for tingling, numbness, insomnia.

Assessments

1. LUMBAR DISC DISPLACEMENT - 722.10 (Primary)

Treatment

1. LUMBAR DISC DISPLACEMENT
Start Gralise tablet, 600 mg/24 hours, 3 tab(s), orally, once a day, 30 day(s), 90, Refills 0
Pt.'s low back pain and leg pain are the areas with the greatest pain and we will treat it upon return to clinic after authorization. We will also start her on Gralise today to treat her radicular symptoms.

Procedures

Transforaminal Steroid Injection, Lumbar:
Level Bilateral L5 nerve root and S1 nerve root.
Procedure note Plan to perform on return to clinic, after authorization.

Follow Up

Block only, for Dr. Nolan,after authorization

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 06/25/2013 at 03:14 PM EDT

Sign off status: Completed

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TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

06/14/2013 Allison Davis, NP-C

Current Medications
Gralise
omeprazole
Paxil
paroxetine
carisoprodol
Percocet
Claritin-D
Percocet-5/325
Qualaquin
Ambien

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: back, leg. Onset of pain: work injury. Date of Onset: 12/2011. Nature: shooting, aching. Severity: 8/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: bending.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the bilateral S1 nerve distribution nerve distribution to the feet.

Assessments
1. LUMBAR DISC DISPLACEMENT - 722.10 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. LUMBAR POST-LAMINECTOMY - 722.83

Treatment

1. LUMBAR DISC DISPLACEMENT

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, recent blood in stool, ulcers, recent constipation. Positive for recent diarrhea.
Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for joint pain, joint stiffness, arthritis. Positive for muscle pain.
Neurology:
Negative for headaches, tingling, numbness, insomnia, arm weakness, leg weakness. Positive for dizziness.

Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 0
Stop Gralise tablet, 600 mg/24 hours, 3 tab(s), orally, once a day, 30 day(s), 90
Start Lyrica capsule, 50 mg, 1 cap(s), orally, 2 times a day, 30 day(s), 60, Refills 0
Counseled patient on their current medication regimen and discussed how they are tolerating it. Discussed this patient with the attending physician and this treatment plan was decided upon. Pt reports increased mental fogginess and increased sedation level so we will stop Gralise and try her on Lyrica to see if these side effects subside.
Pt continues to wait for her authorization for her injection.

2. THERAPEUTIC DRUG MONITOR
OXY dip performed today to verify compliance with medication policy.

Labs

Lab: UDS Testing	OXY SINGLE DIP
Oxycodone	POS

TODD,SHAKIMA L 6/14/2013 4:40:19 PM >

Procedure Codes
80101 DRUG SCREEN, SINGLE

Follow Up
4 Weeks, for Kristen Giet, PA-C, Medication refill



Electronically signed by JOSEPH NOLAN , MD on 07/09/2013 at 02:41 PM EDT

Sign off status: Completed

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TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

06/18/2013

Kristen Giet, PA

Current Medications
paroxetine
Paxil
omeprazole
Ambien
Qualaquin
Claritin-D
Percocet
carisoprodol

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: Donald.
Description of pain::
Location: back, leg. Onset of pain: work injury. Date of Onset: 12/2011. Nature: sharp, aching, throbbing, tingling. Severity: 7/10 overall. Timing: constant. Helping factors: percocet. Aggravating factors: moving around, bending over. Significant issues: Patient fell last Friday 06/14/2013.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the bilateral S1 nerve distribution nerve distribution to the feet.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)

Treatment

1. LUMBAR POST-LAMINECTOMY
Stop Lyrica, 50 mg
Start Amrix capsule, extended release, 15 mg, 1 cap(s), orally, once a

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss. Positive for recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, kidney disease, bladder problems.
Musculoskeletal:
Negative for joint pain, arthritis. Positive for muscle pain, joint stiffness.
Neurology:
Negative for headaches, arm weakness, leg weakness, insomnia. Positive for dizziness, tingling, numbness.

day, at dinnertime, 30 days, 30, Refills 0
Start Naprelan 750 tablet, extended release, 750 mg (as sodium), 1 tab (s), orally, once a day, 30 day(s), 30, Refills 0
Patient in office today to discuss Lyrica. Pt reports that this medication caused sedation. Will stop Lyrica at this time and will start Naprelan and Amrix.
Pt advised to start taking Naprelan first and then she can take the Amrix. She will start Amrix on the weekend in case she has any sedation issues.

Follow Up
Keep previous appointment



Electronically signed by JOSEPH NOLAN , MD on 06/25/2013 at 08:32 AM EDT

Electronically co-signed by KRISTEN (PA-C) GIET on 07/17/2013 at 11:11 AM EDT

Sign off status: Completed

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TRIDENT
PAIN CENTER

PATE, PATRICIA

[illegible]: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

07/23/2013

Allison Davis, NP-C

Current Medications
omeprazole
Ambien
Percocet-5/325
Qualaquin
Claritin-D
carisoprodol
Amrix
Naprelan 750
Paxil

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: lower back, leg. Onset of pain: work injury. Date of Onset: 12/2011. Nature: shooting. Severity: 7/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: standing, sitting, bending.
Pain relief from previous injection::
Date: 07/09/13. Injection: Lumbar transforaminal epidural injection. Pain relief: moderate (>50%) initial pain relief, of low back pain. Duration of relief: the pain is still not back to its original level.

Vital Signs
Wt 190, Ht 5'6", BP Initial 143/90, HR Initial 90, Temp Initial 97.8, PO2 Initial 97, Pain Initial 7/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Radiating Symptoms: mild lumbar radiculitis pain with ROM S1 nerve distribution to the foot which is tingling, that is intermittent in nature.

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss. Positive for recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness. Positive for tingling, numbness, leg weakness.

Assessments

1. LUMBAR FACET ARTHROPATHY - 721.3 (Primary)

Treatment

1. LUMBAR FACET ARTHROPATHY
Start Tizanidine Hydrochloride tablet, 4 mg, 2 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 0
Pt.'s low back pain is the area with the greatest pain and we will treat it upon return to clinic after authorization. Pt reports starting a rash after starting Amrix. We will switch her to Zanaflex today to see if she tolerates it better.

Procedures

Facet, Lumbar Injection::
Level Bilateral L3/L4, L4/L5, L5/S1.
Procedure note Plan to perform on return to clinic, after authorization.

Follow Up

Block only, for Dr. Nolan,after authorization



Electronically signed by JOSEPH NOLAN , MD on 07/29/2013 at 08:51 AM EDT

Sign off status: Completed

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TRIDENT
PAIN CENTER

PATE, PATRICIA

[illegible]
Home: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

09/05/2013

J. Edward Nolan, MD

Current Medications
Percocet-5/325
Qualaquin
Claritin-D
carisoprodol
Amrix
Naprelan 750
Paxil
Tizanidine Hydrochloride
omeprazole
Ambien

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Pain relief from previous injection::
Date: 08/01/13. Injection: Lumbar facet injection. Pain relief: moderate (>50%) initial pain relief upper lower back. Duration of relief: still benefiting from some relief in the upper lower back but still remains significant in the lower back
Description of pain::
Location: low back, leg. Onset of pain: lifting injury. Date of Onset: 12/11. Nature: sharp, aching, burning, tingling, shooting. Severity: 6/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: bending, sitting.

Vital Signs
Ht 5'6", BP Initial 148/95, HR Initial 95, Temp Initial 96.5, PO2 Initial 99, Pain Initial 6/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints. Radiating Symptoms: moderate lumbar radiculitis pain with ROM S1 nerve distribution to the foot which is tingling, that is intermittent in nature.

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness, leg weakness. Positive for tingling, numbness.

Assessments

1. LUMBAR DISC DISPLACEMENT - 722.10 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. LUMBAR FACET ARTHROPATHY - 721.3

Treatment

1. LUMBAR DISC DISPLACEMENT
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, TID PRN PAIN, DO NOT FILL UNTIL 08/07/13, 30 day(s), 90, Refills 0
Continue Tizanidine Hydrochloride tablet, 4 mg, 2 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 0
Start Cymbalta delayed release capsule, 60 mg, 1 cap(s), orally, once a day, 30 day(s), 30, Refills 0
Counseled patient on their current medication regimen and discussed how they are tolerating it. Discussed this patient with the attending physician and this treatment and procedure plan was decided upon. Patient denies any significant side effects that need to be addressed. We will also start pt on Cymbalta for additional increased pain control as she desires another non narcotic pain option, I believe this will be a better option for her than the Paxil she is currently taking.
Pt.'s radicular leg pain is the area with the greatest pain and we will treat it upon return to clinic after auth.

2. THERAPEUTIC DRUG MONITOR
Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate.

Procedures

Epidural, Lumbar Steroid Injection::
Level Left L5/S1.
Procedure note plan to perform on return to clinic, after authorization.

Labs

Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	POS

TODD,SHAKIMA L 9/5/2013 11:44:51 AM > sent to in house lab ADKINS,GINA 9/5/2013 3:33:34 PM > IN HOUSE UDS

Procedure Codes

TRIDENT
PAIN CENTER

PATE, PATRICIA

[illegible], SC 29410

Guarantor: PATE, PATRICIA Insurance: [illegible]
ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

10/04/2013

Kristen Giet, PA

Current Medications
Ambien QHS
Cymbalta 60 mg delayed release capsule 1 cap (s) once every two day
Percocet-5/325 5/325mg TID PRN
Qualaquin QHS
Claritin-D daily
carisoprodol PRN
Tizanidine Hydrochloride 4mg 2 tablets TID PRN

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: lower back. Onset of pain: work injury. Date of Onset: 12/2011. Nature: aching, burning, tingling, shooting. Severity: 5/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: sitting too long standing.

Vital Signs
Ht 5'6", BP Initial 128/89, HR Initial 85, Temp Initial 96.7, PO2 Initial 99, Pain Initial 5/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the left lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine. Iliac crest: moderate pain at the left iliac crest with extenstion and rotation of the spine.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. LUMBAR FACET ARTHROPATHY - 721.3

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.

Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation. Positive for recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.

Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.

Musculoskeletal:
Negative for muscle pain, joint pain, joint stiffness, arthritis.

Neurology:
Negative for dizziness, arm weakness, leg weakness. Positive for headaches, tingling, numbness, insomnia.

5. MUSCLE SPASMS - 728.85

Treatment

1. LUMBAR POST-LAMINECTOMY
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, TID PRN PAIN, 90, Refills 0
Discussed this patient with the attending physician and this treatment plan was decided upon. Patient denies any significant side effects that need to be addressed. Pt reports that numbness and tingling in LE has been reduced from last injection. She is also doing well with Percocet although she is having some diarrhea with Cymbalta. She has reduced to every other day but continues to have loose stool 3-4 times per day. We will have her discontinue the Cymbalta at this time to see if bowels resolve and then restart to see if diarrhea returns.

2. THERAPEUTIC DRUG MONITOR
Urinary drug screen performed today to assess patient's compliance in taking prescribed medications as well as to assess for the use of non prescribed prescription medications and illicit substances that will help determine the appropriate future pain management medication options.

3. MUSCLE SPASMS
Continue Tizanidine Hydrochloride tablet, 4 mg, 2 tab(s), orally, TID PRN PAIN, 30 day(s), 90, Refills 2

4. Others
Pt is continues to work full time. She reports that it has been difficult due to pain however they have hired another employee which should help. Per Dr Nolan, we will address MMI status, IR, and treatment plan at November 26, 2013 appt.

Labs

Lab: UDS Testing

TODD,SHAKIMA L 10/4/2013 10:38:04 AM > Specimen sent to lab GIET,KRISTEN (PA-C) R 10/4/2013 11:21:09 AM > millennium

Follow Up
4 Weeks, Medication refill, for Kristen Giet, PA-C

Electronically signed by JOSEPH NOLAN , MD on 10/29/2013

TRIDENT
PAIN CENTER

PATE, PATRICIA

Home: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

11/01/2013

Kristen Giet, PA

Current Medications
Ambien QHS
Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) TID PRN PAIN
Claritin-D daily
Cymbalta 60 mg delayed release capsule 1 cap (s) once every two day
quinine 324 mg capsule 2 cap(s) at bedtime
omeprazole 40 mg delayed release capsule 1 cap(s) once a day
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Reason for Appointment
1. Low back pain
2. Leg pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.
Description of pain::
Location: lower back, leg. Onset of pain: work injury. Date of Onset: 12/2011. Nature: sharp, aching, burning, throbbing, tingling, shooting. Severity: 9/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: standing, sitting, bending, getting up and down.

Vital Signs
Ht 5'6", BP Initial 121/86, HR Initial 93, Temp Initial 97.9, PO2 Initial 99, Pain Initial 9/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the left lumbar paraspinous musculature in a bandlike distribution. Radiating Symptoms: moderate lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the foot.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent fatigue, recent weight loss. Positive for night sweats, recent weight gain.

Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia, arm weakness. Positive for tingling, numbness, leg weakness.

Treatment
1. LUMBAR POST-LAMINECTOMY
Decrease Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to BID, 30, Refills 0
Start OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, every 12 hours, 30 day(s), 30, Refills 0
Discussed this patient with the attending physician and this treatment plan was decided upon. Pt reports that she is having to double up on her Percocet due to increased pain. She reports it is not often but she has difficulties at work with getting up and down. She has work restrictions from Dr. Stuart's office however she has trouble following restrictions at work. She does get some more relief from taking an extra dose of Percocet. We will reduce Percocet to BID and will start OxyContin.

2. THERAPEUTIC DRUG MONITOR
Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate.

Labs
Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	POS

Seagraves,Lindsay 11/1/2013 10:50:48 AM > Collected specimen in house only ADKINS(MLT),GINA 11/1/2013 12:29:19 PM > IN HOUSE UDS

Procedure Codes
82570 ASSAY OF URINE CREATININE
82055 ASSAY OF ETHANOL
80101 DRUG SCREEN, SINGLE

Follow Up
2 Weeks, Medication refill, for Kristen Giet, PA-C



TRIDENT
PAIN CENTER

PATRICIA

Home: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

11/15/2013

Kristen Giet, PA

Current Medications
Claritin-D daily
Tizanidine Hydrochloride 4 mg tablet 2 tab(s) TID PRN PAIN
Ambien QHS
OxyContin 10 mg tablet, extended release 1 tab(s) every 12 hours
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to BID
omeprazole 40 mg delayed release capsule 1 cap(s) once a day
quinine 324 mg capsule 2 cap(s) at bedtime
Cymbalta 60 mg delayed release capsule 1 cap (s) once every two day

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Reason for Appointment
1. Low back pain

History of Present Illness
Description of pain::
Location: lower back. Onset of pain: work injury. Date of Onset: 12/2011. Severity: 5/10 overall. Timing: constant. Helping factors: pain medications. Aggravating factors: bending, standing, sitting.
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: No.

Vital Signs
Ht 5'6", BP Initial 125/88, HR Initial 105, Temp Initial 97.6, PO2 Initial 98, Pain Initial 5/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical.

Physical Examination
Lumbo/Sacral::
Lumbar: moderate pain in the left lumbar paraspinous musculature in a bandlike distribution.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, will refill at next appt

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Review of Systems
Constitutional:
Negative for recent fever, recent weight loss. Positive for recent fatigue, night sweats, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, insomnia, arm weakness. Positive for dizziness, tingling, numbness, leg weakness.

Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to BID, 10, Refills 0
Discussed this patient with the attending physician and this treatment plan was decided upon. Patient reports that the OxyContin originally caused significant fatigue when she was taking it BID so she reduced to qhs. This has helped her significantly at night but she cannot take it during the day. She is hesitant to take more Percocet because she thinks that it still makes her feel strange. She will try and halve the Percocet during the day to see if this helps but she is aware that she cannot halve the OxyContin. She saw Dr. Stuart yesterday who advised her that she did not need further surgery at this time. Pt has an appt coming up with Dr. Nolan and has enough OxyContin to get to that appt. We will give her #10 Percocet to get to that appt.

2. THERAPEUTIC DRUG MONITOR
Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate.

Labs

Lab: UDS Testing	
Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	POS
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	POS

TODD,SHAKIMA L 11/15/2013 9:31:57 AM > urine collected, in house lab only ADKINS(MLT),GINA 11/15/2013 10:15:48 AM > IN HOUSE UDS

Procedure Codes
82570 ASSAY OF URINE CREATININE
82055 ASSAY OF ETHANOL
G0431 DRUG SCR QUAL; MULTI CLASS PT ENC

Follow Up
Keep previous appointment



TRIDENT PAIN CENTER, PA
9267-G Medical Plaza Drive, North Charleston, SC 29406
Phone (843) 797-3636 • Fax (843) 797-3637

WORK RESTRICTIONS:

Date: 11/15/13

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☑ The patient may return to work on 11/18/13, **light duty** with the following restrictions:
- ☑ No lifting greater than 15 lbs
- ☑ No bending, squatting, or crawling
- ☐ No pushing/pulling heavy objects

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office 11/26/13. We will update you in regards to the patient's work status at that time. Thank you for your consideration.

Sincerely,

J. Edward Nolan MD / amanda Phillips

J. Edward Nolan, MD
Medical Director

[redacted]

TRIDENT
PAIN CENTER

PATE, PATRICIA

[illegible], SC-29410
Home: 843-554-4305
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

11/26/2013

J. Edward Nolan, MD

Current Medications
omeprazole
Percocet-5/325
OxyContin
Ambien
Tizanidine Hydrochloride
Claritin-D
quinine
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain
2. Gluteus Pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Driver::
Present in office: Yes, Donald.
Pain relief from previous injection::
Date: 09/23/13. Injection: Lumbar epidural steroid injection. Pain relief: significant (>80%) initial pain relief of low back pain and of leg pain. Duration of relief: the pain has slowly returned since the last injection.
Description of pain::
Location: lower back, buttocks. Onset of pain: work injury. Date of Onset: 12/14/2011. Nature: aching, burning, throbbing, tingling. Severity: 6/10 overall. Timing: constant. Helping factors: pain medications, rest. Aggravating factors: getting up and down.

Vital Signs
Wt 184, Ht 5'6", BP Initial 113/88, HR Initial 83, Temp Initial 96.8, PO2 Initial 94, Pain Initial 6/10.

Examination
General examination:
Appearance: Patient is a well-developed well-nourished female in distress appropriate to pain complaint. Patient is well groomed with an appropriate affect for pain complaint. Mental status: Patient is alert, awake and oriented X 3. Short and long term memory intact. Normal language skills and normal fund of knowledge. Cranial N./Reflexes Cranial n. 2-12 intact and symmetrical. Sensory function: decreased sensation in left lower extremity. Motor Function: Coordination is normal. Muscle strength is decreased 4/5 (good) left lower extremity. Tone is normal. Gait is antalgic.

Physical Examination

Lumbo/Sacral::
Lumbar: moderate pain in the bilateral lumbar paraspinous musculature in a bandlike distribution with extension and rotation of the spine with tenderness to palpation overlying the facet joints L>>R.

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.

Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin sores, skin cancer. Positive for recent skin rash.

Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.

Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.

Neurology:
Negative for headaches, insomnia, arm weakness. Positive for dizziness, tingling, numbness, leg weakness.

Sacro-Iliac Joint:: moderate to severe pain on the left with pelvic compression and to palpation.

Hip/Lower extremities::
Lower extremity moderate to severe in the left Posterior Femoral Cutaneous Nerve distribution and Lateral Femoral Cutaneous Nerve distribution to the knee.

Assessments

1. LUMBAR FACET ARTHROPATHY - 721.3 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. LUMBAR POST-LAMINECTOMY - 722.83
5. SI JOINT PAIN - 724.6

Treatment

1. LUMBAR FACET ARTHROPATHY

Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, 30
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, 90, Refills 0
Pt.'s low back pain is the area with the greatest pain and we will treat it on return to clinic. I am not ready to place at MMI at this point. I would like to see how treating her low back in conjunction with her SI joint provides relief. We will renew work restrictions today, no lifting over 15 lbs, no bending, squatting, or crawling, no pushing/pulling heavy objects. She is also not to be getting up and down more than 10 times a day. Job should remain more sedentary.

2. THERAPEUTIC DRUG MONITOR

Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate.

3. LUMBAR POST-LAMINECTOMY

Pt has seen Dr. Stuart recently and has been told that he is unable to surgically intervene in her pain control at this time.

4. SI JOINT PAIN

Pt's SI joint pain is significant and we will also treat this area on return to clinic after authorization.

Procedures

Transforaminal Steroid Injection, Lumbar::
Level Bilateral L4 nerve root, L5 nerve root, and Left S1 nerve root.

Procedure note Plan to perform on return to clinic, after authorization.

Sacro-Iliac Joint Injection::
Location Left.
Procedure note plan to perform on return to clinic, after authorization.

Labs

Lab: UDS Testing

TRIDENT PAIN CENTER
J. Edward Nolan, MD · Kristen R. Giet, PA-C
9267-G Medical Plaza Drive, North Charleston, SC 29406
P (843) 797-3633 · F (843) 797-3637
www.tridentpaincenter.com

WORK RESTRICTIONS:

Date: 11/26/13

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☒ The patient may return to work on 11/26/13, **light duty** with the following restrictions:
- ☒ No lifting greater than 15 lbs
- ☒ No bending, squatting, or crawling
- ☒ No pushing/pulling heavy objects

Pt is not to get up and down more than 10 times/day Stay seated as much as possible

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office TBT likely 1/15/14 will update you in regards to the patient's work status at that time. Thank you for your consideration.

Sincerely,

J. Edward Nolan, MD
Medical Director

[redacted] 247

TRIDENT
PAIN CENTER

PATE, PATRICIA

[redacted], SC 29410
Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

12/13/2013 J. Edward Nolan, MD

Current Medications
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
OxyContin 10 mg tablet, extended release 1 tab(s) qhs
quinine
Claritin-D
Tizanidine Hydrochloride
Ambien
omeprazole
Medication List reviewed and reconciled with the patient

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure

Reason for Appointment
1. Low back pain
2. Hip pain

History of Present Illness
Anticoagulants::
None: Patient denies anticoagulant use.
Description of pain::
Location: lower back, hip L>R. Onset of pain: lifting injury. Date of Onset: 12/11. Nature: aching, dull, numbness, tingling, burning, throbbing. Severity: 8/10 overall. Timing: worse in the evening, intermittent. Helping factors: injections by this clinic, pain medications, rest. Aggravating factors: activity, house work.
Driver::
Present in office: Yes, Donald.

Vital Signs
Wt 185, Ht 5'6", BP Initial 127/87, HR Initial 88, Temp Initial 97.3, PO2 Initial 97, Pain Initial 8/10, BP Proc 118/82, HR Proc 95, PO2 Proc 96, D/C BP 121/81, D/C HR 84, D/C PO2 99, D/C Pain 3/10.

Examination
General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments
1. LUMBAR POST-LAMINECTOMY - 722.83 (Primary)
2. LONG-TERM USE MEDS NEC - V58.69
3. THERAPEUTIC DRUG MONITOR - V58.83
4. SI JOINT PAIN - 724.6

Treatment
1. LUMBAR POST-LAMINECTOMY
Continue OxyContin tablet, extended release, 10 mg, 1 tab(s), orally, qhs, DO NOT FILL UNTIL 12/30/13, 30
Continue Percocet-5/325 tablet, 325 mg-5 mg, 1 tab(s), orally, up to TID PRN PAIN, DO NOT FILL UNTIL 12/24/13, 90, Refills 0
Pt.'s low back pain is the area with the greatest pain and we will treat it today.

2. THERAPEUTIC DRUG MONITOR

Patient denies recent hospitalization

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent constipation, , recent diarrhea.
Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease, prostate problems.
Musculoskeletal:
Negative for joint pain, joint stiffness, arthritis. Positive for muscle pain.
Neurology:
Negative for headaches, dizziness, tingling, numbness, insomnia, arm weakness, leg weakness.

Urine drug analysis performed in house today to verify compliance with current drug therapy. In office screen today was appropriate..

3. SI JOINT PAIN
Will treat patient's SI joint pain on return to clinic.

Procedures

Sedation::
Versed 7 mg West,Brittney 12/13/2013 10:49:52 AM > .
Synera 2 patches applied lumbar region 30 minutes prior to procedure West,Brittney 12/13/2013 10:53:06 AM > .
Location left deltoid.
Sedation Level 3/5 (OAA/S).
Supplies/Services::
Skin Prep Betadine x 3.
Needles 25 gauge x 5 inch spinal needle.
Local Anesthetic Lidocaine 1% 5 cc (preservative free).
Steroid Celestone 9 mg (preservative free).
Omnipaque 1 cc.
Other Procedure Tray, Epiduragram, Conscious Sedation.
Transforaminal Steroid Injection, Lumbar::
Level Bilateral L4 nerve root, L5 nerve root, and Left S1 nerve root.

Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The appropriate levels were identified using fluoroscopic imaging. The injection site was anesthetized as noted above. A 25 gauge Quincke spinal needle as noted above was directed to the 6 o'clock position of the pedicle using a line of site approach with the C-arm rotated in an oblique view and advanced to the mid-point of the neural foramen. Needle position was confirmed using both AP and oblique views with lateral views used as needed. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected as noted above to confirm needle placement. No evidence of intravascular or intrathecal placement was observed. The steroid noted above was injected in equal doses at each site. The needle was flushed with the local anesthetic noted above and removed intact. The skin was then cleansed and a sterile dressing applied to the injection sites.
Fluoroscopy Time 25 sec.
Complications None, the patient tolerated the procedure well and no complications were encountered.
Epiduragram::
Procedure Note An epiduragram was performed using fluoroscopic imaging with the following results:.
Omnipaque dye 1 cc injected into the epidural space.
Bony structure intact.
Pressure required normal.
Pain on injection moderate.
Filling defects a moderate amount of filling defects inferiorly on the left.

Contrast flow moderate obstruction to flow, superiorly, on the left.
IMPRESSION moderate epidural inflammation, moderate obstruction to contrast flow within the epidural space.

Sacro-Iliac Joint Injection::
Location Left.
Procedure note plan to perform on return to clinic.

Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition.
Discharge The patient was instructed to avoid driving for 24 hours, discharge instructions were given to the patient, patient was discharged with vital signs stable Pt escorted to driver with written discharge instructions West,Brittney 12/13/2013 12:03:44 PM > .

Labs

Lab: UDS Testing

Benzodiazepines	NEG
Barbiturates	NEG
Amphetamines	NEG
THC	NEG
Opiates	NEG
Cocaine	NEG
Methadone	NEG
Oxycodone	POS
ETOH	NEG
Buprenorphine	NEG
Creatinine	POS

West,Brittney 12/13/2013 10:47:52 AM > Urine collected, send to in house only ADKINS(MLT),GINA 12/13/2013 2:26:58 PM > IN HOUSE UDS

Procedure Codes
82570 ASSAY OF URINE CREATININE
82055 ASSAY OF ETHANOL
80101 DRUG SCREEN, SINGLE

Follow Up
Next available appointment, Block only, for Allison Davis, NP-C, 2 Months, for Allison Davis, NP-C, Injection Eval to see if patient requires further injections

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 01/09/2014

TRIDENT
PAIN CENTER

PATE, PATRICIA

Guarantor: PATE, PATRICIA Insurance: STATE ACCIDENT FUND WC Payer ID: Paper
Referring: JOSEPH E NOLAN
Appointment Facility: TRIDENT PAIN CENTER

12/17/2013

Allison Davis, NP-C

Current Medications
omeprazole
Percocet-5/325 325 mg-5 mg tablet 1 tab(s) up to TID PRN PAIN
Ambien
OxyContin 10 mg tablet, extended release 1 tab(s) qhs
Tizanidine Hydrochloride
Claritin-D
quinine

Past Medical History
Digestive Problems
Esophageal reflux
Seasonal Allergies
Muscle Pain
Walking Problems
Depression

Surgical History
Gallbladder 1985
Hysterectomy 1998
Back Surgery 2012
Tooth extraction 9/13/2013

Family History
Father: alive
Mother: alive

Social History
Education: High School.
Occupation: Copy Center.
Recent place of employment: College of Charleston.
Work Status: Full Time.
Injured at work: Yes.
Marital Status: Married.
no Children.
Smoking: 1/2 pack per day for 15 years, Quit 2003.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Patient denies recent hospitalization

Reason for Appointment
1. Low back pain

History of Present Illness
Driver::
Present in office: No.
Anticoagulants::
None: Patient denies anticoagulant use.
Description of pain::
Location: lower back. Onset of pain: lifting injury. Date of Onset: 12/15/11. Nature: dull, aching. Severity: 5/10 overall. Timing: constant. Helping factors: injections by this clinic, pain medications, rest. Aggravating factors: bending, getting up and down.

Vital Signs
Wt 183, Ht 5'6", BP Initial 129/87, HR Initial 90, Temp Initial 97.2, PO2 Initial 94, Pain Initial 5/10, D/C BP 121/84, D/C HR 86, D/C PO2 99, D/C Pain 5/10.

Examination
General examination:
Patient evaluated on previous visit and is here for an injection only today.

Assessments
1. SI JOINT PAIN - 724.6 (Primary)

Treatment
1. SI JOINT PAIN
Pt's SI joint pain is the area of greatest pain and we will treat it today.

Procedures
Sedation::
Versed Patient refused.
Supplies/Services::
Skin Prep Betadine x 3.
Needles 25 gauge x 3.5 inch spinal needle.
Local Anesthetic Lidocaine 1% 2 cc (preservative free).
Steroid Celestone 4.5 mg (preservative free) Wasted — Celestone 4.5 mg (preservative free).
Omnipaque No Omnipaque was used.
Other Procedure Tray Fluoroscopy.

Review of Systems

Constitutional:
Negative for recent fever, recent fatigue, night sweats, recent weight loss, recent weight gain.
Gastroenterology:
Negative for GERD, abdominal pain, ulcers, recent blood in stool, recent constipation, recent diarrhea.

Dermatology:
Negative for recent skin rash, recent skin sores, skin cancer.
Genitourinary:
Negative for urinary tract infections, bladder problems, kidney disease.
Musculoskeletal:
Negative for arthritis. Positive for muscle pain, joint pain, joint stiffness.
Neurology:
Negative for headaches, dizziness, insomnia. Positive for tingling, numbness, arm weakness, leg weakness.

Sacro-Iliac Joint Injection::
Location Left.
Procedure note Informed consent was obtained from the patient. The patient was placed in the prone position in the fluoroscopy suite. Appropriate monitors were applied. The skin was prepped X 3 as noted above and draped in a sterile fashion. The sacro-iliac joints were identified using fluoroscopic imaging. The injection site overlying the sacro-iliac joint was anesthetized as noted above. A spinal needle as noted above was advanced to each sacro-iliac joint under fluoroscopic guidance. Placement was confirmed with multiple views. Aspiration was negative for CSF, heme, and air. No paresthesias were elicited during needle placement. Radiopaque dye was injected in divided doses at each site. No evidence of intravascular or intrathecal placement was observed. A solution containing the appropriate medication as noted above was injected in divided doses. The needle was flushed and removed intact from the skin. The skin was cleansed and a sterile dressing applied to the injection sites.
Fluoroscopy Time 5 sec.
Complications None, the patient tolerated the procedure well and no complications were encountered.
Recovery and Discharge:
Recovery The patient was was taken to the recovery room and monitored until alert, awake, and in oriented condition.
Discharge The patient was instructed to avoid driving for 24 hours discharge instructions were given to the patient, patient was discharged with vital signs stable.

Follow Up
Keep previous appointment

J. Nolan MD

Electronically signed by JOSEPH NOLAN , MD on 01/08/2014 at 03:07 PM EST

Electronically co-signed by ALLISON DAVIS (NP-C) on 08/11/2014 at 09:32 AM EDT

Sign off status: Completed

TRIDENT PAIN CENTER

J. Edward Nolan, MD · Kristen R. Giet, PA-C
9267-G Medical Plaza Drive, North Charleston, SC 29406
P (843) 797-3636 F (843) 797-3637
www.tridentpaincenter.com

WORK RESTRICTIONS:

Date: 1/7/14

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☒ The patient may return to work on Continued from 11/26/13, **light duty** with the following restrictions:

- ☒ No lifting greater than 15 lbs
- ☒ No bending, squatting, or crawling
- ☒ No pushing/pulling heavy objects

Pt is not to get up and down more than 10x/day. Pt is to stay seated as much as possible.

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office 2/13/14. We will update you in regards to the patient's work status at that time. Thank you for your consideration.

Sincerely,

Allison Davis, NP-C

J. Edward Nolan, MD / Allison Davis, NP-C
Medical Director

[redacted]

SOUTH CAROLINA
STATE ACCIDENT FUND

HARRY B. GREGORY, JR., Director

February 26, 2014

Dr. Edward Nolan
Tirdent Pain Center
9267 G Medical Plaza Dr
N Charleston, SC 29406

Re: Patricia Pate vs COLLEGE OF CHARLESTON
SF#: 2011-004217
WCC#: 1121370
D/A: 12/14/2011
DOB:

Dr. Nolan,

Please answer the following questions on the above named patient. We need this information in order to properly process her claim.

You recently placed Ms. Pate at maximum medical improvement on 2/13/14.

Does Ms. Pate have an impairment rating for her injury on 12/14/2011? ☑YES ☐NO

If yes, please list 23% DRE Cat IV

If yes, is it inclusive of or in addition to the 40% to the lumbar spine given to her by Dr Marzluff on 09/19/2012? ☑Inclusive Of ☐In Addition To

Thank you in advance for answering these questions. Feel free to contact this office with any questions or concerns you may have regarding this information.

Thanks and have a great day!

Jennifer Stone
Claims Adjuster
State Accident Fund
P.O. Box 102100
Columbia, SC 29221
Phone: 803-896-5913
Fax: 803-612-2715

2-10-14

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SOUTH CAROLINA
STATE ACCIDENT FUND

HARRY B. GREGORY, JR., Director

April 2, 2014

Dr. Edward Nolan
Trident Pain Center
9267 G Medical Plaza Drive
N Charleston, SC 29406

Re: Patricia Pate vs COLLEGE OF CHARLESTON
SF#: 2011-004217
WCC#: 1121370
D/A: 12/14/2011
DOB:

Dr Nolan,

Please inform this office if the above named claimant may continue her current job duties. Attached is her job description and her FCE. Please check one of the boxes below so we may inform her employer if her current job is acceptable given her restrictions. We appreciate your assistance in this matter.

☑Yes ☐NO

Thanks and have a great day!

Jennifer Stone
Claims Adjuster
State Accident Fund
P.O. Box 102100
Columbia, SC 29221
Phone: 803-896-5913
Fax: 803-612-2715

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TRIDENT PAIN CENTER

J. Edward Nolan, MD • Allyson J. Thatcher, MD • Kristen R. Giet, PA-C • Allison F. Davis, NP-C
9267-G Medical Plaza Drive, North Charleston, SC 29406
108 North Highway 52, Moncks Corner, SC 29461
(P) 843-797-3636 (F) 843-797-3637
www.tridentpaincenter.com

WORK RESTRICTIONS:

Date: 4/23/14

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☑ The patient may return to work on 4/24/14, **light duty** with the following restrictions:

- ☑ No lifting greater than 15 lbs
- ☐ No bending, squatting, or crawling
- ☐ No pushing/pulling heavy objects

Standing no more than 1 hour at a time then must sit at least 2 hours. may require 5-10 min breaks during this time to briefly change position.

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office _____. We will update you in regards to the patient's work status at that time. Thank you for your consideration.

Pt cannot perform medium workload daily. FCE increased her pain.

Sincerely,

J. Edward Nolan MD | KRUMA

J. Edward Nolan, MD
Medical Director

TRIDENT PAIN CENTER
FOR ALL • QUALITY OF LIFE

9267-G Medical Plaza Dr.
N. Charleston, SC
29406

108 N. Hwy 52
Moncks Corner, SC
29461

302 Medical Park Dr.,
Ste 207-A
Walterboro, SC
29488

Coming Soon
1341 Old Georgetown Rd.
Mt. Pleasant, SC
29464

Phone
843-797-3636

Fax
843-797-3637

Web
tridentpaincenter.com

10/3/14

Patient: Patricia Pate
DOB:

To Whom It May Concern:

This letter is in reference to Ms. Patricia Pate whom I have been treating for her work injury sustained on 12/2011. She has been under my care since 5/14/2013. Recently she has been hospitalized on 9/17/14 resulting in a diagnosis of pulmonary embolism which will require daily use of an anticoagulant for a period of approximately 6 months. The addition of this medication will hinder my ability to continue injection therapy until this issue has resolved. She has received benefit from injection therapy and with treatment she continued to perform her job duties.

She presented to my office today and on exam I am concerned about her ability to continue to perform her job as required. In light of this and our inability to resume injection therapy until her pulmonary embolisms are resolved, I recommended that she be placed out of work for a period of two (2) months and her work status will be evaluated at each visit to our office to determine if she is able to return to work at that time. Several measures have been taken to try to provide her some form of pain relief to include increasing pain medication strength and frequency and adding physical therapy until we are able to resume treatment with injection therapy.

Sincerely,

J. Edward Nolan, MD
Board Certified Interventional Pain Management
JEN/afd

ROPER ST. FRANCIS PHYSICIAN PARTNERS

PCP: Donald T Hanna

PATE, PATRICIA

Home: 843-554-4[illegible]
Guarantor: PATE, PATRICIA

Appointment Facility: Chas Neurosurgical Associates NC

11/13/2013

R. Morgan Stuart, MD

Current Medications

Percocet 5-325 MG Tablet 1 tablet as needed every 6 hrs
Qualaquin
Claritin-D 12 Hour
Omeprazole
Ambien
OxyContin
Medication List reviewed and reconciled with the patient

Past Medical History

SEASONAL ALLERGIES
GERD
MUSCLE PAIN
DEPRESSION

Surgical History

CHOLECYSTECTOMY 1985
HYSTERECTOMY 1998
TRANSORAMINAL INTERBODY FUSION L4-5 (Dr. Marzluff) 05/15/2012

Family History

Father: alive LBP, CVA
Mother: alive LBP
Spouse: alive
FHX DM, HTN.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

SEE ABOVE

Reason for Appointment

1. FILM REVIEW-XR, MR LSpine at TCR

History of Present Illness

::

The patient presents to the office today for routine scheduled follow up for film review. In the interim since the last office visit she underwent an MRI of the lumbar spine and xrays. Her pain and neurologic complaints are unchanged.

Examination

General Examination:

GENERAL APPEARANCE: alert, well hydrated, in no distress

NEUROLOGIC: unchanged.

Radiographs:

Summary of Radiographic Findings: MRI lumbar spine reveals prior L4-5 interbody fusion with no evidence of complication. There is only mild degenerative disease at the other levels. Xrays reveal no hardware loosening or complication..

Assessments

1. Low Back pain - 724.2 (Primary)

Treatment

1. Low Back pain

Treatment Notes: I reviewed the radiographic findings with the patient in detail. Overall I do not see any complication relating to her prior surgery. There is no advanced adjacent level disease. I am at somewhat of a loss to explain her ongoing pain complaints. I do not feel there is additional surgery indicated at this point. I encouraged her to follow up with Dr. Nolan for additional non-operative pain management strategies. , I spent approximately 15 minutes of face-to -face time with the patient which was entirely devoted to counseling and coordination of care.

Follow Up

prn



Electronically signed by R MORGAN STUART MD on 11/15/2013 at 01:34 PM EST

Sign off status: Completed

Chas Neurosurgical Associates NC
9275 B MEDICAL PLAZA DR
NORTH CHARLESTON, SC 29406-9140
Tel: 843-723-8823
Fax: 843-606-8059

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

WORKSTRATEGIES
Keeping America on the Job!
Select PHYSICAL THERAPY

FUNCTIONAL CAPACITY EVALUATION

NAME: Patricia A. Pate
EMPLOYER: College of Charleston
DATE OF INJURY: 12/14/2011
DATE OF EVALUATION: 3/11/2014
DATE OF REPORT: 3/11/2014
I.D. NO.: 610341961

REFERRED BY: Physician
PHYSICIAN: Dr. Joseph Nolan
INSURANCE CARRIER: State Accident Fund
INSURANCE REP: Katherine Averette, RN
INSURANCE I.D. NO.: 032011004217
DATE OF BIRTH:
SEX: FEMALE

DIAGNOSIS	SIDE (L/R/B)	SURGERY STATUS (Y/N)	SURGERY DATE
1: LUMBAR DISC DISPLACEMENT		Y	09/19/2012

VITAL SIGNS

HEIGHT: 66 inches WEIGHT: 180 lbs. HAND DOMINANCE: RIGHT
RESTING HEART RATE: 95 bpm RESTING BLOOD PRESSURE: 155/84 (B/P) mmHg
STARTING TIME: 3/11/2014 12:50:29 ENDING TIME: 3/11/2014 16:45:51

PURPOSE OF ASSESSMENT: FCE Type: General Abilities;

SUMMARY

Patricia A. Pate demonstrated the ability to occasionally lift up to 25 lbs. Floor to Waist, 25 lbs. Waist to Shoulder, carry up to 25 lbs., push 32 lbs. of force, and pull 36 lbs. of force. Patricia A. Pate demonstrated Constant sitting, Frequent standing, Frequent walking, Frequent stair climbing, Frequent reaching at desk level, Frequent reach floor level, Frequent balancing, Frequent stooping, Frequent kneeling, Frequent crouching, Frequent crawling, Frequent object handling, Frequent fingering, Frequent simple hand grasp, Frequent firm hand grasp, Frequent fine/gross hand manipulation. Patricia A. Pate completed a single stage treadmill test at 2.5 mph and 5% grade. This was sufficient to predict Patricia A. Pate's functional aerobic capacity at 3.18 METS for an 8 hour time period.

Deficits identified during testing include severe limitations in lumbar AROM, weakness in core/trunk musculature, and weakness in bilateral hips left greater than right.

Patricia A. Pate demonstrated consistent performance throughout testing. This, in combination with physiological responses (heart rate and respiratory rate), movement and muscle recruitment patterns both aware and unaware of observation, indicates that the results of this evaluation can be considered to be an accurate representation of Patricia A. Pate's functional abilities.

PHYSICAL DEMAND LEVEL

MEDIUM

Thank you for referring Patricia A. Pate to Select Physical Therapy. If you have any further questions regarding this evaluation, please do not hesitate to contact us.

Professionally,

Evaluator: John Chadwick Ownbey
Title: MPT, Center Manager / Date: 3/17/2014

cc:

Remainder of page intentionally left blank

FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB. [redacted] INSURANCE I.D. NO.: 032011004217

PHYSICAL ABILITIES ASSESSMENT (PAA)

MEDIUM

Material Handling :	Occasional (0 - 33%)	Frequent (33% - 66%)	Constant (66% - 100%)	Job Position	Comments
Lift - Floor to Waist	25	15	N/A		See Comments
Lift - Waist to Shoulder	25	15	N/A		See Comments
Lift - Floor to Shoulder	25	15	N/A		See Comments
Carry - Bimanual	25		N/A		See Comments
Push	32	20	N/A		See Comments
Pull	36	20	N/A		See Comments
Additional Testing:					
N/A	N/A	N/A	N/A		

Positional Tolerance :	Frequency	Job Position	Comments
Sit	Constant		
Stand	Frequent		
Walk	Frequent		
Climb Stairs	Frequent		See Comments
Climb Ladders	Frequent		See Comments
Reach Desk Level	Frequent		
Reach Overhead	Frequent		
Reach Floor Level	Frequent		
Balance	Frequent		
Stoop	Frequent		See Comments
Kneel	Frequent		See Comments
Crouch	Frequent		
Crawl	Frequent		See Comments

Manipulative Ability:	Frequency				Job Position	Comments
Object Handling	Right:	Frequent	Left:	Frequent		R: / L:
Fingering	Right:	Frequent	Left:	Frequent		R: / L:
Simple Hand Grasp	Right:	Frequent	Left:	Frequent		R: / L:
Firm Hand Grasp	Right:	Frequent	Left:	Frequent		R: / L:
Fine Manipulation	Right:	Frequent	Left:	Frequent		R: / L:

Consistency Profile:	Consistent Test Performance	
Maximal Voluntary Effort	Consistent	10 of 10 CV Scores < 15%; 2 of 2 of Bell Shaped Curve Distributions
Pinch Strength Testing	Consistent	6 of 6 CV Scores < 15%
Isometric Push / Pull	Consistent	2 of 2 CV Scores < 15%
Dynamic Lift Test	Consistent	Expected Linear Heart Rate Increase.
Observed Movement Patterns	Consistent	
Waddell's Testing	Not Tested	

Evaluator: John Chadwick Ownbey Date: 3/17/2014

Title: MPT, Center Manager / *Evaluator Signature*

FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB INSURANCE I.D. NO.: 032011004217

SUBJECTIVE HISTORY:

Patricia A. Pate is a 53 year old female with the current diagnosis of lumbar disc displacement, onset 12/14/2011. Patricia A. Pate reports that the injury occurred when she injured her low back attempting to lift a box of paperwork from the floor while at work at the College of Charleston. After failed conservative treatment with her primary care physician (Dr. Donald Hanna), a MRI revealed multi-level lumbar HNP. Client was referred to a back specialist (Dr. Joseph Marzluff-neurosurgeon). Client completed a trail of 3 epidural injections prior to electing to have a lumbar fusion on 05/15/2012 by Dr. Marzluff. Client continues to be treated by pain management Dr. Joseph Nolan to control her low back pain. Client has returned to work but not to full duty. Present symptoms include: a constant dull, ache in low back left > right that intermittently radiates in left lower extremity from her back to her knee that she describes as a numbness/tingling.

Current medication includes: Tizanidine 4 mg, Oxycontin 10 mg, Qualaquin 324 mg, Percocet 5-325 mg, Ambien 10 mg.

Patricia A. Pate reports the following relevant past medical history: unremarkable other than listed surgeries: Gall Bladder 1985, Hysterectomy 1998, Lumbar Fusion 2012.

Previous testing for this injury/illness (as reported by Patricia A. Pate) includes: X-ray- Negative for fracture, Postivie for DDD. MRI- Diffuse spondylosis is mostly mild, with moderate central stenosis at L4-L5. Shallow concentric disc osteophyte complex has superimposed shallow protusion left intro to extraforaminally with associated annular tear.
AND
Previous treatment for this injury/illness includes: Physical Therapy- Atlas Rehab 8-12 weeks after surgery.

Patricia A. Pate reported constant dull, ache across low back left greater than right with intermittent numbness/tingling in left LE from her back to knee at a current intensity of 3 (0 = no pain; 1,2,3 = low; 4,5,6 = moderate; 7,8,9 = severe; 10 = emergency pain). Patricia A. Pate reported that the pain ranges from 2 at best to 8 at its worst. Patricia A. Pate stated that bending, twisting, & stooping aggravates Patricia A. Pate's symptoms, and that injections, pain meds, activity modifications, and rest provides relief. Perceived abilities include: sitting 60 minutes, standing 30 minutes, walking 30 minutes, driving 60 minutes, and lifting 10-15 lbs.

Patricia A. Pate is independent with activities of daily living (ADLs) including: dressing, grooming, bathing, and hygiene. Client is able to do light cooking, clean, and laundry. Client has modified shelf in laundry room to limit stooping. Client does not do heavier household chores such as baseboards, yardwork, or washing cars. Patricia A. Pate describes a typical day as: awakes, gets dressed, drives to work, performs sedentary work demands 8:30-5:00, and does light household chores.

Patricia A. Pate was driven by a family member to/from the FCE appointment today.

Additional Subjective Information includes: N/A

VOCATIONAL/JOB HISTORY:

Patricia A. Pate is currently working on modified duty by the College of Charleston as Assistant Manager in the copy center where she has worked for about five and a half years. A Job Description was received. Information Regarding Job Description was obtained from employer but no specific positional tolerances or material handling requirements were listed. FCE was performed to patient's safe maximal abilities.

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FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB INSURANCE I.D. NO.: 032011004217

MUSCULOSKELETAL SCREENING SUMMARY

Gait:	Client ambulates with a relatively normal gait pattern with a slight decrease in stance time on her left LE.
Posture:	Client presents with a more upright posture than the average individual attempting to protect her low back in a decrease in normal thoracic kyphosis. Client's shoulder and iliac crest levels are normal and equal. Client does demonstrate mild increase in forward head and rounded shoulder.
Soft Tissues:	+TTP= c/o pain right lumbar paraspinals, c/o pain w/wincing left lumbar paraspinals
Flexibility:	Client has normal UE flexibility noted with a normal Apley's test.
Range of Motion:	Refer to Active Range of Motion / Strength Measurements Form
Strength:	Refer to Active Range of Motion / Strength Measurements Form
Neurological:	Client reports diminished sensation throughout entire L UE/LE
Additional Testing:	Core strength- 90-90 hold = 30 seconds pain 3/10; Bridge 3.5" bottom lift hold = 30 seconds pain 3/10; Cogwheel MMT in L UE/LE with regional complaints of pain (numbness/tingling in no known dermatomal pattern in left LE. + Slump L LE; B SLS = 30s+; Able to complete a full squat without lumbar flexion.

ENDURANCE / AEROBIC CAPACITY

Sub-Maximal Treadmill Test ☑ Completed Test ☐ Incomplete Test ☐ Not Tested

VO2max: 28 ml/kg/min 3.18 METS Moderate Work

HR Increase: YES Respiration Increase: YES Blood Pressure: 158/82 mmHg

Comments:
Client was able to walk up to 20 minutes at one time on the treadmill to demonstrate frequent walking at 0-5% incline and 2.0-2.5 mph reporting an increase in LBP as the length of time walking increase. Client reported a peak in LBP as 5/10 post-test.

Remainder of page intentionally left blank

FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB: INSURANCE I.D. NO.: 032011004217

MATERIAL HANDLING

Waist to Shoulder Dynamic Lift Test

Occasional Lift		Heart Rate		RPL	RFT		Frequent Lift		Heart Rate		RPL	RFT
25	lbs.	122	bpm	8	Pain		15	lbs.	130	bpm	7	Pain
Start Heart Rate		101	bpm		HR Increase?	YES	Start Heart Rate:		104	bpm	HR Increase?	YES
Constant Lift N/A .lbs				Heart Rate N/A bpm								

Comments:	Client was able to safely lift up to 25 lbs from waist to shoulder with good mechanics reporting 6/10 LBP. Client requested to stop at 25 lbs secondary to increasing LBP. Client was also able to safely lift up to 15 lbs frequently before requesting to stop secondary to 7/10 LBP. Client was short of breath (SOB) after frequent waist to shoulder lifting.

Floor to Waist Dynamic Lift Test

Occasional Lift		Heart Rate		RPL	RFT		Frequent Lift		Heart Rate		RPL	RFT
25	lbs.	121	bpm	7	Pain		15	lbs.	130	bpm	7	Pain
Start Heart Rate		100	bpm		HR Increase?	YES	Start Heart Rate:		104	bpm	HR Increase?	YES
Constant Lift N/A .lbs				Heart Rate N/A bpm								

Comments:	Client was able to safely lift up to 25 lbs from floor to waist with good mechanics reporting 6/10 LBP. Client requested to stop secondary to increasing LBP at 25 lbs. Client was also able to safely lift up to 15 lbs frequently from floor to waist before requesting to stop secondary to 7/10 LBP that began radiating into her left posterior hip.

Floor to Shoulder Dynamic Lift Test

Occasional Lift		Heart Rate		RPL	RFT		Frequent Lift		Heart Rate		RPL	RFT
25	lbs.	129	bpm	8	Pain		15	lbs.	131	bpm	8	Pain
Start Heart Rate		102	bpm		HR Increase?	YES	Start Heart Rate:		104	bpm	HR Increase?	YES
Constant Lift N/A .lbs				Heart Rate N/A bpm								

Comments:	Client was able to safely lift up to 25 lbs with good mechanics from floor to shoulder before requesting to stop secondary to 6/10 LBP. Client was also able to frequently lift up to 15 lbs with good mechanics reporting 7/10 LBP at the end of the lift.

Lift Capacity Performance: Consistent

Carry Testing

Occasional Carry		Heart Rate		RPL	RFT		Frequent Carry		Heart Rate		RPL	RFT
25	lbs. Bimanual	115	bpm	7	Pain			lbs.		bpm		
N/A	lbs Right	N/A	bpm	N/A			N/A	lbs.	N/A	bpm	N/A	
N/A	lbs Left	N/A	bpm	N/A			N/A	lbs.	N/A	bpm	N/A	
Start Heart Rate		103	bpm		HR Increase?	YES	Start Heart Rate:			bpm	HR Increase?	N/A
Constant Carry N/A .lbs				Heart Rate N/A bpm								

Comments:	Client was able to safely lift and carry up to 25 lbs about 40 feet across the clinic before requesting to stop secondary to 6/10 LBP. Client was also able to frequently carry up to 15 lbs across 40 feet before requesting to stop secondary to 6/10 LB and increasing pain into left glut.

Push / Pull Testing

Occasional Push	Occasional Pull	Frequent Push/Pull	Heart Rate	RPL	RFT
32 lbs.	36 lbs.	20 lbs.	122 bpm	7	Pain
Peak Heart Rate: 108 bpm	Peak Heart Rate: 110 bpm	Start Heart Rate:	100 bpm	HR Increase?	YES
Constant Push/Pull N/A .lbs	Heart Rate N/A bpm				

Comments:	Client was able to generate up to 32 lbs of pushing force and 36 lbs of pulling force with the push/pull gauge during performance consistency testing. Client was also able to frequently push/pull a weight sled with up to 20 lbs of force across 30 feet in the clinic. Client started at 30 lbs for the first trail but reduced force to 25 lbs secondary to increased LBP. Client also reduced the force after the 2nd trail, and finally completed the last 3 push/pulls at 20 lbs of force

Additional Testing

N/A		Heart Rate		RPL	RFT		N/A		Heart Rate		RPL	RFT
N/A	lbs.	N/A	bpm	N/A			N/A	lbs.	N/A	bpm	N/A	
Start Heart Rate		N/A	bpm		HR Increase?	N/A	Start Heart Rate:		N/A	bpm	HR Increase?	N/A
Constant N/A .lbs				Heart Rate N/A bpm								

Comments:	N/A

* RPL - Rate of Perceived Load

* RFT - Reason For Termination

Post Material Handling Blood Pressure: 127/86 mmHg

FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB INSURANCE I.D. NO.: 032011004217

POSITIONAL TOLERANCE

	Frequency	Comments
Sitting	Constant	Positional Change Observed. Client was easily able to sit up to 30 minutes at one time with frequent position changes to demostrate constant
Standing	Frequent	Elevated pain level. Client was able to stand up to 25 minutes at home time reporting 6/10 LBP.
Walking	Frequent	Elevated pain level. Client was able to walk up to 20 minutes on the treadmill reporting 6/10 LBP.
Stair Climbing	Frequent	Elevated pain level. Client became SOB but was able to complete climbing up and down 8 flights of stairs reporting 5/10 LBP.
Climb Ladders	Frequent	Elevated pain level. Client was able to climb up and down the first 3 rungs of a 6 foot ladder 16 times reporting 5/10 and demonstrating SOB.
Reach Desk Level	Frequent	No Deficit Observed.
Reach Overhead	Frequent	No Deficit Observed.
Reach Floor Level	Frequent	No Deficit Observed.
Balance	Frequent	No Deficit Observed. B SLS 30s+
Stoop	Frequent	Elevated pain level. Client was able to frequently stoop but reports 6/10 LBP and prefers work at chest heights to avoid stooping 2° LBP
Kneel	Frequent	Elevated pain level. Client was able to frequently kneel but reports increased LBP especially transitioning to standing. Client was able to stand once without assistance but prefers to use a stationary object for assistance to return to standing.
Crouch	Frequent	No Deficit Observed.
Crawl	Frequent	Elevated pain level. Client was able to frequent crawl under a 31" height but demonstrated SOB and reported 8/10 LBP.
	Frequent	No Deficit Observed.

MANIPULATIVE ABILITY

	Frequency	Comments
R Object Handling	Frequent	No Deficit Observed.
L Object Handling	Frequent	No Deficit Observed.
R Fingering	Frequent	No Deficit Observed.
L Fingering	Frequent	No Deficit Observed.
R Simple Hand Grasp	Frequent	No Deficit Observed.
L Simple Hand Grasp	Frequent	No Deficit Observed.
R Firm Hand Grasp	Frequent	No Deficit Observed. Grip strength peaked at 61 lbs.
L Firm Hand Grasp	Frequent	No Deficit Observed. Grip strength peaked at 61 lbs.
R Fine Manipulation	Frequent	No Deficit Observed. Completed 14 sticks into the peg holes in 30 seconds on the Purdue Pegboard.
L Fine Manipulation	Frequent	No Deficit Observed. Completed 12 sticks into the peg holes in 30 seconds on the Purdue Pegboard.

Observed Movement Patterns:	Consistent

Description of Positional Tolerance Testing/Comments:
Client had the most difficulty performing frequent stooping, crawling, kneeling, and ladder climbing.

Remainder of page intentionally left blank

FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB INSURANCE I.D. NO.: 032011004217

POST TEST VITAL SIGNS: Heart Rate: 96 bpm Blood Pressure: 141/97 mmHg

POST TEST PAIN LEVEL 7/10

MUSCULOSKELETON SCREENING POST-TEST SUMMARY

Gait Analysis:
Client demonstrated a slight increase in antalgic gait demonstrating decreased stance time on left LE post-test secondary to pain.

Posture Analysis:
No change.

Soft Tissue Assessment:
c/o more tenderness to palpation over a wider region of lumbar spine left greater than right and into left glut post-test.

Flexibility:
No change.

Range Of Motion:
Lumbar AROM flex 20°, ext 2°, right SB 17°, left SB 14°; R shoulder AROM flex 155° AB 170°; L shoulder AROM flex 120° AB 145°

Strength:
No change.

Neurological:
No change.

Additional Tests:
N/A

ADDITIONAL INFORMATION N/A

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FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB: INSURANCE I.D. NO.: 032011004217

PERFORMANCE CONSISTENCY

Maximal Voluntary Effort ☐ Computerized Data Collection - see attached report

Grip Test	Grip Position														
	1			2			3			4			5		
Right Hand	57	54	57	61	55	56	52	48	53	42	42	44	38	35	34
Average	56			57.33			51			42.67			35.67		
Coefficient of Variation *	3%			5%			4%			2%			5%		
Left Hand	39	41	42	57	61	58	56	52	55	41	44	46	36	37	37
Average	40.67			58.67			54.33			43.67			36.67		
Coefficient of Variation *	3%			3%			3%			5%			1%		

10 of 10 CV Scores < 15% Consistent Test Performance | 2 of 2 of Bell Shaped Curve Distributions

HR(s): 106

Comments:

Pinch Strength Testing ☐ Computerized Data Collection - see attached report

Pinch Test	Tip Pinch			Palmar Pinch			Key Pinch		
Right Hand	11	12	11	13	14	12	17	19	19
Average	11.33			13			18.33		
Coefficient of Variation *	4%			6%			5%		
Left Hand	9	9	8	11	11	9	16	13	12
Average	8.67			10.33			13.67		
Coefficient of Variation *	5%			9%			12%		

6 of 6 CV Scores < 15% Consistent Test Performance

HR(s): 104

Comments:

Isometric Push / Pull ☐ Computerized Data Collection - see attached report

Test	Heart Rate	Trials(Pounds of Force)			Average	Standard Deviation	Coefficient of Variation*
		Trial 1	Trial 2	Trial 3			
Isometric Push	108	30	28	32	30	1.63	5%
Isometric Pull	110	35	32	36	34.33	1.7	5%

2 of 2 CV Scores < 15% Consistent Test Performance

Comments:

Performance Consistency Summary: Consistent Test Performance

Additional Performance Consistency Testing ☑ N/A

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FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOE INSURANCE I.D. NO.: 032011004217

ACTIVE RANGE OF MOTION / STRENGTH

☐ N/A

SPINE		NORM	AROM (Degrees)
Cervical	Flexion	50°	32
	Extension	60°	56
	Right Lateral Flexion	45°	32
	Left Lateral Flexion	45°	36
	Right Rotation	80°	78
	Left Rotation	80°	74
Thoracic	Flexion	60°	NT
	Right Rotation	30°	NT
	Left Rotation	30°	NT
Lumbar	Flexion	60°	20
	Extension	25°	5
	Right Lateral Flexion	25°	18
	Left Lateral Flexion	25°	12
	Right SLR	80°	80
	Left SLR	80°	75

☐ N/A

UPPER EXTREMITY		NORM	Right AROM	Left AROM	Right Strength	Left Strength
Shoulder	Flexion	180°	170	170	4+/5	4/5
	Extension	50°	WNL	WNL	5/5	5/5
	Abduction	180°	WNL	WNL	4+/5	4/5
	Adduction	40°	WNL	WNL	5/5	5/5
	Internal Rotation	90°	WNL	WNL	5/5	5/5
	External Rotation	90°	WNL	WNL	5/5	5/5
Elbow	Flexion	140°	WNL	WNL	5/5	5/5
	Extension	0°	WNL	WNL	5/5	5/5
	Supination	80°	WNL	WNL	5/5	5/5
	Pronation	80°	WNL	WNL	5/5	5/5
Wrist	Flexion	80° *	WNL	WNL	5/5	5/5
	Extension	70° *	WNL	WNL	5/5	5/5
	Radial Deviation	20°	WNL	WNL	5/5	5/5
	Ulnar Deviation	30°	WNL	WNL	5/5	5/5

☐ N/A

LOWER EXTREMITY		NORM	Right AROM	Left AROM	Right Strength	Left Strength
Hip	Flexion	120° **	120	110	4/5	4-/5
	Extension	30° **	WNL	WNL	4+/5	4/5
	Abduction	45° **	WNL	WNL	4/5	4-/5
	Adduction	30° **	WNL	WNL	5/5	4+/5
	Internal Rotation	45° **	35	50	4+/5	4-/5
	External Rotation	45° **	55	50	4+/5	4-/5
Knee	Flexion	135° **	WNL	WNL	5/5	4+/5
	Extension	0° **	WNL	WNL	5/5	4+/5
Ankle	Plantar Flexion	50° **	WNL	WNL	5/5	4+/5
	Dorsiflexion	20° **	WNL	WNL	5/5	4/5
	Inversion	35° **	WNL	WNL	5/5	4/5
	Eversion	15° **	WNL	WNL	5/5	4/5

Normative Data - AMA Guides to the Evaluation of Permanent Impairment, 5th Edition

* Normative Data - Rehabilitation of the Hand: Surgery and Therapy, 4th Edition

** Normative Data - American Academy of Orthopedic Surgeons

FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB: INSURANCE I.D. NO.: 032011004217

ACTIVE RANGE OF MOTION / STRENGTH (continued)

☑ N/A

HAND		NORM *	Right AROM (Degrees)	Left AROM (Degrees)	Right Strength	Left Strength
Thumb	CMC Flexion	15° *	N/A	N/A	N/A	N/A
	CMC Extension	20° *	N/A	N/A	N/A	N/A
	CMC Abduction	70° *	N/A	N/A	N/A	N/A
	MCP Flexion	50° *	N/A	N/A	N/A	N/A
	MCP Extension	0° *	N/A	N/A	N/A	N/A
	IP Flexion	80° *	N/A	N/A	N/A	N/A
	IP Extension	0° *	N/A	N/A	N/A	N/A
Index	MCP Flexion	90°	N/A	N/A	N/A	N/A
	MCP Extension	Up to 45°	N/A	N/A	N/A	N/A
	PIP Flexion	110°	N/A	N/A	N/A	N/A
	PIP Extension	0°	N/A	N/A	N/A	N/A
	DIP Flexion	60°	N/A	N/A	N/A	N/A
	DIP Extension	0°	N/A	N/A	N/A	N/A
Long	MCP Flexion	90°	N/A	N/A	N/A	N/A
	MCP Extension	Up to 45°	N/A	N/A	N/A	N/A
	PIP Flexion	110°	N/A	N/A	N/A	N/A
	PIP Extension	0°	N/A	N/A	N/A	N/A
	DIP Flexion	60°	N/A	N/A	N/A	N/A
	DIP Extension	0°	N/A	N/A	N/A	N/A
Ring	MCP Flexion	90°	N/A	N/A	N/A	N/A
	MCP Extension	Up to 45°	N/A	N/A	N/A	N/A
	PIP Flexion	110°	N/A	N/A	N/A	N/A
	PIP Extension	0°	N/A	N/A	N/A	N/A
	DIP Flexion	60°	N/A	N/A	N/A	N/A
	DIP Extension	0°	N/A	N/A	N/A	N/A
Small	MCP Flexion	90°	N/A	N/A	N/A	N/A
	MCP Extension	Up to 45°	N/A	N/A	N/A	N/A
	PIP Flexion	110°	N/A	N/A	N/A	N/A
	PIP Extension	0°	N/A	N/A	N/A	N/A
	DIP Flexion	60°	N/A	N/A	N/A	N/A
	DIP Extension	0°	N/A	N/A	N/A	N/A

Normative Data - American Academy of Orthopedic Surgeons, Rehabilitation of the Hand: Surgery and Therapy, 4th Edition

☑ N/A

Hand Volume	Right			Left		
Pretest		N/A ml	Pretest		N/A ml	
Post Test		N/A ml	Post Test		N/A ml	
Difference	N/A	N/A ml	Difference	N/A	N/A ml	

* Rehabilitation of the Hand: Surgery and Therapy,4th Edition

- Fluid volume changes are often 30 to 50 ml or more between one measurement and the next if swelling is present.

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FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB: INSURANCE I.D. NO.: 032011004217

ACTIVE RANGE OF MOTION / STRENGTH (continued)

☑ N/A

Circumference		Right			Left	
N/A	Pretest		N/A cm	Pretest		N/A cm
	Post Test		N/A cm	Post Test		N/A cm
	Difference	N/A	N/A cm	Difference	N/A	N/A cm
N/A	*R (Pretest)		N/A cm	Pretest		N/A cm
*R - Right	*R (Post Test)		N/A cm	Post Test		N/A cm
	*R (Difference)	N/A	N/A cm	Difference	N/A	N/A cm
N/A	Pretest		N/A cm	Pretest		N/A cm
	Post Test		N/A cm	Post Test		N/A cm
	Difference	N/A	N/A cm	Difference	N/A	N/A cm

* Rehabilitation of the Hand: Survey and Therapy, 4th Edition - Circumference measurements of the hand and fingers or areas of swelling.

☑ N/A

Opposition					
	Right	Index - N/A	Long - N/A	Ring - N/A	Small - N/A
	Left	Index - N/A	Long - N/A	Ring - N/A	Small - N/A

* American Academy of Orthopedic Surgeons - Tip of thumb to base or tip of small digit.

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FUNCTIONAL CAPACITY EVALUATION

Re: Patricia A. Pate DOB: INSURANCE I.D. NO.: 032011004217

PHYSICAL DEMAND CATEGORY (U.S. Department of Labor, Dictionary of Occupational Titles)

Sedentary	Exerting up to 10 lbs. of force occasionally (Occasionally: activity or condition exists up to 1/3 of the time) and/or a negligible amount of force frequently (Frequently: activity or condition exists from 1/3 to 2/3 of the time to lift, carry, push, pull or otherwise move objects, including human body.
Light	Exerting up to 20 lbs. of force occasionally, and/or up to 10 lbs. force frequently, and/or a negligible amount of force constantly (Constantly: activity or condition exists from 2/3 or more of the time) to move objects. Physical demand requirements are in excess of those for Sedentary Work.
Medium	Exerting 20 lbs. to 50 lbs. of force occasionally, and/or 10 lbs. to 25 lbs. of force frequently, and/or greater than negligible up to 10 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.
Heavy	Exerting 50 lbs. to 100 lbs. of force occasionally, and/or 25 lbs to 50 lbs. of force frequently, and/or 10 lbs. to 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.
Very Heavy	Exerting in excess of 100 lbs. of force occasionally, and/or in excess of 50 lbs. of force frequently, and/or in excess of 20 lbs.of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

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- (B) Duplex doppler

vcountry Hematology and Oncology
Roper St. Francis Physicians

M. DAUD NAWABI, MD
GRETCHEN A. MEYER, MD
MATTHEW A. BELDNER, MD
JEFFREY S. ROSE, MD
YANIS BELLIL, MD

Back surg 2012
Leg pain mainly
Lots of stress events
Asst manager Clothes Store
Right unemployed

PATIENT HISTORY FORM

Biographical Information

Today's Date: 10 / 18 / 14

Last Name Pate **First Name** Patricia **Middle** Ann **Acct#** _____

Date of Birth __ / __ / __

- Duplex dopplers @ Trident
- 2 weeks / 3 days

Chief Complaint (What is the reason for your visit today?)

Blood Clots - Lungs both sides

History of Present Illness

- Allergies
- Better SOB - pneumonia
- Leg/calf swelling on left

1. What is the problem? breathing difficulties
2. When did you first notice it? 9-15-14
3. How and where was it first diagnosed? Please give the names of any physicians involved.
   9-17-14 Dr. Donald Hanna Office - Tri County Radiology
4. Does it interfere with your normal daily functioning? How?
   Yes

Past Medical History

1. Please list any other illnesses that you have. None
2. Please list your medications, including over the counter types. Please include the dose and how often you take them. (other side)
3. Are you allergic to any medications? Please describe the reaction when you take it. Penicillin (hive (welt
4. Do you smoke? If so, how much and when did you start? NO Occ. Etoh Married 18 yrs
5. Does cancer or blood disease run in the family? Please give details (who and what kind). NO
6. Have you had surgery before? Please list the name of the procedure, date and place.
   Back 5-15-12 Trident Hospital
   Hysterectomy 1998 St. Francis
   Gall Bladder Trident 1985

- Mother Pulmonary Cancer DX 3 months ago
- Father 2 yrs ago
- No children

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MT. PLEASANT, S.C. 29464

2 C 352 ARLIE HALL BLVD.
ESTON, S.C. 29414

9313 MEDICAL PLAZA DRIVE SUITE 204
CHARLESTON, S.C. 29406

Lowcountry Hematology & Oncology
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M. Daud Nawabi, MD
Gretchen A. Meyer, MD
Matthew A. Beldner, MD
Jeffrey S. Rose, MD
Yanis Bellil, MD

CONSULTATION

LOCATION: North Charleston

PATIENT: PATE, PATRICIA
DATE OF BIRTH
DATE OF VISIT: 10/8/2014

Referring Physician(s): Carey McNamara, PA-C

REASON FOR CONSULTATION: Evaluation of pulmonary embolism.

CHIEF COMPLAINT: "My breathing is better."

HISTORY OF PRESENT ILLNESS: Ms. Pate is a very pleasant 53-year-old woman who has no prior history of thrombosis but does have an extensive family history of thrombosis who started experiencing difficulty breathing September 15, 2014. This was brought to the attention of her primary care physician who ordered a CT scan of the chest with IV contrast September 17, 2014, which revealed numerous pulmonary emboli involving the right pulmonary artery, involving the right first and second order upper and lower lobe pulmonary arteries, as well as left secondary order upper and lower pulmonary arteries. There was a 3.5 mm right lower lobe nodule but no other findings that were significant within the chest. There was a 15 mm right thyroid hypodensity. The patient was subsequently admitted to Trident Medical Center for two days and three nights where she was placed on anticoagulation, Xarelto 15 mg b.i.d.

In speaking with the patient today, this is her first event of thrombosis. She has been hospitalized three times in the past for a cholecystectomy, hysterectomy, as well as a back surgery but has had no issues with postoperative thrombosis. She is not taking any estrogen or progesterone-containing products and she denies any recent prolonged travel or immobility. There is no other instigating factor identified putting her at risk for thrombosis. The patient does admit to having some waxing and waning lower extremity swelling over the past couple of years but her bilateral duplex Doppler is reportedly normal from Trident Medical Center during her hospital stay.

A referral has been made to help manage her bilateral pulmonary embolism as well as assess the cause of her PE.

PAST MEDICAL HISTORY:

1. Hyperlipidemia.
2. Depression and anxiety.
3. Chronic low back pain.
4. History of gastroesophageal reflux disease.
5. Allergic rhinitis.

PAST SURGICAL HISTORY:

1. Status post low back surgery 05/15/2012.
2. Status post hysterectomy 1998.
3. Status post cholecystectomy 1985.

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CONSULTATION

LOCATION: North Charleston

PATIENT: PATE, PATRICIA
DATE OF BIRTH:
DATE OF VISIT: 10/8/2014

PHYSICAL EXAMINATION: Vital signs: Temperature 99.3. Pulse 95. Respirations 18. Blood pressure 115/84. O2 saturation 98% on room air. Weight 199 pounds. Height 63 inches. In general, the patient is a well-developed, healthy-appearing woman who is overweight. HEENT: Normocephalic/atraumatic. Mucous membranes are moist and intact. Oropharynx is clear. There is no scleral icterus. There are no mucocytes or mouth sores. Neck is supple. She has a palpable mass in the left supraclavicular fossa. The patient states this is an extra cervical rib. There is no axillary lymphadenopathy. Breast exam was deferred today. Lungs are clear to auscultation bilaterally. Heart: Regular rate and rhythm without murmurs, gallops, or rubs. Abdomen is obese, soft, nontender, nondistended, without palpable hepatosplenomegaly. There is no inguinal lymphadenopathy. Lower extremities reveal a mild lower extremity nonpitting edema. She has chronic venous stasis changes in both legs. She has some varicosities on the right. Neurologic exam is nonfocal. Skin: There is no rash or lesion, although the patient does have some mild livido about both knees.

LABORATORY DATA: Labs are currently pending.

IMPRESSION: Ms. Pate is a very pleasant 53-year-old woman who presents with the following medical problems:

1. Unprovoked bilateral pulmonary embolism. This occurred with a strong family history of thrombosis in both her father as well as her mother.
2. Chronic venous stasis. Lower extremity duplex Doppler is reportedly normal.
3. ECOG Performance Status of 0.

PLAN: I had a nice discussion with Ms. Pate as well as her husband, Donald. I explained to them that unfortunately I cannot delineate a cause of her pulmonary embolism. This would be described as an unprovoked event as there were no instigating factors leading to this. A review of her medication list also revealed no offending agents as well. However, the patient does have a strong family history of thrombosis and I think an inheritable thrombophilia panel is recommended. I will proceed with a factor V Leiden mutation test, prothrombin gene mutation test, as well as protein-C, protein-S, and AT-3 levels. The patient was also noted to have some mild livido about her knees. This can be a sign of lupus anticoagulant and, therefore, and assessment for this process has been obtained as well.

Regarding the duration of therapy, at a minimum she should take 6 months of therapy. If she is nervous about this, I would also be agreeable to one year's time. Even though this is an unprovoked event, I do not think life-long anticoagulation is indicated.

At the end of our course of therapy, at either 6 months or one year, I will have her hold her therapy for 4 weeks and perform a D-dimer. Using the Vienna prediction model, I will predict the risk of recurrence and we will have a discussion whether further therapy is indicated. At a minimum, she will be placed on aspirin upon completion of Xarelto which will decrease her risk of recurrence by approximately 30%.

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CONSULTATION

LOCATION: North Charleston

PATIENT: PATE, PATRICIA
DATE OF BIRTH:
DATE OF VISIT: 10/8/2014

She will return to the clinic in 2 weeks' time for follow-up. The patient does have Xarelto prescribed by her primary care physician.

She is to contact me sooner with any concerns or questions.

Jeffrey S. Rose, MD
JR/TP-jj

LOWCOUNTRY
HEMATOLOGY & ONCOLOGY
ROPER ST. FRANCIS PHYSICIANS

www.lowcountryhematology-oncology.com

M. Daud Nawabi, MD • Gretchen A. Meyer, MD
Matthew A. Beldner, MD • Jeffrey S. Rose, MD
Yanis Bellil, MD

October 8, 2014

Carey McNamara, PA-C
100 Springhall Drive
Goose Creek, SC 29445

PATIENT: PATE, PATRICIA
DATE OF BIRTH

Dear Ms. McNamara:

I would like to thank you for the referral of Ms. Pate. As you are aware, she is a very pleasant 50-year-old woman who has developed an unprovoked bilateral pulmonary embolism. An extensive review of her medications as well as her personal history do not reveal an overt cause of her thrombosis, although her family history is significant for thrombosis in both her mother as well as her father. As such, a thrombophilia panel has been evaluated. I do recommend she continue on her course of Xarelto. At a minimum, I would recommend 6 months' duration of therapy but possibly longer. This is reviewed in my note in more depth.

I certainly do appreciate the opportunity to help you care for this patient. If you have any concerns or questions, please do not hesitate to call at any time. My cellular phone is 323-2007.

Sincerely,

Jeffrey S. Rose, MD
JR/TP-jj

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Yanis Bellil, MD

FOLLOWUP

PATIENT: PATE, PATRICIA
DATE OF BIRTH:
DATE OF VISIT: 12/3/2014

Referring Physician: Carey McNamara, PA-C

DIAGNOSIS: Unprovoked pulmonary embolism.

CURRENT THERAPY: Xarelto 20 mg daily.

CHIEF COMPLAINT: "I'm worried about my job."

INTERVAL HISTORY: Ms. Pate returns today. She is quite tearful in our office. The patient recently returned to her job as an assistant at the copy center at the university. The patient states that they are apparently transitioning to a new computer system, and she is concerned about her ability to perform her job. She states that her boss has been hard on her, and it has been difficult returning to work. She is under a significant amount of stress regarding this.

Physically, she is doing well. Her shortness of breath has markedly improved. She has minimal shortness of breath, if any, remaining. She denies any chest pain or palpitations. Her exercise tolerance has improved. She is tolerating her Xarelto, although she does experience some bruising about her lower extremities but no bleeding symptoms.

Past medical history, medications, past surgical history, allergies, family history, and social history are unchanged from note dated 10/8/2014.

REVIEW OF SYSTEMS: The patient denies any fever, chills, or symptoms of infection. No headaches, blurred or double vision. No chest pain, palpitations, cough, shortness of breath, paroxysmal nocturnal dyspnea, or orthopnea. No abdominal pain, nausea, vomiting, diarrhea, or constipation. No bleeding symptoms of epistaxis, hematochezia, melena, or hematuria. No dysuria. No easy bruising, petechiae, or purpura. No lower extremity swelling or discomfort. Review of systems is otherwise per interval history.

PHYSICAL EXAMINATION: Vital signs: Temperature 97.9, pulse 90, respirations 18, blood pressure 135/85, O2 saturation 97% on room air. Weight 187 pounds. In general, the patient is a well-developed, healthy-appearing woman who is overweight. HEENT: Normocephalic/atraumatic. Mucous membranes are moist and intact. Oropharynx is clear. There is no scleral icterus. There is no mucositis or mouth sores. Neck is supple. She has a palpable mass in the left supraclavicular fossa. The patient states this is an extra cervical rib. There is no axillary lymphadenopathy. Breast exam was deferred today. Lungs are clear to auscultation bilaterally. Heart: Regular rate and rhythm without murmurs, gallops, or rubs. Abdomen is obese, soft, nontender, nondistended, without palpable hepatosplenomegaly. There is no inguinal lymphadenopathy. Lower extremities reveal a mild lower extremity nonpitting edema. She has chronic venous stasis changes in both legs. She has some varicosities on the right. Neurologic exam is nonfocal. Skin: There is no rash or lesion, although the patient does have some mild livido about both knees.

LABORATORY TESTING: CBC reveals white count 3.5, hemoglobin 13.2, platelet count 366,000.

IMPRESSION: Ms. Pate is a very pleasant 53-year-old woman with the following medical problems:

1. Unprovoked bilateral pulmonary embolism. This occurred with a strong family history of thrombosis in both her father as well as her mother. Hypercoagulable workup has been negative to date. She did have a positive lupus anticoagulant panel, although this is likely secondary to the use of Xarelto.
2. Chronic venous stasis. Lower extremity duplex Doppler is reportedly normal.
3. Job-related stress.
4. ECOG performance status is 0.

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Lowcountry Hematology & Oncology
Roper St. Francis Physicians

M. Daud Nawabi, MD
Gretchen A. Meyer, MD
Matthew A. Beldner, MD
Jeffrey S. Rose, MD
Yanis Bellil, MD

PLAN:

1. I met with Ms. Pate today. She appears to be tolerating her Xarelto quite well. She is approximately 3 months into her course of therapy. At a minimum, I would prefer she proceed with a 1-year course of therapy, possibly longer. Upon her completion of 1 year of therapy, I will hold her anticoagulation, repeat her lupus anticoagulant testing as well as obtain a D-dimer for prognostic purposes. Given her strong family history and the unprovoked nature of her thrombosis, lifelong anticoagulation may be preferred but is not absolutely necessary.
2. She will return to clinic in 2 months' time with a CBC with differential and CMP. I offered her words of encouragement regarding her job and also offered her ways she could help train herself with her computer system.

I spent 35 minutes caring for this patient with greater than 50% in counseling.

Jeffrey S. Rose, MD

JSR:cm
D: 12/3/2014 T: 12/11/2014

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Gretchen A. Meyer, MD
Matthew A. Beldner, MD
Jeffrey S. Rose, MD
Yanis Bellil, MD

IMPRESSION: Ms. Pate is a very pleasant 54-year-old woman with the following medical problems:

1. Unprovoked bilateral pulmonary embolism. This occurred with a strong family history of thrombosis in both her father as well as her mother. Hypercoagulable workup has been negative to date. She did have a positive lupus anticoagulant panel, although this is likely secondary to the use of Xarelto.
2. Chronic venous stasis. Lower extremity duplex Doppler is reportedly normal.
3. ECOG performance status zero.

PLAN:

1. From a hematologic perspective, Ms. Pate is doing great. Will continue to follow her clinically. She is currently completing her fifth month of treatment. Given her family history as well as the unprovoked nature of this event, I have again recommended at least 1 year's time of therapy if not an indefinite course of therapy. Will again reassess this at each visit.
2. I gave her words of encouragement regarding her job. Hopefully, this will open up some new avenues for her as she was previously having significant issue with her coworkers and boss at her previous job.
3. She is to contact me sooner with any concerns or questions.

I spent 35 minutes caring for this patient with greater than 50% in counseling.

Jeffrey S. Rose, MD

JSR:cm
D: 2/4/2015 T: 2/5/2015

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5.27.15

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Jeffrey S. Rose, MD
Yanis Bellil, MD

FOLLOWUP

PATIENT: PATE, PATRICIA **Referring Physician:** Carey McNamara, PA-C
DATE OF BIRT
DATE OF VISIT: 4/15/2015

DIAGNOSIS: Unprovoked pulmonary embolism.

CURRENT THERAPY: Xarelto 20 mg daily.

CHIEF COMPLAINT: "I'm doing well."

INTERVAL HISTORY: Ms. Pate returns today for followup. Since our last visit, she has again done well. She is tolerating her Xarelto without any significant toxicity. No easy bruising. No bleeding symptoms of hemoptysis, hematemesis, melena, hematochezia, or epistaxis. As noted previously, she did have some blood when she wiped after defecation and was found to have one of two positive Hemoccult cards by her primary care physician. As previously noted, she underwent colonoscopy in 2013, which revealed a benign polyp, as well as EGD at that juncture, which was normal per her report. Her hemoglobin remains stable from 10/2014.

The patient is currently not working. We did receive some paperwork that she is seeking disability. She is currently helping take care of her elderly parents.

Past medical history, medications, past surgical history, allergies, family history, and social history are unchanged from note dated 10/8/2014.

REVIEW OF SYSTEMS: The patient denies any fever, chills, or symptoms of infection. No headaches, blurred or double vision. No chest pain, palpitations, cough, shortness of breath, paroxysmal nocturnal dyspnea, or orthopnea. No abdominal pain, nausea, vomiting, diarrhea, or constipation. No bleeding symptoms of epistaxis, hematochezia, melena, or hematuria. No dysuria. No easy bruising, petechiae, or purpura. No lower extremity swelling or discomfort. Review of systems is otherwise per interval history.

PHYSICAL EXAMINATION: Vital signs: Temperature 98.2, pulse 88, respirations 18, blood pressure 114/81, O2 saturation 97% on room air. Weight 187 pounds. In general, the patient is a well-developed, healthy-appearing woman who is overweight. HEENT: Normocephalic/atraumatic. Mucous membranes are moist and intact. Oropharynx is clear. There is no scleral icterus. There is no mucositis or mouth sores. Neck is supple. She has a palpable mass in the left supraclavicular fossa. The patient states this is an extra cervical rib. There is no axillary lymphadenopathy. Breast exam was deferred today. Lungs are clear to auscultation bilaterally. Heart: Regular rate and rhythm without murmurs, gallops, or rubs. Abdomen is obese, soft, nontender, nondistended, without palpable hepatosplenomegaly. There is no inguinal lymphadenopathy. Lower extremities reveal a mild lower extremity nonpitting edema. She has chronic venous stasis changes in both legs. She has some varicosities on the right. Neurologic exam is nonfocal. Skin: There is no rash or lesion, although the patient does have some mild livido about both knees.

LABORATORY TESTING: CBC reveals white count 3.4, hemoglobin 12.0, platelet count 349,000.

IMPRESSION: Ms. Pate is a very pleasant 54-year-old woman with the following medical problems:
1. Unprovoked bilateral pulmonary embolism. This occurred with a strong family history of thrombosis in both her father as well as her mother. Hypercoagulable workup has been negative to date. She did have a positive lupus anticoagulant panel, although this is likely secondary to the use of Xarelto.
2. Chronic venous stasis. Lower extremity duplex Doppler is reportedly normal.
3. ECOG performance status 0.

M. Daud Nawabi, MD
Gretchen A. Meyer, MD
Matthew A. Beldner, MD
Jeffrey S. Rose, MD
Yanis Bellil, MD

PATE, PATRICIA
4/15/2015
FOLLOWUP
PAGE 2

PLAN:

1. Ms. Pate continues to do well, and she is tolerating Xarelto well. Tentatively our plan is to complete at least 1 year of Xarelto therapy. At the end of 1 year's time, we will consider discontinuation of therapy and transition to an oral aspirin. When discussing this with the patient today, she did voice some hesitancy and some anxiousness regarding stopping her Xarelto. I explained to her that when it comes time to think about cessation of anticoagulation, we will analyze the cost of the medication, tolerance to the medication, as well as the patient's personal preference. These are all things we will take under consideration.
2. However, we have another 5 months of therapy prior to making that decision, so I asked her not to worry about this until that juncture.
3. The patient has a history of heme-positive stools by Hemoccult testing by her primary care physician as well as blood-streaked stools reported to me at our last visit. The patient has had a normal EGD and colonoscopy in 2013 and will continue to follow these symptoms closely. Her hemoglobin remains stable.
4. She will return to clinic in 2 months' time with a CBC with differential and a CMP. She is to contact me sooner with any concerns or questions.

Jeffrey S. Rose, MD

JSR:cm
D: 4/15/2015 T: 4/21/2015

(843)556-5977 *Dyana Lowndes-Rosen, M.D.* *(843)556-0701Fax*
655 St. Andrews Blvd.
Charleston, SC 29407

December 10, 2014

Max Sparwasser, Esquire
Max Sparwasser Law Firm, LLC
PO Box 2307
Mt. Pleasant, SC 29465

Re: Name of Examinee: Patricia Pate v. College of Charleston
DOB
W/C File No: 2011 004217
DOI: 12/14/2011

Subject: Form 27 Subpoena Exhibit A

Dear Mr. Sparwasser,

As you and I discussed at length by phone I was surprised to receive such a subpoena from you demanding information that has not been demanded of me in my forty-two years as a physician until the present. I also explained by phone that compiling five years worth of information would require an inordinate amount of time and manpower. You offered to limit the information requested to two years and accordingly I am submitting answers to your Exhibit "A" of the Form 27 Subpoena as follows:

1. Regards compensation agreements with insurance companies: There are not and have never been any compensation agreement between me and any person or entity (unless you consider my being a M.D. provider who accepts the terms offered by private insurance companies such as Blue Cross/Blue Shield, UHC etc. for treatment of private patients as do most physicians).
2. I will not provide copies of patient reports regarding my opinions on the type of care and causation of injuries that individuals have received. Physician-patient confidentiality must be honored in such a request. I have a computer spreadsheet from June of 2012 through November 2014 showing that out of the roughly two hundred and forty Workers' Compensation referrals during that period, approximately one hundred were evaluations without treatment. Most claimants are sent to me for evaluation and treatment.
3. As per your request for documentation regarding income received from consulting services which include the rendering of medical opinions regarding the extent of treatment etc., I charge and accept what I believe is the standard W/C fee of $750.00 for psychiatry IME's including record review and transcription. Your request was regarding individuals who I have not become the treating physician which as stated in item #2 above is roughly one hundred individuals.
4. I have not rendered courtroom testimony in many years, certainly more than ten years, and have not appeared in any trial for more than ten years. I have rendered several depositions but I have never made a list of these depositions and I don't believe could possibly compile that information.
5. I consider your item #5 too general and overly broad to understand. I assume by lawsuits you again mean all Workers' Compensation claims brought by claimants with whom I have been involved.

6. I generally receive W/C referrals from the W/C adjusters. We send them our bill and the W/C carrier pays it. My assumption is that both defense counsel & plaintiff counsel approve the adjuster's referrals. It is my understanding that under SC law all diagnostic and treatment services for Workers' Compensation insured patients must be authorized by the adjuster before any medical service is rendered. Also, I receive referrals from plaintiff attorneys both with and without the adjuster authorizing the evaluation. I do not have documentation regarding how many times I have been retained in any capacity by defense counsel or plaintiff's counsel but know that I receive both. I have not converted to electronic medical records and have not ever in the many years counted or listed my sources of referrals nor any of the income specifics on your list.

Mr. Sparwasser, this is the second time you have sent me a subpoena like this before your client is even seen. I hope I have answered your questions. To be candid with you, it is my opinion that subpoenas such as you have delivered to me are an effective way for you to turn away medical providers who would otherwise be available to help your clients.

Sincerely,

Dyana Lowndes-Rosen, M.D.

DLR/mar

Cc: Mikell H. Wyman, Esq.
Jennifer Stone (via e-mail)
SC Workers' Compensation Commission

(843)556-5977 *Dyana Lowndes-Rosen, M.D.* (843)556-0701Fax
655 St. Andrews Blvd.
Charleston, SC 29407

January 13, 2015

INDEPENDENT PSYCHIATRIC EVALUATION

Jennifer Stone, Adjuster
State Accident Fund
PO Box 102100
Columbia, SC 29221-5000
VIA FACSIMILE: 803-612-2715

Re: Name of Examinee: Patricia Pate
DOB: [redacted]
W/C Claim #: 2011 004217
DOI: 12/14/2011

Date of Examination: January 12, 2015

Pertinent Sources of Information:

Records Examined:
- Summerville Medical Center, Admission 5/15/2012
- Joseph M. Marzluff, MD, Office Note of 1/30/2013
- Trident Pain Center, Joseph Edward Nolan, MD, 5/15/2013 - 9/10/2014
- SC Diagnostic Imaging, XR-L-Spine, 11/6/2013

Observation of and Interview with the Claimant

Reason for Psychiatric Referral:

Ms. Pate is referred by adjuster Jennifer Stone of the State Accident Fund, insurer for the employer in the Worker's Compensation Claim. Request is made for independent psychiatric evaluation particularly as it pertains to the work related injury.

Disclosure of Confidentiality:

I met with Ms. Pate in my office on January 12, 2015. I explained to her that I am an independent psychiatrist who upon request is willing to review medical records and interview with a claimant for purposes of providing evaluative report, recommendations, and responding to any questions presented. I explained to Ms. Pate that there are limits on the confidentiality of psychiatric independent examinations and that what she tells me and my opinions will be shared with the insurance company, attorneys for both the plaintiff and the defense, and as required in any future legal matters of discovery. Ms. Pate was further informed that this is solely a forensic

psychiatric evaluation and psychiatric treatment will only follow if there is authorization and also agreement between the claimant as my patient and I as the claimant's psychiatrist. Ms. Pate acknowledged understanding that all relevant information provided me both by review of medical records and interview will be provided to the above stated parties.

Claimant's Primary Complaint:

Pain

Pertinent History:

Ms. Pate is a fifty-four year old female who dates her on the job accident to December 14, 2011 when while on her job at the College of Charleston she did heavy lifting and had onset of back pain and Dysesthesias of the legs. She did not improve sufficiently with five months of conservative therapy including two epidural steroid injections. With her continuing to be symptomatic particularly concerning her legs she was admitted on May 15, 2012 with a diagnosis of Spondylolisthesis, L4-5 and Stenosis for Lumbar Decompression and Fusion. This was accomplished by Dr. Marzloff.

The next medical note available to me is of January 13, 2013 by Dr. Joseph Marzluff. She appeared to him for evaluation of increasing back and left hip pain. He had seen her previously to be doing reasonably well following her surgery but she then complained to him of multiple problems, including incontinence of her bowels. She continued to complain to Dr Nolan on her visits through September 2014 and it has been Dr. Nolan's report that she has also had bilateral radicular leg pain.

Past Family, Medical, and Social History:

Past Medical History:

- Illness: Digestive Problems, Esophageal Reflux, seasonal allergies, muscle pain, depression, high cholesterol, clots in lungs September 2014
- Operations: Gall Bladder 1985, Hysterectomy 1998, Back Surgery 2012
- Injuries
- Treatment

Personal Psychological History:

Claimant reports depression since W/C accident. She is on Paxil 25mg CR daily by her LMD Dr. Hanner. She also had a prior trial on Cymbalta, which she was not able to take. There is further a listing of the antidepressant Venlafaxine (Effexor), which she says she does not know she has taken.

Developmental and Social History:

She was born and reared in Dorchester, SC and after gradustion from high school began working. She has been married for twenty-eight years and the couple have no children together.

Educational and Occupational:

Summerville high school education, graduate. Worked at the Copy Center at the College of Charleston since 2009. Prior to College of Charleston, worked at Citadel Print Shop for ten years.

Review of Systems:

- General, Skin, Breast: Denies
- Head: Denies
- Eyes: Denies
- Ears: Denies
- Nose: Denies
- Respiratory: On blood thinner due to clots in lungs
- Cardiovascular: Increased cholesterol (cardiology appointment scheduled)
- Gastrointestinal: Digestive issues, Esophageal Reflux
- Genitourinary: Denies
- Neurological: Positive for tingling, numbness, leg weakness, radicular pain
- Musculoskeletal: Positive for joint pain, muscle pain, joint stiffness
- Endocrine: On diabetes medication but patient says no diagnosis
- Allergies: Seasonal, Penicillin
- All other ROS complaints are denied other than recorded.

Alcohol and Substances:

Occasional beer – no nicotine

Review of Medical Records:

Reviewed and incorporated in this report.

Current and recent medications:

- Oxycontin 10mg E/R, 2/day
- Percocet 5/325, 3/day
- Effexor 50mg, 2/day by written report but she says no knowledge
- Ambien 12.5mg CR, sleep
- Paxil 25mg CR by LMD Dr. Hanner since after accident
- Quinine Sulfate 324
- Methylfolate 15mg
- Fish Oil
- Tizanidine 4mg
- Prilosec 40mg
- Aspirin, low dose

Legal History:

N/A

Clinical Interview and Mental Status Examination:

Ms. Pate's appearance to interview was appropriate. Her husband accompanied her and both were quite pleasant. I did not observe abnormality in her gait although she has bilateral radiculopathy. She was casually dressed and well groomed. Her general behavior, eye contact and attitude were completely cooperative to interview. Her level of psychomotor activity was normal. Her speech rate, rhythm, volume and articulation were normal, relevant, and coherent.

When questioned Ms. Pate stated that her pain physician Dr. Nolan in the fall 2014 suggested that she might want to see a counselor due to depression secondary to her pain. She states much of this depression was because her pain and limitations had continued after surgery, that she went back to work and was not able to handle full time work well. She has subsequently worked a four-hour/day schedule. When asked about her emotional problems she stated that she has pain constantly since surgery and that her despondency has been a consequence. When questioned she also reports having insomnia for which she taken Ambien 12.5mg CR nightly. She further states she enjoys bicycling, walking her dog, her husband and especially at home activities. However her abilities to pleasure are limited because of her motor limitations in that her activities are restricted. She reported she has been tried on three antidepressants since the accident and that the only one she was able to continue was the Paxil. The only further symptoms she reported were of a thirty-pound weight gain.

Throughout interview her mood and affect were congruent with her current life situation as she described. Her thought processes as expressed revealed no delusions, obsessions, compulsions or phobias. Ms. Pate denied being suicidal, homicidal or unduly aggressive. There were no signs of psychosis and perceptual disturbances such as hallucinations were not evident.

Brief mental status examination was performed. When presented with words Ms. Pate was able to repeat them correctly immediately and after one minute and three minutes. She was oriented to time relative to day of the week, date, month, season, and was also oriented to place as tested by identifying my office, the city, county, and state for both my office and her home address. Writing was tested by reviewing the personal information questionnaire. Her sensorium and cognition were clear with orientation, attention, concentration and memory. Assessed level of intelligence was of normal IQ and capability of abstract reasoning.

Her level of insight was assessed by me to be understandable. She recognizes her emotional symptoms are a direct result of her pain and limitations. She stated Dr. Nolan had recommended counseling in the fall but she does not know that counseling would be beneficial. She and I discussed this and I also said to her that if she is already on an antidepressant and pain and limitation are her only emotional problems, counseling benefits would be extremely limited because there would be no change in perception of pain.

Diagnostic Formulation:

Somatic Symptom Disorder with Predominant Pain (300.82)

Recommendations:

Ms. Pate presented as a pleasant lady who is victim of chronic pain syndrome due to lumbar post laminectomy syndrome. She is maintained by her personal physician on an antidepressant drug. I have no reason to believe that counseling would be of substantial benefit in that real physical pain is her primary complaint. She also expressed her belief that she has no need for mental health involvement. She is faced with chronic pain syndrome and is a pain management patient.

Should additional information become available, I reserve the right to amend my opinions.

Dyana Lowndes-Rosen, M.D.

DLR/mar

COLLEGE of CHARLESTON

HUMAN RESOURCES

May 10, 2011

Patricia Ann Pate
1108 Berkeley Street
Hanahan, South Carolina 29410

Re: *Revised Employer Response to Employee's Request for Leave*

Dear Ms. Pate:

We have reviewed your request for leave of absence, along with supporting documentation provided by your physician. This is to inform you of your approval for continuous leave of absence under the Family & Medical Leave Act (FMLA). Your leave will be counted against your FMLA leave entitlement of up to twelve (12) weeks of leave in a twelve (12) month period. Under the provisions of the Family & Medical Leave Act, you must be reinstated to the same or an equivalent job with the same pay, benefits, terms and conditions of employment upon your return to work. Your medical leave has been approved for the period beginning April 8, 2011 and ending May 23, 2011.

We presently maintain in our files a copy of your physician's certification. Should the circumstances described in this certification change and you require additional leave time, you must obtain re-certification from your physician and submit it to the Human Resources Department for approval. The necessary form may be obtained from the College of Charleston web site or the Human Resources Department and must be returned within fifteen (15) working days of receipt. Failure to return the form within the designated timeframe may result in denial of additional leave time and loss of federal job protection under the Family & Medical Leave Act.

The College of Charleston requires that you use accrued sick leave and annual leave while on FMLA leave. Our records indicate that you have 99.58 sick leave hours and 372.50 annual leave hours as of May 1, 2011. All insurance benefits in effect at the time of FMLA will remain in effect throughout the leave provided premiums are paid. Premiums will be deducted from accrued annual leave and/or sick leave until exhausted. If you do not have accrued annual leave or sick leave, or if accrued annual and sick leave are exhausted prior to your return to work, you are responsible for contacting the Benefits Administrator to make arrangements for continued premium payment. Failure to do so could result in the termination of your benefits. You have a 30-day grace period in which to make premium payments. If you do not return to work following FMLA leave for a reason other than the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave or other circumstances beyond your control; you will be responsible for paying both the College/University in addition to your premiums if you wish to keep your insurance in force.

You will be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until such certification is provided.

Should you have questions regarding your FMLA leave or this notice, please feel free to contact me at 953-5513.

Sincerely,

Margie L. Gamble

Margie L. Gamble
HR Benefits Counselor I
Leave Administrator
cc: Cheryl Connor

COLLEGE of CHARLESTON

HUMAN RESOURCES

May 18, 2011

Patricia Pate
1106 Berkeley Street
Hanahan, South Carolina 29410

Re: Employer Response to Employee's Request for Leave

Dear Ms. Pate:

We have reviewed your request for leave of absence, along with supporting documentation provided by your physician. This is to inform you of your approval for extended continuous leave of absence under the Family & Medical Leave Act (FMLA). Your leave will be counted against your FMLA leave entitlement of up to twelve (12) weeks of leave in a twelve (12) month period. Under the provisions of the Family & Medical Leave Act, you must be reinstated to the same or an equivalent job with the same pay, benefits, terms and conditions of employment upon your return to work. Your medical leave has been approved for the period beginning May 24, 2011 and ending June 30, 2011.

We presently maintain in our files a copy of your physician's certification. Should the circumstances described in this certification change and you require additional leave time, you must obtain re-certification from your physician and submit it to the Human Resources Department for approval. The necessary form may be obtained from the College of Charleston web site or the Human Resources Department and must be returned within fifteen (15) working days of receipt. Failure to return the form within the designated timeframe may result in denial of additional leave time and loss of federal job protection under the Family & Medical Leave Act.

The College of Charleston requires that you use accrued sick leave and annual leave while on FMLA leave. Our records indicate that you have 99.58 sick leave hours and 372.50 annual leave hours as of May 1, 2011. All insurance benefits in effect at the time of FMLA will remain in effect throughout the leave provided premiums are paid. Premiums will be deducted from accrued annual leave and/or sick leave until exhausted. If you do not have accrued annual leave or sick leave, or if accrued annual and sick leave are exhausted prior to your return to work, you are responsible for contacting the Benefits Administrator to make arrangements for continued premium payment. Failure to do so could result in the termination of your benefits. You have a 30-day grace period in which to make premium payments. If you do not return to work following FMLA leave for a reason other than the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave or other circumstances beyond your control; you will be responsible for paying both the College/University in addition to your premiums if you wish to keep your insurance in force.

You will be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until such certification is provided.

Should you have questions regarding your FMLA leave or this notice, please feel free to contact me at 953-5513.

Sincerely,

Margie L. Gamble

Margie L. Gamble
HR Benefits Counselor I
Leave Administrator
cc: Cheryl Connor

COLLEGE of CHARLESTON

November 7, 2011

To Whom It May Concern:

Patricia Pate is a full time employee at the College of Charleston. She was approved for leave under the Family Medical Leave Act from April 8, 2011 until May 31, 2011.

Her weekly rate of pay is $513.80.

If you have any questions, please feel free to contact me.

Sincerely,

Doug Hill

Benefits Counelor

EMPLOYEE STATEMENT OF INJURY

Patricia Pate (Employee's Full Name) — (Social Security Number) — **12-14-2011** (Date of Accident)

On December 14, 2011 while working at the College for Charleston Copy Center, at approximately 8:30 a.m. an employee working for the recycle Department arrived to pick up our recycle paper. The paper was in a rather large box that was too heavy for one person to lift. When the gentleman attempted to lift the box I assisted him to pick it up off the floor, at which time I felt a sharp pain in my back.

The information above is an accurate description of the sequence of events that led up to the injury that I sustained while performing my required job duties at the College of Charleston.

Patricia A Pate
(Employee's Signature)

Jan. 17, 2012 (Statement Date) 1:45 (Time)

(Form WC-05 09-17-01)

COLLEGE of CHARLESTON

HUMAN RESOURCES

INJURED WORKER RESTRICTION FORM

August 30, 2012

TO: Cheryl Connor

FROM: Doug Hill
Workers' Compensation Coordinator

RE: Patricia Pate

Dear Cheryl Connor,

Patricia Pate has been cleared to return to work on 8/31/12 with the following work restrictions:

No standing or sitting more than 2 hours at a time: ✓
No walking more than 1 hour at a time. ✓
No driving more than 2 hours at a time. n/a
Lifting allowed: 1- 10 lbs Frequently; 11-30 lbs – Occasionally no lifting required
No lifting more than 30 lbs n/a
Bending/Stooping/Occasionally not required as part of job

Given these work restrictions, please indicate which one of the following apply:

- ☑ Employee will be able to perform their regular job duties.
- ☐ Employee's regular job can be performed with modifications.
- ☐ Employee can perform other job tasks within the department.
- ☐ Appropriate work for employee cannot be found within the department.

Supervisor's Signature

8/30/12
Date

Please sign/date and return this form to Doug Hill in the Department of Human Resources. Call 843-953-7320 if you have any questions.

Memorandum

To: Patty Pate
From: Cheryl Connor
Date: February 26, 2013
RE: Revised Operating Procedures

During the evaluation process for your 2012 performance rating, I have had the opportunity to review all aspects of your position and make necessary changes to accommodate your work restrictions. Your position description (responsibilities and duties) will not change but I have adjusted the percentage of time dedicated to each duty to reflect these changes. As the percentage of time has been reduced on the 2nd duty –*daily operation of Copy Center*- and the 4th duty-*assisting with the collection of cash from vending*-this will allow additional time to be dedicated to the other aspects of your position that you have not previously been asked to perform.

With the shift in some of your responsibilities, you will be able to focus on **webpage maintenance, updating departmental procedural forms** and establishing a **recycling schedule** for our department as well as for the vend copiers located in the Library. You will begin researching other colleges and universities and the local market for best practices and make recommendations for improvement. See attached description of updated job duties.

I will assist you in any training you may need for these duties to be accomplished and classes are available through Human Resources if you need refreshers in any computer related programs to assist you with these job requirements.

You will be responsible for adhering to your restrictions and delegating to me, Brittany or Sheree when there is a requirement of lifting over 15 pounds, bending, stooping and/or moving stacks of paper from the copiers. This will require you to communicate with co-workers in an effective manner.

Please don't hesitate to ask for assistance when you need it.

7/25/13

This is a bullet list of duties to be performed by Asst. Mgr/Copy Center as established in a revised job description specific to Patty Pate with regard to her work restrictions effective 3/4/13.

On 7/23/13 I requested Patty write a job description of her job based on what she was actually doing in order to prepare a TEMPORARY job description (recruitment to begin August 1, 2013). Currently 2 full time student employees are assisting in the Copy Center, but they will resume full time classes August 15.

My request for Patty to indicate her job as she is performing it was to fill any gaps in the operation of the Copy Center, as well as assist her in accomplishing her duties as Asst. Mgr.

Until she indicates in writing what she is actually doing, I am reluctant incorporate any of her duties into the temporary job description.

1. Maintain accurate records of revenue and expenditures (35%)

- Enter data in database (except for the period (JULY) in which I am reviewing data against spreadsheet with $ changes)
- Reconciling IDT revenue, Cougar Card revenue, Invoice revenue
- Printing and filing printed database reports of each revenue type
- Maintain hard copy and electronic copies of IDT's
- Submit IDT's to Controller's Office for processing

2. Daily operation of Copy Center (20%)

- Receives Copy request from Campus departments
- Highlight required information when IDT is submitted
- Contact customer if CCRF (Copy Center Request Form) is not submitted or information is omitted
- Write job # (found on servers) of each file with IDT/CCRF form
- Program job on the server with attributes of job (single/double sided, paper type, folding, stapling etc)
- Place job in job jacket- ready for production
- PROCESS orders WHEN student and/or temp employee is not available to do such while staying within limitations set forth by doctor

3. Maintain webpage, database and departmental procedure forms (20%)

- Periodically review webpage for accuracy and make note of changes/additions/deletions for submission to webmaster, give to mgr for review
- Update Request Forms by noting changes/additions/deletions via hardcopy and submit to mgr (don't expect Patty to make electronic changes on these forms yet, as she does not know how to change .pdf files)
- Maintain ample supply of forms at front counter
- Send electronic forms to customers as needed or reference customer to webpage where electronic files can be found

4. Assists in the sorting and counting of cash from vend locations (5%)

- Assist with sorting and counting of money as needed.

5. Assist manager with market research to identify industry best practices and ensure compliance with sustainability guidelines. Responsible for recycling all paper, printer cartridges and toner cartridges. (15%)

- Periodically check websites of different colleges/universites as well of CofC webpage for options of sustainablity and recycled paper etc....make recommendations to mgr
- Recycle all equipment toner and printer cartridges for Copy Center copiers
- Schedule pick up with library for recyclable toner and printer cartidges.

6. Maintain inventory of supplies in the Copy Center, this includes toner, drums, fusers, binders, presentation covers, shrink wrap and office supplies. (5%)

- Order supplies (binders, covers, coils, combs etc) by shopping a minimum of three vendors for best prices. Prepare online shopping carts for review by mgr.
- Order toner, drums and fusers online via Xerox Corp.
- Take regular inventory of supplies and keep record of inventory

Effective immediately for 2013 evaluation period.

Description of Job responsibility/duty (% of total time)

- **Maintain accurate records of revenue and expenditures (35)**

Patty is responsible for entering all job information in the data base for pricing and reports. Patty is responsible for reconciliation of all IDT revenue, Copy Center Cougar Card revenue and Invoice revenue. Responsible for printing monthly reports of each revenue type and attaching reports to hard copies of job order forms. Responsible for maintaining hard copy in office and digital copy of IDT's on the server. Patty will scan all IDT's and add .pdf of IDT to our production folder for submission to the Controller's office.

- **Daily operation of Copy Center (20)**
  Re: Processing Job Orders

Patty is responsible for receiving copy requests. She will log all information and highlight the required information of job when an IDT is submitted via email or in person. Patty will call or email customer to get any information that is not on CCRF, if CCRF form is NOT received with IDT, Patty will complete one by calling or emailing customer for required information. Patty will place work order in a job jacket, write the appropriate job # on IDT/CCRF, program **job on the server with all required attributes of job** (single/double sided, paper type, folding, stapling, etc.) and place job jacket in the rack for production.
DEFAULT (Temporary or student staff member will take job jacket, prepare a proof on the correct stock and give to Patty for approval of stock and quality. Once the job is approved internally, the temp or student staff member will contact the customer via telephone or email to come by and approve the proof. Job will be processed by the temp or student employee once the customer has signed off on it. Job will be placed on the shelf and job jacket given to Patty for pricing and notification to customer). *** When no temporary or student employee is available OR during peak periods, Patty will process orders while acting within limitations set forth by doctor-no lifting more than 15 pounds, no frequent bending or stooping.**

- **Maintain webpage, database and departmental procedural forms. (20)**

Patty is the Copy Center's liaison to webmaster for maintenance of Copy Center webpage. *Set up meeting with Katie Ford to establish a procedure for submitting webpage changes. Monitor webpage for links and information and submit updates as necessary.* Patty is responsible for updating Request Forms (Copy Center Request form, Cougar Card Request form, Invoice Request form and Poster Request form) electronically. Patty maintains an ample supply of forms at front counter and sends electronic forms to customers upon request. *A folder will be created for the electronic files and changes are made as necessary. Submit (once approved by Manager) to webmaster to upload revised forms to webpage.*

- **Assists in the sorting and counting of cash from copier vending locations. (5)**

Patty is responsible for assisting the manager in the sorting and counting of the cash collected from the copier vending locations.

- **Assist manager with market research to identify industry best practices and ensure compliance with sustainability guidelines. Responsible for recycling all paper, printer cartridges and toner cartridges. (15)**

Patty is responsible for monitoring the Copy Center services and prices. Responsible for researching other colleges and universities as well as local market for cost comparison and services offered; make recommendations to manager. *Research websites and make contact with other mangers/assistant managers to gather information. Establish a spreadsheet to record information.* Patty is responsible for recycling fuser/drum cartridges and toner cartridges for Copy Center and for vend copiers located in the Library. *Establish a schedule with the circulation desk in the Library for pick-up of empty cartridges for recycling. Assign the temporary or student employee to pick up the recyclable items from Library.* Monitor the paper recycle bins and notify Physical Plant via Maintenance Direct if a special collection is necessary. *Set up short cut for Maintenance Direct on your computer.*

- **Maintain inventory of supplies in the Copy Center, this includes paper, toner, drums, fusers, binders, presentation covers, shrink wrap and office supplies. (5)**

as of Sept

7/25/13

This is a bullet list of duties to be performed by Asst. Mgr/Copy Center as established in a revised job description specific to Patty Pate with regard to her work restrictions effective 3/4/13.

On 7/23/13 I requested Patty write a job description of her job based on what she was actually doing in order to prepare a TEMPORARY job description (recruitment to begin August 1, 2013). Currently 2 full time student employees are assisting in the Copy Center, but they will resume full time classes August 15.

My request for Patty to indicate her job as she is performing it was to fill any gaps in the operation of the Copy Center, as well as assist her in accomplishing her duties as Asst. Mgr.

Until she indicates in writing what she is actually doing, I am reluctant incorporate any of her duties into the temporary job description.

1. Maintain accurate records of revenue and expenditures (35%)

- Enter data in database (except for the period (JULY) in which I am reviewing data against spreadsheet with $ changes)
- Reconciling IDT revenue, Cougar Card revenue, Invoice revenue
- Printing and filing printed database reports of each revenue type
- Maintain hard copy and electronic copies of IDT's
- Submit IDT's to Controller's Office for processing

2. Daily operation of Copy Center (20%)

- Receives Copy request from Campus departments
- Highlight required information when IDT is submitted
- Contact customer if CCRF (Copy Center Request Form) is not submitted or information is omitted
- Write job # (found on servers) of each file with IDT/CCRF form
- Program job on the server with attributes of job (single/double sided, paper type, folding, stapling etc)
- Place job in job jacket- ready for production
- PROCESS orders WHEN student and/or temp employee is not available to do such while staying within limitations set forth by doctor

3. Maintain webpage, database and departmental procedure forms (20%)

- Periodically review webpage for accuracy and make note of changes/additions/deletions for submission to webmaster, give to mgr for review
- Update Request Forms by noting changes/additions/deletions via hardcopy and submit to mgr (Does not actually make electronic changes on these forms yet as she does not know how to change pdf files)
- Maintain ample supply of forms at front counter
- Send electronic forms to customers as needed or refer customers to webpage where electronic files can be found

4. Assists in the sorting and counting of cash from vend locations (5%)

- Assist with sorting and counting of money as needed.

5. Assist manager with market research to identify industry best practices and ensure compliance with sustainability guidelines. Responsible for recycling all paper, printer cartridges and toner cartridges. (15%)

- Periodically check websites of different colleges/universites as well of CofC webpage for options of sustainablity and recycled paper etc....make recommendations to mgr
- Recycle all equipment toner and printer cartridges for Copy Center copiers
- Schedule pick up with library for recyclable toner and printer cartidges.

6. Maintain inventory of supplies in the Copy Center, this includes toner, drums, fusers, binders, presentation covers, shrink wrap and office supplies. (5%)

- Order supplies (binders, covers, coils, combs etc) by shopping a minimum of three vendors for best prices. Prepare online shopping carts for review by mgr.
- Order toner, drums and fusers online via Xerox Corp.
- Take regular inventory of supplies and keep record of inventory

Effective immediately for 2013 evaluation period.

Description of Job responsibility/duty (% of total time)

- **Maintain accurate records of revenue and expenditures (35)**

Patty is responsible for entering all job information in the data base for pricing and reports. Patty is responsible for reconciliation of all IDT revenue, Copy Center Cougar Card revenue and Invoice revenue. Responsible for printing monthly reports of each revenue type and attaching reports to hard copies of job order forms. Responsible for maintaining hard copy in office and digital copy of IDT's on the server. Patty will scan all IDT's and add .pdf of IDT to our production folder for submission to the Controller's office.

- **Daily operation of Copy Center (20)**
  Re: Processing Job Orders

Patty is responsible for receiving copy requests. She will log all information and highlight the required information of job when an IDT is submitted via email or in person. Patty will call or email customer to get any information that is not on CCRF, if CCRF form is NOT received with IDT, Patty will complete one by calling or emailing customer for required information. Patty will place work order in a job jacket, write the appropriate job # on IDT/CCRF, **program job on the server with all required attributes of job** (single/double sided, paper type, folding, stapling, etc.) and place job jacket in the rack for production.
DEFAULT (Temporary or student staff member will take job jacket, prepare a proof on the correct stock and give to Patty for approval of stock and quality. Once the job is approved internally, the temp or student staff member will contact the customer via telephone or email to come by and approve the proof. Job will be processed by the temp or student employee once the customer has signed off on it. Job will be placed on the shelf and job jacket given to Patty for pricing and notification to customer). *** When no temporary or student employee is available OR during peak periods, Patty will process orders while acting within limitations set forth by doctor-no lifting more than 15 pounds, no frequent bending or stooping.**

- **Maintain webpage, database and departmental procedural forms. (20)**

Patty is the Copy Center's liaison to webmaster for maintenance of Copy Center webpage. *Set up meeting with Katie Ford to establish a procedure for submitting webpage changes. Monitor webpage for links and information and submit updates as necessary.* Patty is responsible for updating Request Forms (Copy Center Request form, Cougar Card Request form, Invoice Request form and Poster Request form) electronically. Patty maintains an ample supply of forms at front counter and sends electronic forms to customers upon request. *A folder will be created for the electronic files and changes are made as necessary. Submit (once approved by Manager) to webmaster to upload revised forms to webpage.*

- **Assists in the sorting and counting of cash from copier vending locations. (5)**

Patty is responsible for assisting the manager in the sorting and counting of the cash collected from the copier vending locations.

- **Assist manager with market research to identify industry best practices and ensure compliance with sustainability guidelines. Responsible for recycling all paper, printer cartridges and toner cartridges. (15)**

Patty is responsible for monitoring the Copy Center services and prices. Responsible for researching other colleges and universities as well as local market for cost comparison and services offered; make recommendations to manager. *Research websites and make contact with other mangers/assistant managers to gather information. Establish a spreadsheet to record information.* Patty is responsible for recycling fuser/drum cartridges and toner cartridges for Copy Center and for vend copiers located in the Library. *Establish a schedule with the circulation desk in the Library for pick-up of empty cartridges for recycling. Assign the temporary or student employee to pick up the recyclable items from Library.* Monitor the paper recycle bins and notify Physical Plant via Maintenance Direct if a special collection is necessary. *Set up short cut for Maintenance Direct on your computer.*

- **Maintain inventory of supplies in the Copy Center, this includes paper, toner, drums, fusers, binders, presentation covers, shrink wrap and office supplies. (5)**

Memorandum

To: Patricia Pate

From: Cheryl Connor

Re: Written reprimand

Date: July 25, 2013

In accordance with the College of Charleston Code of Conduct, you are being issued this Written Reprimand for the following violation:

Refusal to Accept a Reasonable and Proper Order from an Authorized Supervisor

On Tuesday, July 23, 2013, your supervisor, Cheryl Connor, asked you to look over your Position Description and provide her with a list of duties that you are completing on a daily and weekly basis. This information is needed so that Cheryl can write a Position Description for a Temporary Employee that will be hired next month. You did not provide her with the requested information before you left work on Tuesday. Cheryl sent you an email on Wednesday, July 24, again asking you to submit the requested information by 10:00 this morning. When Cheryl asked you this morning at 9:30 if you had received the email, you acknowledged that you had read it. At 10:15, she asked if you had completed it and you responded "I am not doing it." Cheryl again explained why this information was important but you still refused to comply.

As Assistant Manager, you are an important member of the Copy Center. You are expected to maintain a high level of professionalism and lead others by your example while following the direction of the Copy Center Manager. This type of Insubordination is unprofessional and will not be tolerated.

Future violations of the College of Charleston Code of Conduct will result in further disciplinary action, up to, and including, termination of employment.

Your signature acknowledges that you have received a copy of this memo. It does not necessarily signify agreement with the content.

Signature

Date

CC: **Human Resources**
Human Relations
Amy Orr

BD30/00002

Memorandum

To: Patricia Pate

From: Cheryl Connor

Re: Written reprimand

Date: July 25, 2013

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As Assistant Manager, you are an important member of the Copy Center. You are expected to maintain a high level of professionalism and lead others by your example while following the direction of the Copy Center Manager. This type of Insubordination is unprofessional and will not be tolerated.

Future violations of the College of Charleston Code of Conduct will result in further disciplinary action, up to, and including, termination of employment.

Your signature acknowledges that you have received a copy of this memo. It does not necessarily signify agreement with the content.

Mrs. Pate was presented with this memo and refused to sign it.

Signature **Date** 7.25.13

CC: **Human Resources**
Human Relations
Amy Orr

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: Patricia Ann Pate

Date: 10/15/2014

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on October 15, 2014 and decided:

✓ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

✓ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: 09/16/2014 thru 12/3/14

____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

✓ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

____ We are requiring you to substitute or use paid leave during your FMLA leave.

✓ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ____ is ✓ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

____ **Additional information is needed to determine if your FMLA leave request can be approved:**

____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____ (Provide at least seven calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

____ Your FMLA Leave request is Not Approved.
____ The FMLA does not apply to your leave request.
____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Form WH-382 January 2009

COLLEGE OF CHARLESTON
HUMAN RESOURCES NOTIFICATION FORM

EMPLOYEE NAME Patricia Ann Pate DEPT Copy Center POS# _____

NEW ANNUAL SALARY _____ NEXT PERFORMANCE REVIEW DATE _____ CLASS CODE/SLOT _____

THIS ASSIGNMENT IS THE RESULT OF:

ASSIGNMENT TO NEW POSITION	CHANGE IN ASSIGNMENT TO EXISTING POSITION	EMPLOEE CLASS	EFFECTIVE DATE
			11/07/14

CWID	ASSIGNMENT START DATE	ASSIGNMENT END DATE
10366174		

EVENT START	CODES STOP	PRIOR LINK	FTE	HOURS

REMARKS: Employee is to be placed on LWOP starting November 7, 2014, until she returns from FMLA.
Available leave - AL 22.74, Sick 9.40, all will be exhausted on 11/7/2014 (Supplemental Payroll 22).

Tammy L. McFadden
Name

11/14/2014
Date

SALARY

EARNING SCHEDULE	HOURLY RATE	FLAG	ANNUAL	CODE

TIMEKEEPING LOCATION	LABOR OBJECT	EXTENDED PAY DATE	ASSIGNMENT	
			DIV	DEPT

TRIDENT PAIN CENTER
FOR ALL • QUALITY OF LIFE

9267-G Medical Plaza Dr.
N. Charleston, SC
29406

108 N. Hwy 52
Moncks Corner, SC
29461

302 Medical Park Dr.,
Ste 207-A
Walterboro, SC
29488

Coming Soon
1341 Old Georgetown Rd.
Mt. Pleasant, SC
29464

Phone
843-797-3636

Fax
843-797-3637

Web
tridentpaincenter.com

WORK RESTRICTIONS:

Date: 11/24/14

To Whom It May Concern:

Patricia Pate was seen at Trident Pain Center today and I respectfully request you excuse any absence related to their care.

☐ The patient may return to work on _____, **full duty** with no restrictions.

☒ The patient may return to work on 12/4/14, **light duty** with the following restrictions: 4 hours per day for 2 weeks

- ☒ No lifting greater than 15# lbs
- ☒ No bending, squatting, or crawling
- ☒ No pushing/pulling heavy objects

☐ The patient is instructed to remain **out of work** until further notice.

These restrictions apply until the patient is seen in this office 12/19/14. We will update you in regards to the patient's work status at that time. Thank you for your consideration.

Sincerely,

J. Edward Nolan, MD
Medical Director

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B. Questions to help determine whether an accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) is interfering with job performance or accessing a benefit of employment?
unable to lift > 15 lbs, stand or sit without frequent rest periods / change in position

What job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?
Chronic pain requires pt to take frequent breaks / change of position

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?
may be unable to stand or sit for extended periods such as 8hr day

C. Questions to help determine effective accommodation options.

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

Do you have any suggestions regarding possible accommodations to improve job performance?

If so, what are they? reduce lifting loads to 15 lbs or less, allow for frequent rest periods and time to change position ergonomic seating and desk options

How would your suggestions improve the employee's job performance?
patient will likely be able to work full days with these accomodations and will be out of work less due to flare up of pain

D. Other questions or comments.

Medical Professional's Name J. Edward Hilton, MD Phone 843 | 9973636 | fax 843 797 8637
Address 9267-G Medical Plaza Dr. N. Charleston, SC 29406
Medical Professional's Signature [signature] Date 11-26-14

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

COLLEGE of CHARLESTON

1770

Human Relations and Minority Affairs

TO: Patty Pate, Printing Manager, Copy Center

FROM: Kimberly Gertner, Director, Office of Human Relations and Minority Affairs

DATE: December 5, 2014

RE: Response to Request for Accommodations

CC: Cheryl Connor, Director, Copy Center

This correspondence is to notify you of the College of Charleston's response to your request for accommodations. As you may recall, you asked for the following accommodations: (1) Reduce lifting loads to 15 pounds or less; (2) Allow for frequent rest periods and time to change position; and (3) Ergonomic seating and desk options.

Based upon the information you and your healthcare provider have submitted to the Office of Human Relations and Minority Affairs, the College of Charleston approves your request for accommodations as provided herein.

The Copy Center is able to grant your request to reduce lifting loads to 15 pounds or less. With respect to your request for time to change position, the Copy Center is able to grant this request. Please sit or stand, as needed. The Copy Center is also able to accommodate your request for frequent rest periods. Lastly, the Copy Center has obtained and provided you with an ergonomic chair. In the event, you wish to explore the ergonomics of your workspace further, please let your supervisor know and arrangements can be made to have this assessment completed.

In closing, the College trusts that this response meets your needs. Please be aware that you or the College may review and/or modify these arrangements should circumstances so necessitate.

Please sign below indicating that you acknowledge and accept these accommodations as stated herein. If you have any questions, please do not hesitate to contact this office.

Patty Pate Date

COLLEGE OF CHARLESTON
HUMAN RESOURCES NOTIFICATION FORM

EMPLOYEE NAME Patricia Ann Pate DEPT Copy Center POS#

NEW ANNUAL SALARY NEXT PERFORMANCE REVIEW DATE CLASS CODE/SLOT

THIS ASSIGNMENT IS THE RESULT OF:

ASSIGNMENT TO NEW POSITION | CHANGE IN ASSIGNMENT TO EXISTING POSITION | EMPLOEE CLASS | EFFECTIVE DATE

12/05/14

CWID 10366174 | ASSIGNMENT START DATE | ASSIGNMENT END DATE

EVENT START | CODES STOP | PRIOR LINK | FTE | HOURS

REMARKS: Employee has exhausted all leave and is on a reduced working schedule. She only works 4 hours a day. Employee returned to work on 12/4/2014. She called out 12/5and 12/12, for this pay period. Also called o 12/16, and 12/17. Please adjust pay.
Thank you!

Tammy L. McFadden
Name

12/17/2014
Date

SALARY

EARNING SCHEDULE	HOURLY RATE	FLAG	ANNUAL	CODE

TIMEKEEPING LOCATION	LABOR OBJECT	EXTENDED PAY DATE	ASSIGNMENT	
			DIV	DEPT

COLLEGE OF CHARLESTON
HUMAN RESOURCES NOTIFICATION FORM

EMPLOYEE NAME Patricia Ann Pate DEPT Copy Center POS#

NEW ANNUAL SALARY NEXT PERFORMANCE REVIEW DATE CLASS CODE/SLOT

THIS ASSIGNMENT IS THE RESULT OF:

ASSIGNMENT TO NEW POSITION | CHANGE IN ASSIGNMENT TO EXISTING POSITION | EMPLOEE CLASS | EFFECTIVE DATE

01/29/2015

CWID 10366174 | ASSIGNMENT START DATE | ASSIGNMENT END DATE

EVENT START | CODES STOP | PRIOR LINK | FTE | HOURS

REMARKS: Employee is to be placed on LWOP starting January 29, 2015 thru July 28, 2015.

Tammy L. McFadden
Name

02/02/2015
Date

SALARY

EARNING SCHEDULE	HOURLY RATE	FLAG	ANNUAL	CODE

TIMEKEEPING LOCATION	LABOR OBJECT	EXTENDED PAY DATE	ASSIGNMENT	
			DIV	DEPT

EXTENDED DISABILITY LEAVE REQUEST

In accordance with SC Human Resources Regulation 19-712.01(I), I hereby request extended disability leave. I understand and attest to the following: For any extended period of certified disability due to illness, injury or maternity, I may apply for leave without pay which, along with any paid leave taken, shall not exceed one hundred eighty (180) calendar days. Upon receipt of appropriate documentation, the leave without pay shall be granted with reinstatement privileges to the same position or one of comparable pay band for which I am qualified The College of Charleston requires a healthcare practitioner's certificate or other acceptable documentation describing (1) the date on which the serious health condition commenced, (2) the probable duration of the condition, (3) the projected date of return to work, and (4) appropriate medical facts within the knowledge of the health care practitioner regarding the condition. The College of Charleston may require additional documentation from the healthcare practitioner issuing the certificate or may secure additional medical opinions from other healthcare practitioners. The amount of leave authorized shall not exceed one hundred eighty (180) calendar days for a certified disability due to illness, injury, or maternity.

I have the option of using or retaining accrued annual leave prior to going on leave without pay. Unless this disability is as a result of a Worker's Compensation case, I will use all sick leave before going on leave without pay status unless the College grants an exception at my request.

Patricia A. Fall 1/30/15

Employee Signature Date

1/30/2015

College of Charleston HR Approval Date

Rev. 10.14 (kw ola)

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675 www.wcc.sc.gov

WCC File #: 1121370
Carrier File #: 2011-4217
Carrier Code #:
Employer FEIN #:

Claimant's Name: Patricia Pate SSN: ___
Addres
C State:
Home Phone: ( ) - Work Phone: ( ) -
Preparer's Name: Stephen B. Samuels Law Firm: Samuels Law Firm

Employer's Name: College of Charleston
Address: 66 George Street
City: Charleston State: SC Zip: 29424
Insurance Carrier: State Accident Fund
Preparer's Phone #: (803) 779-4000

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☒ Claimant ☐ Employer (check one) Date of Injury or Illness: 12/14/2011

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

Please see Attachment to Form 30.

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

☐ **Mediation**

☐ Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.

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 Margaret Urbanic, Clawson & Staubes, LLC, 126 Seven Farms Dr., Ste 200, Charleston, SC 29492, Kirsten Barr, Trask & Howell, LLC, PO Box 2167, Mt. Pleasant, SC 29465, Mikell Wyman, Gallivan White & Boyd, PA, PO Box 22768, Charleston, SC 29413, and Page Snyder, State Accident Fund, PO Box 102100, Columbia, SC 29221 on the 27th day of May 2016, by ☒ first class postage ☐ certified mail ☐ personal service.

Preparer's Signature | Attorney for Claimant (Title) | Stephen@samuelslawfirm.net (Email) | May 27, 2016 (Date)

Check this box if you are not represented by an attorney ☐

Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov.

If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-205 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.

10. Whether the Single Commissioner erred as a matter of fact and law in ruling "any loss of wage-earning capacity is not the proximate result of the December 14, 2011 accident."

11. Whether the Single Commissioner erred as a matter of law in misapplying Geathers v. 3V, Inc. 371 S.C. 570, 641 S.E.2d 29 (2007) when there was no later injurious exposure nor an intervening "accident."

12. Whether the Single Commissioner erred as a matter of law in denying further medical treatment by erroneously concluding "there is no medical evidence stated to a reasonable degree of medical certainty that the Claimant currently requires any additional medical treatment to lessen the period of disability directly related to the December 14, 2011 accident when it is undisputed that Claimant's need for pain management arises directly out of the work accident.

13. Whether the Single Commissioner erred as a matter of law in limiting the award to the back.

STATE OF SOUTH CAROLINA	)	BEFORE THE SOUTH CAROLINA
	)	WORKERS' COMPENSATION COMMISSION
COUNTY OF CHARLESTON	)	
Patricia Pate,	)	
	)	
Claimant,	)	
	)	
-vs-	)	
	)	**BRIEF OF APPELLANT**
College of Charleston,	)	
	)	
Employer,	)	
	)	
and	)	
	)	
State Accident Fund,	)	
	)	
Carrier,	)	
	)	
Defendants,	)	
	)	

Claimant, by and through her undersigned attorney, hereby submits her Brief of Appellant in support of her claim for workers' compensation benefits.

STATEMENT OF THE CASE

This is an appeal from a Form 50 hearing. The Claimant, Patricia Pate, was employed as an assistant manager at the Copy Center at the College of Charleston. Pate suffered an admitted injury by accident to her back and legs on December 14, 2011.

Pate underwent an instrumented lumbar fusion surgery by Dr. Joseph Marzluff on May 15, 2012. [APA page 134]. Pate returned to work at the Copy Center with restrictions following her surgery. Dr. Marzluff assigned a 40% impairment rating to the spine – based on 30% whole person DRE Category V with an additional 10% for chronic pain. [14B]. Dr. Marzluff noted she was

ATTACHMENT TO FORM 30

Patricia Pate v. University of Charleston and State Accident Fund
WCC File No. 1121370

Grounds of Appeal:

1. Whether the Single Commissioner erred as a matter of fact and law in finding tha "Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment."

2. Whether the Single Commissioner erred as a matter of fact and law in denying additional medical treatment when such treatment was necessary to treat Claimant's chronic pain resulting from her surgery.

3. Whether the Single Commissioner erred as a matter of law in holding an intervening act can break the chain of causation in a workers' compensation claim when there is no legal authority for such a holding.

4. Whether the Single Commissioner erred as a matter of fact and law in denying psychological injury.

5. Whether the Single Commissioner erred as a matter of fact and law in failing to find Claimant permanently and totally disabled.

6. Whether the Single Commissioner erred as a matter of fact and law in awarding 23% permanent loss of use of the back.

7. Whether the Single Commissioner erred as a matter of fact and law in ruling that "any increase above the permanet impairment would require impermissible surmise, conjecture and/or speculation."

8. Whether the Single Commissioner erred as a matter of fact and law in finding "Claimant's current condition, subjective complaints, need for medical treatment, and work restrictions have all been significantly increased and aggravated by the subsequent, intervening pulmonary embolisms.

9. Whether the Single Commissioner erred as a matter of fact and law in ruling "Claimant is not entitled to future medical treatment, as none is recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury."

suffering from increasing pain and bowel incontinence. He opined "A lot of the problems that she was having were related to the stuff she was doing at work aggravated her back." [Marzluff dep. Page 5, lines 1-13].

Dr. Marzluff retired. Dr. Edward Nolan of the Trident Pain Center took over Pate's long-term pain management on December 17, 2013. He treated Pate with SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, and medications (OxyContin, Percocet and Tizanidine). He also ordered a lumbar back brace. On February 28, 2014, Dr. Nolan opined Pate was at MMI. He opined she would require ongoing palliative treatment including all these modalities. [APA pages 7-8]. Dr. Nolan assigned a 23% whole person rating based on DRE Category IV. [APA page 126(a)].

On April 23, 2014, Dr. Nolan reported:

> [s]he has returned to work full time with no restrictions on 4/11/14 but reports that her pain and anxiety are elevated. She reports that the getting up and down and standing for prolonged periods of time are a major issue. Her FCE showed that she could perform medium work however pt does report that her pan was elevated after the FCE and she cannot do this type of work daily. **In order to keep pt working, pt cannot stand more than 1 hour at a time then must sit for at least 2 hours. She may require breaks during these times to change positions for a short period of time (5-10 minutes). She cannot lift more than 15 pounds.** [APA page 29 (emphasis added)].

Pate continued seeing Dr. Nolan for treatment once a month. Her pain consistently ranged from 5-7 out of 10. She remained on narcotic pain medication and received injections about every two months.

Pate temporarily stopped working on September 15, 2014 when she was hospitalized for a pulmonary embolism. On the last visit before she stopped working, Dr. Nolan noted "Pt was referred for a low back brace 2/21/14 but has yet to receive it. Will again request this from her w/c

today as we have already identified that this would be highly beneficial for her during her work hours." Dr. Nolan also noted she was scheduled to see her psychologist, Dr. Kee, for further discussion regarding her depression. [APA page 59].

On September 22, 2014, Pate returned to Dr. Nolan. Dr. Nolan reported:

> Pt has recently been hospitalized for blood clots in the lungs. Will now be on Xarelto [anti-coagulent] for the next 3-6 months. Percocet has been d/c'd however she is not getting as much relief from the Oxydodone IR 5 mg therefore we will ask her to start doubling what she has to 10 mg and provide her with a new prescription at this time. Also pt will not be eligible for injections for the next 3-6 month period. [APA page 66].

On October 23, 2014, Dr. Nolan wrote:

> She states the increase of OxyContin to BID has helped but she is ultimately unable to perform her job duties as required. Due to her inability to receive needed injection therapy until 2/2015 due to pulmonary embolisms we recommend she be placed out of work at this time and a letter will be drafted to this effect. I will continue to monitor her work status at each visit. Medication management and trigger point injections will be her treatment options at this time. [APA page 70].

On November 24, 2014, Dr. Nolan reported:

> She continues to remain out of work per our last letter requesting 2 months out. She reports improvement in ability to cope with pain since she has been out of work. She has provided an accommodation request from her employer which we will complete and send back. At this point, we recommend pt to plan for return to work after 12/03/14 at 4 hours per day for 2 weeks with accommodations which will be available per her paperwork brought to be filled out today and then we will re-evaluate her work status 2 weeks after that. [APA page 81, 83].

Pate returned to work at the Copy Center with these restrictions on December 4, 2014. Even with the restrictions, she called out on December 5, 12, 16 and 17. [APA page 307].

On December 22, 2014, Dr. Nolan continued the restrictions of 4 hour per day, 4 days per week, with "No bending, squatting or crawling, no lifting greater than 15 pounds, and no pushing or pulling heavy objects." [APA page 93].

On January 21, 2015, Dr. Nolan performed a Caudal Epidural Steroid Injection. This was the first LESI performed since the injections were suspended due to the pulmonary embolisms. [APA pages 96-98].

On February 5, 2015, Dr. Nolan continued Pate on sedentary restrictions of 4 hours per day, 4 days a week. [APA page 101].

The Copy Center ultimately determined it could not accommodate Pate's restrictions. She was placed on LWOP (leave without pay) on January 29, 2015. [APA pages 308-309].

ISSUES ON APPEAL

1. Whether the Single Commissioner erred as a matter of fact and law in finding that "Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it relates to Claimant's disability and continued medical treatment."

2. Whether the Single Commissioner erred as a matter of fact and law in denying additional medical treatment when such treatment was necessary to treat Claimant's chronic pain resulting from her surgery.

3. Whether the Single Commissioner erred as a matter of law in holding an intervening act can break the chain of causation in a workers' compensation claim when there is no legal authority for such a holding.

4. Whether the Single Commissioner erred as a matter of fact and law in denying psychological injury.

5. Whether the Single Commissioner erred as a matter of fact and law in failing to find Claimant permanently and totally disabled.

6. Whether the Single Commissioner erred as a matter of fact and law in awarding 23% permanent loss of use of the back.

7. Whether the Single Commissioner erred as a matter of fact and law in ruling that "any increase above the permanent impairment would require impermissible surmise, conjecture and/or speculation."

8. Whether the Single Commissioner erred as a matter of fact and law in finding

"Claimant's current condition, subjective complaints, need for medical treatment, and work restrictions have all been significantly increased and aggravated by the subsequent, intervening pulmonary embolisms."

9. Whether the Single Commissioner erred as a matter of fact and law in ruling "Claimant is not entitled to future medical treatment, as none is recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury."

10. Whether the Single Commissioner erred as a matter of fact and law in ruling "any loss of wage-earning capacity is not the proximate result of the December 14, 2011 accident."

11. Whether the Single Commissioner erred as a matter of law in misapplying Geathers v. 3V, Inc. 371 S.C. 570, 641 S.E.2d 29 (2007) when there was no later injurious exposure nor an intervening "accident."

12. Whether the Single Commissioner erred as a matter of law in denying further medical treatment by erroneously concluding "there is no medical evidence stated to a reasonable degree of medical certainty that the Claimant currently requires any additional medical treatment to lessen the period of disability directly related to the December 14, 2011 accident when it is undisputed that Claimant's need for pain management arises directly out of the work accident.

13. Whether the Single Commissioner erred as a matter of law in limiting the award to the back.

ARGUMENT

1. An unrelated medical condition cannot constitute an intervening cause sufficient to break the chain of causation.

The Single Commissioner ruled "Claimant is not entitled to. . . any benefits . . . pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007)." [Order, page 13, Conclusion of law 4 and 5]. Such a ruling has no support in the law and is an erroneous misapplication of Geathers.

In Geathers, the Supreme Court adopted the "last injurious exposure rule." The *last injurious exposure* rule:

> places full liability upon the carrier covering the risk at the time of the most recent injury that bears a causal relation to the disability. Consistent with the rule that an employer takes its employee as it finds her, the last injurious exposure rule makes the insurer at risk at the time of the second injury liable even if the second injury would have been much less severe in the absence of the prior condition and even if the prior injury significantly contributed to the final condition.

The *last injurious exposure* rule is simply a rule to avoid apportionment and put liability on the carrier covering the most recent injury. It has absolutely no application to the facts of this case. It cannot be used as a means to deny further benefits when there is no subsequent carrier nor any later injurious exposure. *There is no second accident in this case.*

The fundamental principle applying to this case is "that a nonwork-related condition is not a superseding, intervening event that breaks the causal connection between a work-related injury and a claimant's disability."[1] Brockel v. N.D. Workforce Safety & Ins., 843 N.W.2d 15, 23-24 (N.D. 2014). This rule was followed in South Carolina in Orr v. Elastomeric Prods., 323 S.C. 342, 474 S.E.2d 448 (Ct. App.1996). In Orr, the claimant unexpectedly became pregnant following back surgery for her injury. Due to the pregnancy, she was unable to participate in physical therapy, spurring the carrier to seek to suspend her compensation. The Court of Appeals rejected this argument, reasoning "The fact that Orr's pregnancy indirectly prolonged the period during which she was unemployable does not change the fact that *her injury, not her pregnancy, rendered her unable to work.*" Id. at 449 (emphasis added).

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[1]A clear majority of jurisdictions – including South Carolina – follow this rule. See, e.g., Thurston v. Guys With Tools, Ltd., 217 P.3d 824 (Alaska 2009); Moore v. Component Assembly Sys., 158 Md.App. 388, 857 A.2d 549 (2004); Schock v. Morristown Mem'l Hosp./Atlantic Health Sys., 2010 WL 2793949 *6 (N.J.Super.A.D. July 2, 2010); Thomas v. Burggraf Restoration, 31 P.3d 402 (Okla.Ct.Civ.App.2001); Workmen's Comp. Appeal Bd. v. Chamberlain Mfg. Corp., 336 A.2d 659 (1975); Orr v. Elastomeric Prods., 323 S.C. 342, 474 S.E.2d 448 (Ct.App.1996); Wood v. Fletcher Allen Health Care, 739 A.2d 1201 (1999).

The Alaska Supreme Court addressed a factual situation somewhat similar to the instant case in Thurston v. Guys With Tools, Ltd., 217 P.3d 824 (Alaska 2009). In Thurston, the claimant sustained an admitted knee injury. She then was diagnosed with unrelated lung cancer and underwent radiation treatment and chemotherapy. She was a candidate for a knee replacement, but was unable to undergo the surgery due to the cancer. The Alaska Workers' Compensation Board found that the combination of Thurston's knee disability and cancer rendered her totally disabled. The Alaska Workers' Compensation Appeals Commission remanded for a rehearing.

The Alaska Supreme Court set out the rule for deciding this case. In cases involving a "subsequent independent condition — in this case Thurston's cancer — the employee must show that the work-related condition is a substantial factor in the overall disability. . . . To be eligible for TTD or PTD benefits Thurston needs to show that her work-related disability is a substantial factor in her total disability, without regard to whether her cancer could independently have caused the total disability. The test does not require the Board to pretend that Thurston does not have cancer." Id. at 828. The court added "to deny coverage to an employee in such circumstances would 'create a windfall to employers simply because of the employee's misfortune in developing an independent medical condition.'" Id. at 829, *citing* Estate of Ensley v. Anglo Alask Const. Inc., 773 P.2d 955 (Alaska 1989)(reversing denial of compensation for injured worker who developed cancer because "The Board did not make the factual finding that his back condition no longer prevented him from returning to work; rather the Board relied on the fact that he subsequently underwent cancer treatment to justify its decision that he was no longer disabled.").

It was error of the Single Commissioner to deny ongoing medical treatment and disability compensation under the theory that the pulmonary embolus was an intervening cause. The rule she

appeared to be following is "Every natural consequence that flows from a work-related compensable injury is also compensable unless the consequence is the result of an independent, intervening cause sufficient to break the chain of causation." Whitfield v. Daniel Constr. Co., 226 S.C. 37, 40-41, 83 S.E.2d 460, 462 (1954).

The case law consistently requires an intervening cause to be a subsequent *accident* attributable to the *claimant's own intentional conduct*. See, e.g. Tims v. J.D. Kitts Constr., 393 S.C. 496, 713 S.E.2d 340 (Ct. App. 2011)(rejecting argument that heatstroke suffered by quadriplegic from being left in his attributable's car was an independent intervening cause because "neither Claimant's decision to ride in his caregiver's car nor his caregiver's negligence was an independent, intervening cause sufficient to break the chain of causation."), *citing* 1 Arthur Larson & Lex K. Larson, Larso"s Workers' Compensation Law § 10.01, 10-1 (2010) (stating that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment, unless it is the result of an independent, intervening cause attributable to the claimant's own intentional conduct).

In the instant case, Pate is not seeking treatment for the pulmonary embolus nor is she contending the pulmonary embolus aggravated her compensable injury. She is simply seeking disability compensation and treatment for her original back injury (along with treatment for causally related radiculopathy and psychological overlay). To the extent that her disability was arguably increased by the temporary restriction on epidural steroid injections occasioned by her use of Xarelto, use of this medication does not constitute an intervening cause.

Professor Larson discusses various scenarios where a claimant's unreasonable refusal to accept medical treatment which could have reduced his disability is considered an intervening cause

sufficient to break the chain of causation. Professor Larson observed:

> Closely related to the problem of claimant misconduct in aggravating an injury by treatment is the problem of aggravating an injury, or preventing its alleviation, by refusal of reasonable treatment, healing, exercise, examination, or surgery, in that the relevant events cluster around the handling of a compensable injury. The degree of claimant misconduct required to break the chain of causation should therefore be not mere negligence, but intentional conduct that is clearly unreasonable.

1 Arthur Larson & Lex K. Larson, Larson's Workers' Compensation Law § 10.10 (2010)

Had Pate unreasonably and intentionally refused injections that could have lessened her disability, then perhaps the temporary cessation of the injections could be considered an intervening cause. However, it is undisputed that Pate willingly underwent injections and other treatment in her attempt to continue working. It was Dr. Nolan's decision to suspend the injections due to the pulmonary embolus; not Pate's. She refused no treatment. As such, the cessation of the injections cannot be considered an intervening cause as a matter of law.

Pate's need for medical treatment and disability must be analyzed in light of her overall condition. She only "needs to show that her work-related disability is a substantial factor in her total disability, without regard to whether her [pulmonary embolus] could independently have caused the total disability." Thurston v. Guys With Tools, Ltd., 217 P.3d 824 (Alaska 2009). She has no restrictions from the pulmonary embolus. As all her restrictions and all of her treatment are directly related to her workplace injury, she should be found permanently and totally disabled.

2. Claimant's work restrictions and need for ongoing medical treatment are directly related to her workplace injury.

At the hearing, Defendants argued "It's our position that the Claimant suffered a subsequent intervening injury in September of 2014 when she was hospitalized for multiple pulmonary embolisms, which are unrelated to her employment and unrelated to this injury.... So any disability

or loss of wage earning is proximally caused by these personal health problems, not by the accident." [Tr. Page 5, line 22-page 6, line 1; page 7, lines 2-4). The Single Commissioner ruled "The greater weight of the evidence indicates that Claimant is currently out of work due to a non-work-related personal health problem (pulmonary embolisms) and; therefore, any loss of wage-earning capacity is not the proximate result of the December 14, 2011 accident." [Order, page 13, Conclusion of Law 2]. This conclusion is not supported by the evidence.

A. Work Restrictions and Disability.

Pate has always had substantial restrictions due to her back injury. On April 23, 2014 (before the pulmonary embolus), Dr. Nolan opined: **"In order to keep pt working, pt cannot stand more than 1 hour at a time then must sit for at least 2 hours. She may require breaks during these times to change positions for a short period of time (5-10 minutes). She cannot lift more than 15 pounds.** [APA page 29 (emphasis added)]. Pate continued to work in what was essentially sheltered employment for as long as she could manage her pain.

Pate developed the pulmonary embolus on September 14, 2014. She was hospitalized for several days. During this time, Pate's back pain increased to a level where she was not able to work. Dr. Nolan wrote her out of work for two months. He then returned her to work with restrictions of 4 hour per day, 4 days per week, with "No bending, squatting or crawling, no lifting greater than 15 pounds, and no pushing or pulling heavy objects." [APA page 93].

Pate returned to work at the Copy Center with these restrictions on December 4, 2014. Even with the restrictions, she called out on December 5, 12, 16 and 17. [APA page 307]. Ultimately, the Copy Center determined it could not accommodate Pate's restrictions. She was placed on LWOP (leave without pay) on January 29, 2015 – less than two months into the period of increased

restrictions. [APA pages 308-309].

Notably, during the period Pate was working 4 hours per day, Dr. Nolan performed a Caudal Epidural Steroid Injection (on January 21, 2015,). [APA pages 96-98]. This is important because it confirms her disabling increase in pain is due to the natural progression of her condition – not going without ESI's.

The fact Pate is permanently and totally disabled is not in dispute. Pate is disabled because no employer (including the Copy Shop) could accommodate her work restrictions. The work restrictions are directly due to the workplace injury. *She has no restrictions from the pulmonary embolus*. The Single Commissioner was simply wrong when she concluded: "Claimant's current condition, subjective complaints, need for medical treatment, and work restrictions have all been significantly increased and aggravated by the subsequent, intervening pulmonary embolisms." Similarly, the Single Commissioner's conclusion that the pulmonary embolisms "aggravated her pre-existing back condition according to Claimant's own treating physician" finds no support in the record.

The Decision and Order below should be reversed. Pate should be awarded permanent and total disability compensation.

B. Medical Treatment.

The Single Commissioner ordered that all of Pate's medical treatment be terminated – despite the fact Pate had been receiving continuous ongoing medical treatment for four years. The Commissioner reasoned "Claimant's current subjective complaints and need for medical treatment are not causally-related to the December 14, 2011 accident because the subsequent intervening personal injury (pulmonary embolisms) resulted in increased pain, decreased function, and both

changes and increases in medical treatment claimant received for her low back." [Order, page 13, Conclusion of Law 5].

It is frankly appalling that Pate's medical treatment would be terminated on such a flimsy premise. Even before the pulmonary embolus, it was well-established that Pate would require long-term pain management. Dr. Marzluff testified on March 13, 2013, that she would require physical therapy, pain medications and diagnostic studies. [Marzluff dep., page 13, lines 12-15; APA page 161]. He also recommended an epidural injection in early 2013. [Marzluff dep, pages 16-17]. When Dr. Nolan placed her at MMI on February 14, 2014, he opined Pate "will need ongoing palliative treatment to include steroid injections (no more than 6 per year), trigger point injections, therapeutic exercises, modalities and medication management as needed. Referral to physical therapist." [APA page 8]. On the September 10, 2014 visit immediately before the embolism, Dr. Nolan "prescribed lumbar orthotic support, TENS unit, oxycontin, percocet, and tizanidine hydrochloride (Zanaflex)," along with a transforaminal steroid injection and epiduragram. [APA pages 161-163].

None of this treatment became less necessary because of the pulmonary embolus. Some of the pain medications were changed to cope with increasing pain and her epidural steroid injections where temporary suspended while she was on Xarelto. However, these changes were either temporary or in the normal course of a physician titrating pain medication to adjust to the patient's symptoms. Dr. Nolan even noted how working increased her pain: "She reports improvement in ability to cope with pain since she has been out of work." [APA page 81, 83].

The pain management was not required to treat the pulmonary embolus. The only treatment required for the pulmonary embolus was a course of anti-coagulent therapy (Xarelto). Pate never claimed her employer should pay for the Xarelto. Furthermore, although she was still taking Xarelto

at the time of the hearing, the expectation was that she would eventually be able to cease anti-coagulent therapy.

In short, there is no evidence the pulmonary embolus changed the normal course of Pate's pain managment. Dr. Nolan prescribed the same regime both before and after the pulmonary embolus. The pulmonary embolus did not break the chain of causation. Therefore, the Decision and Order regarding medical treatment must be reversed. Defendants should be ordered to resume treatment as prescribed by Dr. Nolan.

3. Claimant met the legal standard for post-MMI medical treatment.

The Single Commissioner also denied further medical treatment on the separate ground that "there is no medical evidence stated to a reasonable degree of medical certainty that the Claimant currently requires any additional medical treatment to lessen the period of disability directly related to the December 14, 2011 accident." [Order, pages 13-14, Conclusion of Law 5]. This was error.

To begin with, Pate is permanently and totally disabled due to her workplace injuries. As such, she is entitled to lifetime medical treatment. S.C. Code Ann. § 42-15-60(C) (2007). Furthermore, she has retained hardware from her surgery which must also be "furnished during the life of the injured employee." Id. [APA page 121].

As to direct proof, Dr. Marzluff testified *on questioning from Defense Counsel* that "she will probably need intermittent physical therapy and pain medications, perhaps intermittent diagnostic studies." [Marzluff dep., page 13, lines 12-15; APA page 161]. If the answer was not stated to a reasonable degree of medical certainty, it was incumbent on the questioner to raise the insufficiency of the answer at the deposition. The failure to do so constitutes a waiver of the issue. Additionally, Dr. Marzluff stated on the 14B to reasonable degree of medical certainty that Pate would require

additional treatment. [Apa page 161]. His deposition testimony merely specified what that treatment would be.

Dr. Nolan opined Pate "will need ongoing palliative treatment to include steroid injections (no more than 6 per year), trigger point injections, therapeutic exercises, modalities and medication management as needed. Referral to physical therapist." [APA page 8]. His opinion also further explicates on Dr. Marzluff's recommendations.

The language from Dr. Nolan's reports is the functional equivalent of stating his opinions to a reasonable degree of medical certainty. A similar technical argument involving such "magic words" was rejected in Gamble v. Price, 289 S.C. 538, 347 S.E.2d 131 (Ct. App. 1986)(holding expert testimony stated "has sustained disability from this accident" satisfied the standard that testimony must be stated "most probably.").

To the extent that Defendants now deny they are not liable for providing treatment they had been providing continuously for 4 years *in an admitted claim,* they should be estopped from now denying that such treatment is both causally related and will tend to lessen Pate's period of disability. See Jervey v. Martint Environmental, Inc., 721 S.E.2d 469, 396 S.C. 442 (Ct. App. 2012)(employer barred by waiver and estoppel from denying claim which had been accepted for 1 year and 10 months).

4. Claimant's injury was not limited to her back in that she suffered from radiculopathy and psychological overlay.

The Single Commissioner found "the December 14, 2011 accident did not result in injury to, or otherwise affect, any other body member or system." [Order, page 9, Finding of Fact 1]. This was error, as Pate's accident resulted in radiculopathy and SI joint injury along with major

depressive disorder.

A. Radiculopathy and SI Joint Injury.

It is well-established law that radicular symptoms from a back injury are considered an "affect" on the legs. This is so even in the absence of a separate impairment rating. See Hutson v. S.C. State Ports Authority, 390 S.C. 108, 700 S.E.2d 462 (Ct.App. 2010), *reversed on other grounds,* 732 S.E.2d 500, 399 S.C. 381 (2012)(affirming Commission's finding that radicular symptoms in the right leg showed an injury to the back "with affects to the right leg."). This makes sense as the AMA Guides incorporate radiculopathy into the whole person ratings given for spine injuries.

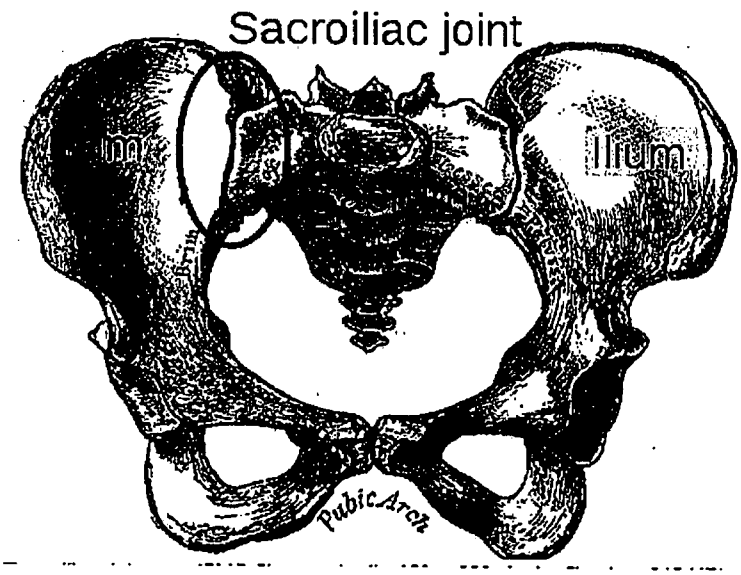
Pate testified that she has pain "in my lower back, and sometimes it leads down to my – into my right thigh through my buttocks. I have more pain on the left side than what it is on the right." [Tr. Page 16, lines 11-15]. This is borne out by the medical records.

Dr. Nolan treated Pate for both back pain radiating into her hip and leg, and SI joint pain. On November 26, 2013, he noted a lumbar injection had given relief, albeit temporarily, of "low back pain and leg pain." From that point, he wanted to "see how treating her lwo back in conjunction with her SI joint provides relief. [APA pages 245-246]. Dr. Nolan continued treating Pane's back, legs and SI joint. He consistently characterizes her pain as "Lower back, buttocks, leg." On August 21, 2014, Dr. Nolan wrote **"Radiating symptoms: moderate to severe lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the knee."** [APA page 55 (emphasis added)]. He assigned a 23% whole person rating for DRE Category IV. This continued from the outset through the last records presented at the hearing. [APA page 116].

In addition to radiculopathy, Pate injured her SI joint – as evidenced by the need for Dr.

Nolan to perform SI joint injections.

The SI joint is an unscheduled member as a matter of law. See Gilliam v. Woodside Mills, 461 S.E.2d 818, 319 S.C. 385 (1995)("as a matter of law the hip socket is part of the pelvis and not part of the leg for workers' compensation purposes"). The SI joint is the articulation between the sacrum and the ilium of the hip bone. Taber's Medical Dictionary. The sacrum supports the spine and is supported in turn by an ilium on each side. The illustration below shows the exact location of the SI joint:



The SI joint is by definition an unscheduled body part. Virtually the same issue presented here was definitively addressed in Gilliam v. Woodside Mills, 461 S.E.2d 818, 319 S.C. 385 (1995). In Gilliam, the employee injured her hip and required a hip replacement. She had no other injuries. The Commission refused to made a general disability award, instead holding that Gilliam was limited to a scheduled member award because the hip socket was part of the leg. The Supreme Court

reversed holding "the hip socket is part of the pelvis and not part of the leg for workers' compensation purposes." Id. The Supreme Court held the issue was one of law – expressly rejecting the employer's contention that it was a substantial evidence issue. As the injury was to an unscheduled member, the Court remanded to the Appellate Panel for a determination of disability under the general disability statute.

Gilliam commands reversal in the instant case. The evidence is overwhelming that the SI joint was permanently injured in the accident. The Single Commissioner's finding that Pate's injury was limited to her back should be reversed.

B. Psychological Overlay.

The Single Commissioner held "Claimant has not met her burden of proving a psychological injury causally-related to her original injury." [Order, page 11, finding of fact 7]. This was error. The Single Commissioner overlooked the evaluation by Dr. Kee, as well as the multiple references of psychological overlay from Dr. Nolan. Defendants presented no evidence to contest the opinions of these two doctors.

Pate was referred to Dr. Kee by Dr. Nolan on August 21, 2014. He specifically wrote:

> Patient is significantly depressed due s/t pain and increased pressures/stressors. I wold like to refer her to Dr. Kee for psychological workup. She states that she feels work is "trying to push her out, that they don't want her there anymore". She does not appear to be coping well. Will see if she can work with Dr. Kee to develop/improve these skills. Will also start her on Effexor 50 mg BID and see how she does. Will have her back in 2 weeks to assess her response.

[APA page 55].

Dr. Nolan's referral specifically relates the depression due to pain and increased pressures/stressors – explaining that this is from not coping with work and her job pushing her out.

Dr. Kee confirmed the diagnosis of major depressive disorder, as well as "problems with

anxiety and going to sleep because of worrying about work." [APA page 164].

This medical evidence confirms that Pate suffered a psychological overlay with major depressive disorder as a result of the pain and disability resulting from her workplace injury. Therefore, the Single Commissioner should be reversed.

4. The 23% permanent partial disability award to the back is based on legal error in that the Single Commissioner mistakenly concluded she could not award more than Dr. Nolan's impairment rating.

The Single Commissioner awarded "23% permanent loss of use of the back as a result of her work injury." Significantly, the Commissioner ruled "Due to Claimant's subsequent intervening pulmonary embolisms, I find any increase above the permanent impairment would require impermissible surmise, conjecture and/or speculation." [Order, page 11, Finding of Fact 9]. The Commissioner's conclusion is controlled by multiple errors of law.

The first error, as argued infra, is that the pulmonary embolus was an intervening accident. This was exacerbated by the erroneous conclusion that Pate's condition, complaints, need for treatment and work restrictions have "all been significantly increased and aggravated by the subsequent, intervening pulmonary embolisms." [Order, page 11, Finding of Fact 9].

Putting that error aside for the moment, the ruling is fundamentally erroneous because of the significant evidence of Pate's disability prior to the pulmonary embolisms. While Dr. Nolan assigned an impairment rating of 23%, Dr. Marzluff assigned a whole person rating of 36%. This should also have been considered.

Dr. Nolan put Pate under significant work restrictions well before the pulmonary embolus. These restrictions would have disqualified Pate from doing a copy manager job at any other employer. It was only the benevolence of the manager at the Copy Shop that allowed her to continue

working after her surgery in the first place (combined with her strong work ethic). Physical restrictions are an important component of a disability award. Indeed, they are the key factor in distinguishing disability from impairment.

The legal error is apparent from the recent case of McMahan v. S.C. Dept. of Education-Transportation, Op. No. 5415 (S.C.Ct.App. filed June 15, 2016)(Shearouse Adv.Sh. No. 24 at 56). In McMahan, the Appellate Panel reversed the single commissioner's posthumous award of permanent and total disability for a claimant who died of unrelated causes prior to reaching MMI. The Appellate Panel made the same error made by the Single Commissioner in this case, reasoning that a disability award for a claimant who had not reached MMI would be speculative.

The Court of Appeals reinstated the Single Commissioner's disability award, reasoning that there was sufficient evidence in the existing record to determine that McMahan was permanently and totally disabled at his death.

McMahan confirms that the Commission should, at a minimum, make an appropriate disability award taking into account Pate's impairment ratings (23% and 36%); permanent restrictions; pain and need for medical treatment; and age, education and lack of skills at the time of MMI. Thus, even if the Commission finds the Single Commissioner was correct in holding the pulmonary embolus was an intervening accident preventing a total disability award, Pate is still entitled to a proper partial disability award based on the totality of the evidence. Therefore, the Single Commissioner's Decision and Order should be reversed.

CONCLUSION

For the foregoing reasons, the Decision and Order below should be reversed. An Order should be entered finding: (1) Pate is permanently and totally disabled; (2) the pulmonary embolus was not an intervening cause sufficient to break the chain of causation; and (3) Pate is entitled to ongoing treatment for her back, radicular symptoms, SI joint, and psychological overlay. Alternatively, should the Full Commission affirm any part of the Order below, Pate is entitled to a permanent partial disability award based on the totality of the evidence.

Respectfully Submitted,



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July 18, 2016
Columbia, South Carolina

BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION APPELLATE PANEL

Patricia Pate v. Employee, -vs- College of Charleston, Employer, -and- State Accident Fund Carrier, Defendants.	W.C.C. FILE NO. 1121370 **RESPONDENTS'S BRIEF**

STATEMENT OF THE CASE

The Claimant experienced low back pain while assisting a co-worker with a box on December 14, 2011 and was subsequently diagnosed with degenerative changes in her lumbar spine. At a hearing before Commissioner Taylor held pursuant to the Defendants' Form 21 and the Forms 50 and 51, the Defendants argued that the Claimant reached maximum medical improvement for her work-related injury by February 14, 2014, when her impairment was rated by Dr. Nolan as 23% to the spine. The Defendants sought a determination of the Claimant's entitlement to benefits under S.C. Code Ann. § 42-9-30, commensurate with that rating and the fact that she was able to return to her regular full time job, earning her regular wages. The Defendants requested a credit for all temporary total disability paid after the date of maximum

medical improvement and claimed that the Claimant has not met her burden of proving entitlement to any additional medical treatment under S.C. Code Ann. § 42-15-60.

The Defendants further argued that the Claimant suffered a subsequent intervening injury in September 2014 when she was hospitalized for multiple pulmonary emboli unrelated to her employment. As a result of this subsequent intervening injury, the Claimant was unable to receive injection therapy for her low back and was placed out of work by Dr. Nolan. The Defendants argued that, despite her low back problem, the Claimant would be working and earning her regular wages but for her subsequent, intervening pulmonary emboli and resulting treatment (anticoagulant therapy), which broke the chain of causation. Therefore, the Defendants argued that the Claimant's current condition, need for medical treatment, or any alleged loss of wage-earning capacity is the responsibility of the Defendants. Commissioner Taylor agreed with this factual and legal argument and awarded the Claimant benefits for the 23% loss of use of the back causally-related to the December 14, 2011 accident, but denied her claim for additional benefits.

EVIDENCE SUMMARY

At the time in question, the Claimant was employed by the Copy Center at the College of Charleston. She described her duties as answering the phone, greeting customers, collating and binding papers, and some computer work. She admits that she "didn't do that much lifting." (T. p.14).

According to the Claimant, after the accident on December 14, 2011, she underwent a lumbar fusion surgery performed by Dr. Joseph Marzluff. Following surgery, she returned to work at the College's copy shop, where her her work restrictions were accommodated for over two (2) years without incident. The Claimant stopped

working when blood clots in September 2014 prevented her from working full time. (T. p.17).

The Claimant testified that she has pain daily, which she described as a "nagging pain." (T. p.16, lines 9). She claimed that the pain she experiences is in her lower back and sometimes into her right thigh. When she has pain, she testified she has to sit down, or lie down, or take more medication. The Claimant testified that she spends her time doing "odds and ends" around the house. She takes prescription medications and uses a TENS unit. The Claimant testified that she also has a back brace, but she does not use it because it is "uncomfortable."

While the Claimant denied problems with low back pain prior to the work accident, she was confronted with the medical records of her family physician, Dr. Hanna, which plainly show that the Claimant was being prescribed Percocet, Flexeril, Lortab, and Flector patches prior to the December 14, 2011 accident. (APA p. 179, p. 174).

The Claimant did admit that she began having new and different symptoms in her legs in the summer of 2014, including discoloration, swelling, and numbness and she also began experiencing shortness of breath. She was ultimately diagnosed with multiple pulmonary embolisms and was hospitalized for several days. As a result of the pulmonary embolisms, she was placed on anticoagulant therapy, which she still required at the time of the hearing before Commissioner Taylor.

Because of the new need for anticoagulant therapy, the Claimant admitted that the treatment for her low back prescribed by Dr. Nolan changed significantly and she was no longer able to receive injection therapy that had helped her in the past. (T. p.23). The Claimant admitted that none of the treatments she received for her back after the

pulmonary embolisms worked as well as the treatment she received before the pulmonary embolisms and she now takes more medication than before. The Claimant also admitted that her back pain increased significantly after the pulmonary embolisms. According to the Claimant, because she was no longer able to have injection therapy for her back, she was taken out of work by Dr. Nolan and restricted to working only four (f) hours a day and four (4) days per week. (T. p.24--25). Prior to the pulmonary emboli, she worked full time, five (5) days per week, despite her low back problem, for more than two (2) years.

Cheryl Connor, manager of the College of Charleston's copy center, testified that after the incident on December 14, 2011, she changed the Claimant's job description to ensure that her work restrictions would be accommodated indefinitely. According to Ms. Connor, things changed in September 2014 when the Claimant was diagnosed with the pulmonary embolisms. In fact, as a result of the pulmonary embolisms, the Claimant was out of work from September until December 2014. In December, the Claimant was restricted to working only four (4) hours per day and four (4) days per week. Ms. Connor explained that she could accommodate these restrictions in December because school was in recess, but she could no longer afford a part-time employee as of January 2015. Ms. Connor testified that she was able to accommodate all of the Claimant's physical work restrictions, only the new time restrictions issued after the Claimant's pulmonary emboli were problematic.

The records of Carolina Family Medicine are also in evidence. In addition to detailing the Claimant's need for narcotic pain medication and muscle relaxers prior to the work accident, these records reveal that the Claimant was diagnosed with multiple pulmonary embolisms in September 2014 and was suffering from shortness of breath, in

addition to the stress of her brother dying from pancreatic cancer. (APA p.205). In November 2014, the Claimant complained to Carolina Family Medicine that she had a new pain in her left lower leg and behind her left knee, which was aggravated by weight bearing, standing, walking, and bending her knee. (APA p.209).

The record also includes the medical reports of Dr. Joseph Marzluff. Dr. Marzluff performed a lumbar fusion at L4-5 for Spondylolisthesis on May 15, 2012. (APA p. 152). Dr. Marzluff released the Claimant at maximum medical improvement on September 19, 2012, at which time he stated that the Claimant had "returned to work on a limited duty bases [sic] and seems to be tolerating that well." (APA p. 160). Dr. Marzluff rated her impairment at "40% of the spine." (APA p. 160). Dr. Marzluff has not evaluated the Claimant since September 2012.

Dr. J. Edward Nolan's records were also submitted into evidence. Dr. Nolan reported on February 13, 2014 that the Claimant "continues to report good pain relief with her injection therapy and medication management and work restrictions." (APA p.8). Dr. Nolan did not speak to whether the Claimant required additional medical treatment to lessen the period of disability and did not issue any statements regarding future medical treatment to a "reasonable degree of medical certainty." As of February 13, 2014, Dr. Nolan stated that the Claimant was at maximum medical improvement and later issued an impairment rating of 23% to the spine.[1] (APA p.126a). In subsequent records, Dr. Nolan noted that the Claimant "returned to work full time with no restrictions on April 11, 2014;" however, on April 23, 2014, he placed restrictions of no lifting greater than fifteen (15) pounds and no standing more than one (1) hour at a

[1] According to Dr. Nolan, the 23% impairment rating was inclusive of a prior impairment rating issued by Dr. Marzluff on September 19, 2012 (36% of the whole person). (APA p. 126a).

time. (APA p. 29). By September 4, 2014, the Claimant rated her pain as a "4/10 overall," despite the fact that she was working full time. (APA p. 58).

According to a statement issued by Dr. Nolan on October 3, 2014, the Claimant had

> *"been hospitalized on 9/17/14 resulting in a diagnosis of pulmonary embolism which will require daily use of an anticoagulant ...The addition of this medication will hinder my ability to continue injection therapy until this issue has resolved. She has received benefit from injection therapy and with treatment she continued to perform her job duties. She presented to my office today and on exam I am concerned about her ability to continue to perform her job as required. In light of this and our inability to resume injection therapy until her pulmonary embolisms are resolved, I recommend that she be placed out of work for a period of two (2) months and her work status will be evaluated at each visit to our office...Several measures have been taken to try to provide her some form of pain relief to include increasing pain medication strength and frequency and adding physical therapy until we are able to resume treatment with injection therapy."* (APA p. 257).

On September 22, 2014, Dr. Nolan had noted that the Claimant was "*not getting as much relief from the Oxycodone IR 5 mg therefore we will ask her to start doubling what she has to 10 mg.*" (APA p.66).

By October 3, 2014, Dr. Nolan noted that, despite doubling her pain medication,

"she is ultimately unable to perform her job duties as required. Due to her inability to receive needed injection therapy until 02/2015 due to pulmonary embolisms we recommended she be placed out of work at this..." (APA p. 70).

In October 2014, Dr. Nolan recommended that the Claimant start physical therapy *"to help with pain relief, particularly during this period of time that she must remain on a blood thinner."* Because of the blood thinner (anticoagulant therapy), the Claimant was also unable to take Percocet, which she felt had helped more than the pain medications she was forced to take after her pulmonary emboli. (APA p. 81). In fact, with the change in her medical treatment necessitated by the pulmonary emboli, the Claimant informed Dr. Nolan that she was having difficulty coping with her pain. In May 2015, Dr. Nolan recommended monthly trigger point injections because the Claimant was *"unable to get injections with Dr. Nolan due to currently being on Xarelto."* (APA p. 120). The Claimant was still taking the anticoagulant medication Xarelto at the time of the hearing.

Arguments

I. It is improper for the Claimant to raise new claims for the first time on appeal.

In her brief to the Appellate Panel, the Claimant argues for the very first time that she is entitled to a general disability award based upon an unscheduled injury to her sacroiliac joint. However, the Claimant filed Forms 50 on August 28, 2014, September 10, 2014, and February 2, 2015 – none of which even allege any injury to the sacroiliac joint. Similarly, the Claimant's Form 58 makes absolutely no mention of the

sacroiliac joint. In fact, at the hearing before Commissioner Taylor, the Claimant's attorney was given a broad opportunity to restate the issues to be addressed, but said nothing about any alleged injury to the sacroiliac joint and made no claim for benefits for any sacroiliac injury. Furthermore, the Claimant's Form 30 makes no mention of any alleged injury to the sacroiliac joint. Yet, the Claimant now argues that Commissioner Taylor's failure to award benefits for an alleged sacroiliac injury "commands reversal." This argument is wholly without merit.

First, it is fundamental that a Hearing Commissioner can only address such issues as are actually presented by the parties. Obviously, Commissioner Taylor committed no legal error in failing to award benefits for a claim that was never made by the Claimant. More importantly, the issue of whether the Claimant is entitled to general disability benefits for an alleged injury to the sacroiliac joint is no preserved for review by the Appellate Panel, as it was not raised before the Hearing Commissioner *See* Wilder Corp. v. Wilke, 330 S.C. 71, 76, 497 S.E.2d 731, 733 (1998) ("It is axiomatic that an issue cannot be raised for the first time on appeal, but must have been raised to and ruled upon by the trial judge to be preserved for appellate review."); *see also* Elam v. S.C. Dep't of Transp., 361 S.C. 9, 23, 602 S.E.2d 772, 779–80 (2004) ("Issues and arguments are preserved for appellate review only when they are raised to and ruled on by the lower court."); RRR, Inc. v. Toggas, 378 S.C. 174, 185, 662 S.E.2d 438, 443 (Ct. App. 2008) (noting a party cannot raise an issue for the first time on appeal). Therefore, the Defendants respectfully request that the Claimant's arguments regarding her sacroiliac joint be dismissed by the Appellate Panel.

II. The Hearing Commissioner properly concluded that the Claimant is not entitled to benefits for an alleged psychological injury.

According to Hearing Commissioner Taylor, the claim for an alleged psychological injury is not supported by the preponderance of the evidence. Specifically, no physician opined that Claimant has any disability or work restrictions as a result of any alleged psychological condition. No physician opined to a reasonable degree of medical certainty that Claimant's alleged psychological condition is causally-related to her original work injury to her lower back. According to Commissioner Taylor, the Claimant's personal history, prior medical history, and current unrelated medical conditions, which include a long-term battle with irritable bowel syndrome and chronic diarrhea and near-fatal pulmonary emboli, weighed into her denial of benefits for a psychological injury as well.

At the hearing before Commissioner Taylor, the Claimant made no mention of depression or any other psychological problem in her testimony. However, she admitted that she had been under significant stress after she was hospitalized with multiple pulmonary emboli and then shortly thereafter her brother died as a result of pancreatic cancer. (T. p.26). This is consistent with the records of the Claimant's personal physicians at Carolina Family Medicine, which repeatedly described the "aggravating factors" in the Claimant's "stress" as "work stressors, brother dying from pancreatic cancer." (APA p. 192, 207, 209). In a psychological evaluation with Dr. Dyana Lowndes-Rosen, the Claimant "expressed her belief that she has no need for mental health involvement" (APA p. 289). Of course, regardless of the multiple causes for any stress or depression in the Claimant's life, the fact remains that at the time of the hearing, no medical expert was recommending treatment or work restrictions for any

alleged psychological injury. Therefore, the Defendants respectfully request that the Hearing Commissioner's findings regarding the Claimant's alleged psychological issues be affirmed in accordance with the greater weight of the evidence in the record.

III. The Hearing Commissioner's conclusion that the Claimant is not entitled to benefits under S.C. Code Ann. § 42-9-10 or § 42-9-20 should be affirmed in accordance with the greater weight of the evidence and the applicable law.

According to Hearing Commissioner Taylor, the Claimant is not entitled to and the any benefits under S.C. Code Ann. § 42-9-10 or § 42-9-20 pursuant to the Supreme Court's holding in Geathers v. 3V, Inc., 371 S.C. 570, 641 S.E.2d 29 (2007):

> *"The Claimant was working in her regular, full time position as the assistant manager of the College of Charleston Copy Center for more than two years after the December 14, 2011 work accident and; therefore, her back injury was not disabling as a matter of law. Instead, the proximate cause of her loss of wage-earning capacity is the multiple pulmonary embolisms she suffered in September 2014, which aggravated her pre-existing back condition according to Claimant's own treating physician."*

In Geathers, the Supreme Court reaffirmed the well-established "Gordon Rule," which holds that

> "where a latent or quiescent weakened, but not disabling, condition resulting from disease is by accidental injury in the course and scope of employment aggravated or accelerated or activated, with resulting disability, such disability is compensable. The same principle is equally applicable where the latent, but not disabling, condition has resulted from

> a prior accidental injury. If the disability is proximately caused by the subsequent accidental injury, compensability is referable to that, and not the earlier one."

The crux of the Gordon rule is necessity of proximate causation, as opposed to mere concurrent causation. In applying the "Gordon Rule" to the facts *sub judice*, the questions presented are:

> (1) was the Claimant's work-related back injury non-disabling prior to the pulmonary emboli?
>
> (2) was the Claimant's disability caused by the pulmonary emboli and resulting treatment?
>
> (3) did the pulmonary embolism and resulting treatment aggravate the Claimant's pre-existing low back problems?

The answer to each of these questions is undoubtedly "yes." As to the first question, the record is clear that the Claimant returned to her regular, full time job as Assistant Manager of the copy center at the College of Charleston on September 12, 2012 and continued working in this position, earning her regular wages despite her low back injury, for over two years before she was hospitalized with multiple pulmonary emboli, unrelated to her employment, in September 2014. Therefore, the Claimant's work-related back injury was simply not disabling as a matter of law.

Regarding the second question, it is equally clear that the Claimant's current disability is the result of the multiple pulmonary emboli in September 2014. Even the Claimant's treating physician, Dr. Nolan, stated "due to pulmonary embolisms we recommended she be placed out of work." (APA p. 70). There is simply no evidence to

suggest that the Claimant would suddenly have ceased working and earning wages after two years without an intervening event such as the multiple pulmonary emboli.

As for the third and final question in the Gordon analysis, it is equally clear that the Claimant's multiple pulmonary emboli and anticoagulant therapy after September 2014 *aggravated* the Claimant's work-related low back injury. The Claimant admitted at the hearing before Commissioner Taylor that her back pain increased after the pulmonary emboli. (T. p. 25). This is also documented in the records of Dr. Nolan. For example, after being diagnosed with the pulmonary emboli in September 2014, Dr. Nolan doubled the Claimant's pain medications because she was no longer able to get the relief from the medication and treatments she availed herself of prior to the anticoagulant therapy. (APA p. 66). Dr. Nolan opined that "[d]ue to her inability to receive needed injection therapy...due to pulmonary embolisms we recommend she be placed out of work." (APA 70).

While the Claimant desperately turns to Alaska and North Dakota in an effort to suggest that the Claimant's multiple pulmonary emboli and resulting disability are of no legal significance in jurisdictions where concurrent or contributing causation is sufficient, she fails to recognize that proof of "proximate cause" is essential in South Carolina, as explained by the Supreme Court in the Geathers case. In Geathers, the Supreme Court rejected the argument that a pre-existing injury was a contributing cause of the employee's disability and need for treatment in favor of a bright line test requiring that proximate causation be used to determine liability.

Clearly, the "proximate cause" of the Claimant's disability (i.e., inability to earn wages) was the multiple pulmonary emboli and resultant anticoagulant therapy. Once the proximate cause is determined, prior contributing causes are of no legal

consequence. According to our courts, "[p]roximate cause requires proof of (1) causation in fact and (2) legal cause." Bramlette v. Charter-Medical-Columbia, 302 S.C. 68, 72, 393 S.E.2d 914, 916 (1990). Causation in fact is demonstrated by establishing the Claimant would not have become disabled "but for" the pulmonary emboli, while legal cause is proved by establishing foreseeability. If the Claimant's sudden disability in September 2014 was not the natural and probable consequence of the December 14, 2011 work injury, such sudden disability after more than two years of full employment was not foreseeable. Vinson v. Hartley, 324 S.C. 389, 400, 477 S.E.2d 715, 721 (Ct.App.1996). Therefore, the Claimant's work-related back injury was neither the proximate cause of her disability as a matter of law and therefore, this disability should not be the responsibility of the Defendants.

IV. The Hearing Commissioner properly determined that the Claimant is not entitled to any additional medical benefits as a matter of law.

According to the Hearing Commissioner, the "Claimant is not entitled to future medical treatment, as none is currently recommended that would tend to lessen her period of disability directly related to the December 14, 2011 work injury." The Hearing Commissioner went on to explain that the Claimant's pain levels and need for medical treatment have increased significantly as a result of her subsequent, intervening pulmonary embolisms. Therefore, because the Claimant's current condition which requires treatment is not directly and proximately caused by the December 14, 2011 accident because the events of September 2014 broke that chain of causation. As in the Geathers case, the Claimant's entitlement to benefits ceased upon proof the her subsequent, intervening pulmonary emboli broke the chain of legal causation.

Furthermore, Dr. Nolan, the Claimant's treating physician, has not made any future medical recommendations to the requisite "reasonable degree of medical certainty." S.C. Code Ann. § 42-15-60 clearly and unequivocally requires proof by medical evidence stated "to a reasonable degree of medical certainty" that additional medical treatment is required to "lessen the period of disability." As noted above, the Claimant's disability is not even causally-related to the December 14, 2011 work accident. More importantly, neither Dr. Nolan, nor any other medical expert, makes any recommendation for additional medical treatment to the requisite degree of medical certainty.

According to the Claimant, the plain and unambiguous requirements of S.C. Code Ann. § 42-15-60 somehow do not apply to her. The Claimant argues that the "language from Dr. Nolan's reports is the functional equivalent of stating his opinions to a reasonable degree of medical certainty," citing a 1986 Court of Appeals decision that was rendered before § 42-15-60 was amended to specifically require such specific language. The Claimant, having admitted that Dr. Nolan did not give any opinions to the required "reasonable degree of medical certainty," goes on to inexplicably argue that Dr. Marzluff's testimony should be sufficient because in 2012 he sated that the Claimant "will probably need intermittent physical therapy and pain medications." Again, Dr. Marzluff failed to give any opinion regarding the need for medical treatment in 2014 to any degree of medical certainty. The burden was squarely upon the Claimant to produce such evidence and her failure to do so correctly resulted in Commissioner Taylor's denial of medical benefits as a matter of law. Quite simply, the "difficulty in proving a fact in a compensation case does not relieve the party on whom the burden rests of proving it, and it does not shift the

burden to the other party." Herndon v. Morgan Mills, Inc., 143 S.E.2d 376, 380-381 (S.C. 1965).

Conclusion

Based upon the foregoing arguments, the greater weight of the evidence in the record, and the applicable law, the Defendants respectfully request that the Decision and Order of Hearing Commissioner Taylor be affirmed in its entirety.

Respectfully submitted,

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Kirsten L. Barr
Attorney for the Defendants

August 1, 2016
Mt. Pleasant, South Carolina

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
Patricia Pate, Claimant, -vs- College of Charleston, Employer, and State Accident Fund, Carrier, Defendants,	WCC File Number 1121370 **CLAIMANT'S PETITION FOR REHEARING OR RECONSIDERATION**

Claimant hereby files her Petition for Rehearing or Reconsideration to the Appellate Panel. On December 22, 2016, the Appellate Panel issued an opinion affirming in part and reversing in part the Decision and Order of the Single Commissioner

As grounds for granting her Petition, Claimant would respectfully show the Appellate Panel may have overlooked or misapprehended the evidence, law and arguments raised on the issues of (1) whether the injury is limited to the back when the evidence conclusively proves the injury to the back affects the buttocks and left leg; and (2) whether Claimant suffered a psychological overlay as a result of her injury and resulting disability.

ARGUMENT

1. Claimant's injury was not limited to her back in that she suffers from "Radiating symptoms: moderate to severe lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the knee."

The Appellate Panel found "Based on the greater weight of the evidence in the record, the December 14, 2011 accident did not result in injury to, or otherwise affect any other body member of system." [Order, page 11, Finding of Fact 1]. Claimant respectfully contends that the Panel overlooked or misapprehended the consistent evidence of radiculopathy and radiculitis, as well as SI joint injury.

Claimant's back injury affected her legs and sacroiliac joint (SI joint) causing additional physical impairment to these body parts. This is supported by Pate's testimony and the medical records of Dr. Nolan. See Hutson v. S.C. State Ports Authority, 390 S.C. 108, 700 S.E.2d 462 (Ct.App.2010), *reversed on other grounds*, 732 S.E.2d 500, 399 S.C. 381 (2012)(affirming Commission's finding that radicular symptoms in the right leg showed an injury to the back "with affects to the right leg."").

Pate testified that she has pain "in my lower back, and sometimes it leads down to my - into my right thigh through my buttocks. I have more pain on the left side than what it is on the right." [Tr. Page 16, lines 11-15]. This is borne out by the medical records.

Dr. Nolan treated Pate for both back pain radiating into her hip and leg, and SI joint pain. On November 26, 2013, he noted a lumbar injection had given relief, albeit temporarily, of "low back pain and leg pain." From that point, he wanted to "see how treating her low back in conjunction with her SI joint provides relief. [APA pages 245-246]. Dr. Nolan continued treating Pane's back,

legs and SI joint. He consistently characterizes her pain as "Lower back, buttocks, leg." On August 21, 2014, Dr. Nolan wrote "Radiating symptoms: moderate to severe lumbar radiculitis pain with ROM in the left L5 nerve distribution and S1 nerve distribution to the knee." [APA page 55 (emphasis added)]. He assigned a 23% whole person rating for DRE Category IV. Pate's ongoing radiculopathy into her left leg continued from the outset through the last records presented at the hearing. [APA page 116]. There is no evidence to the contrary.

Therefore, Claimant requests the Appellate Panel reconsider its decision and hold that Pate's right leg and SI joint were additional body parts affected by the back injury.

2. Claimant's injury was not limited to her back in that she suffers from causally related psychological overlay in the form of major depressive disorder.

The Appellate Panel affirmed the Single Commissioner's finding that "Claimant has not met her burden of proving a psychological injury causally-related to her original injury." [Order, page 11, finding of fact 7]. Claimant respectfully contends the Panel and the Single Commissioner overlooked the evaluation by Dr. Kee, as well as the multiple references of psychological overlay from Dr. Nolan. Defendants presented no evidence to contest the opinions of these two doctors.

The statute provides that mental injuries may be found compensable if "noted in a medical record of an authorized physician that, in the physician's opinion, the condition is at least in part causally related or connected to the injury or accident, whether or not the physician refers the employee for treatment of the condition." S.C. Code Ann. § 42-1-160 (D)(2)(2007). The statutory requirements were met when Pate was referred to Dr. Kee by Dr. Nolan on August 21, 2014. He specifically wrote:

Patient is significantly depressed due s/t pain and increased pressures/stressors. I

> wold like to refer her to Dr. Kee for psychological workup. She states that she feels work is "trying to push her out, that they don't want her there anymore". She does not appear to be coping well. Will see if she can work with Dr. Kee to develop/improve these skills. Will also start her on Effexor 50 mg BID and see how she does. Will have her back in 2 weeks to assess her response.

[APA page 55].

Dr. Nolan's referral specifically relates the depression due to pain from the injury and increased pressures/stressors – explaining that this is from not coping with work and her job pushing her out.

Dr. Kee confirmed the diagnosis of major depressive disorder, as well as "problems with anxiety and going to sleep because of worrying about work." [APA page 164].

This medical evidence confirms that Pate suffered a psychological overlay with major depressive disorder as a result of the pain and disability resulting from her workplace injury. Therefore, Claimant requests the Appellate Panel to reconsider its decision and hold the Single Commissioner should be reversed.

Respectfully Submitted,

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January 23, 2017

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Columbia, SC 29202-1715
803-737-5675 www.wcc.sc.gov

WCC File #: 1121370
Carrier File #: 2011-4217
Carrier Code #:
Employer FEIN #:

Claimant's Name: Patricia Pate SSN:
Address:
City: State:
Home Phone: ( ) - Work Phone: ( ) -
Preparer's Name: Stephen B. Samuels Law Firm: Samuels Law Firm, LLC

Employer's Name: College of Charleston
Address: 66 George Street
City: Charleston State: SC Zip: 29424
Insurance Carrier: State Accident Fund
Preparer's Phone #: (803) 779-4000

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☒ Claimant ☐ Employer (check one) Date of Injury or Illness: 12/14/2011

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

Please see "Attachment to Form 30".

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

☐ **Mediation**

☐ Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.

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 Margaret Urbanic, Clawson & Staubes, LLC, 126 Seven Farms Dr., Ste 200, Charleston, SC 29492; Kirsten Barr, Trask & Howell, LLC, PO Box 2167, Mt. Pleasant, SC 29465; Mikell Wyman, Gallivan White & Boyd, PA, PO Box 22768, Charleston, SC 29413; and Page Hilton, State Accident Fund, PO Box 102100, Columbia, SC 29221 on the 7th day of June 2018, by ☒ first class postage ☐ certified mail ☐ personal service.

Preparer's Signature | Attorney for Claimant (Title) | Stephen@samuelslawfirm.net (Email) | June 7, 2018 (Date)

Check this box if you are not represented by an attorney ☐

Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov.

If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-205 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.

ATTACHMENT TO FORM 30

Patricia Pate v. University of Charleston and State Accident Fund
WCC File No. 1121370

Grounds of Appeal:

1. Whether the Single Commissioner and Appellate Panel erred as a matter of fact and law in denying psychological injury.

2. Whether the Single Commissioner on remand erred as a matter of fact and law in failing to find Claimant permanently and totally disabled when her restrictions prevent her from obtaining suitable gainful employment.

3. Whether the Single Commissioner on remand erred as a matter of fact and law in awarding 40% permanent loss of use of the back when the evidence shows Claimant is presumed permanently and totally disabled due to 50% loss of use of her back and there is no evidence to rebut the presumption.

4 Whether the Single Commissioner and Appellate Panel erred as a matter of law in finding this is a single member case when Claimant suffers from radiculopathy affecting her left leg and an SI joint injury which is an injury to her back and pelvis.

STATE OF SOUTH CAROLINA)	BEFORE THE SOUTH CAROLINA
)	WORKERS' COMPENSATION COMMISSION
COUNTY OF CHARLESTON)	
Patricia A. Pate,)	
)	**WCC File No. 1121370**
Claimant,)	
)	
-vs-)	
)	**BRIEF OF APPELLANT**
University of Charleston,)	
)	
Employer,)	
)	
and)	
)	
State Accident Fund,)	
)	
Carrier,)	
)	
Defendants,)	
)	

Claimant, by and through her undersigned attorney, hereby submits her Brief of Appellant in support of her claim for workers' compensation benefits.

STATEMENT OF THE CASE

This is an appeal from a Decision and Order by the Single Commissioner on Remand from the Full Commission.

This case arises out of an admitted injury occurring on December 14, 2011. The Claimant, Patricia Pate, underwent back surgery which resulted in ongoing treatment and permanent restrictions. The Employer, University of Charleston, accommodated Pate's restrictions up until her treating physician further limited her to 4 hours per day, 4 days per week. She was placed on an indefinite leave of absence without pay on January 29, 2015 when the Employer could not longer

accommodate her restrictions. She began receiving temporary total disability compensation.

Pate filed a Form 50 (Request for Hearing) seeking compensability of her back injury with radiculopathy and SI joint injury, along with psychological overlay. She sought an award of permanent and total disability with lifetime medical treatment.

Defendants filed a Form 51 (Employer's Response to Request for Hearing) admitting a lumbar spine injury, but denying all other injured or affected body parts. Defendants further alleged Pate had suffered an intervening accident when she was hospitalized for a pulmonary embolus. Defendants alleged the pulmonary embolus ended their obligation to provide medical treatment and limited to Pate's disability compensation to the equivalent of the impairment rating.

The case was tried on July 14, 2015 before Commissioner Aisha Taylor. On May 16, 2016 Commissioner Taylor issued a Decision and Order finding *inter alia* that:

- the December 14, 2011 accident did not result in injury to, or otherwise affect, any other body part or system.
- Claimant's multiple pulmonary embolisms are subsequent intervening acts sufficient to break the chain of causation as it related to Claimant's disability and continued medical treatment.
- Claimant has not met her burden of proving a psychological injury causally-related to her original injury.
- Claimant has sustained a 23% permanent loss of use of her back as a result of her work injury [based] on the impairment rating issued by Dr. Nolan . . .
- Claimant is not entitled to future medical treatment.

[Order, dated May 16, 2016, pages 10-11].

Claimant timely filed and served her Form 30 (Notice of Appeal) on May 27, 2016. Oral argument was heard before the Appellate Panel on August 16, 2016.

By Decision and Order dated December 22, 2016, the Appellate Panel Affirmed in Part,

Reversed in Part, and Remanded. The Appellate Panel affirmed the finding that the injury did not affect any other body part, including psychological overlay. The Panel reversed the findings that the pulmonary embolisms were an intervening accident and "remanded to the Single Commissioner to determine the compensation due for Claimants's causally related permanent disability and causally related medical treatment . . ." [Order, dated December 22, 2016, page 16].

On May 24, 2018, Commissioner Taylor issued a Decision and Order on Remand. The Order held:

- Claimant is entitled to a lump sum award for permanent partial disability of 120 weeks based on a loss of use of 40% of the back.
- Claimant is entitled to causally-related future medical treatment pursuant to Section 42-15-60 to include SI joint injections, trigger point injections, epidural steroid injections, A TENS unit, pain medication (currently OcyContin, Percocet, and Tizanidine) and a lumbar back brace.
- Defendants shall pay for causally-related medical expense incurred during the period the Single Commissioner's order was in effect and no treatment was authorized.

[Order, dated May 24, 2018, pages 8-9].

Claimant timely filed and served her Form 30 (Notice of Appeal) on June 7, 2018.

STATEMENT OF THE FACTS

The Claimant, Patricia Pate, was employed as an assistant manager at the Copy Center at the University of Charleston. Pate suffered an admitted injury by accident to her back and legs on December 14, 2011.

Pate underwent an instrumented lumbar fusion surgery by Dr. Joseph Marzluff on May 15, 2012. [APA page 134]. Pate returned to work at the Copy Center with restrictions following her surgery. Dr. Marzluff assigned a 40% impairment rating to the spine – based on 30% whole person DRE Category V with an additional 10% for chronic pain. [14B]. Dr. Marzluff noted she was suffering from increasing pain and bowel incontinence. He opined "A lot of the problems that she

was having were related to the stuff she was doing at work aggravated her back." [Marzluff dep. Page 5, lines 1-13].

Dr. Marzluff retired. Dr. Edward Nolan of the Trident Pain Center took over Pate's long-term pain management on December 17, 2013. He treated Pate with SI joint injections, trigger point injections, epidural steroid injections, a TENS unit, and medications (OxyContin, Percocet and Tizanidine). He also ordered a lumbar back brace. On February 28, 2014, Dr. Nolan opined Pate was at MMI. He opined she would require ongoing palliative treatment including all these modalities. [APA pages 7-8]. Dr. Nolan assigned a 23% whole person rating based on DRE Category IV. [APA page 126(a)].

On April 23, 2014, Dr. Nolan reported:

> [s]he has returned to work full time with no restrictions on 4/11/14 but reports that her pain and anxiety are elevated. She reports that the getting up and down and standing for prolonged periods of time are a major issue. Her FCE showed that she could perform medium work however pt does report that her pain was elevated after the FCE and she cannot do this type of work daily. **In order to keep pt working, pt cannot stand more than 1 hour at a time then must sit for at least 2 hours. She may require breaks during these times to change positions for a short period of time (5-10 minutes). She cannot lift more than 15 pounds.** [APA page 29 (emphasis added)].

Pate continued seeing Dr. Nolan for treatment once a month. Her pain consistently ranged from 5-7 out of 10. She remained on narcotic pain medication and received injections about every two months.

Pate temporarily stopped working on September 15, 2014 when she was hospitalized for an unrelated pulmonary embolism. On the last visit before she stopped working, Dr. Nolan noted "Pt was referred for a low back brace 2/21/14 but has yet to receive it. Will again request this from her w/c today as we have already identified that this would be highly beneficial for her during her work

hours." Dr. Nolan also noted she was scheduled to see her psychologist, Dr. Kee, for further discussion regarding her depression. [APA page 59].

On September 22, 2014, Pate returned to Dr. Nolan. Dr. Nolan reported:

> Pt has recently been hospitalized for blood clots in the lungs. Will now be on Xarelto [anti-coagulent] for the next 3-6 months. Percocet has been d/c'd however she is not getting as much relief from the Oxydodone IR 5 mg therefore we will ask her to start doubling what she has to 10 mg and provide her with a new prescription at this time. Also pt will not be eligible for injections for the next 3-6 month period. [APA page 66].

On October 23, 2014, Dr. Nolan wrote:

> She states the increase of OxyContin to BID has helped but she is ultimately unable to perform her job duties as required. Due to her inability to receive needed injection therapy until 2/2015 due to pulmonary embolisms we recommend she be placed out of work at this time and a letter will be drafted to this effect. I will continue to monitor her work status at each visit. Medication management and trigger point injections will be her treatment options at this time. [APA page 70].

On November 24, 2014, Dr. Nolan reported:

> She continues to remain out of work per our last letter requesting 2 months out. She reports improvement in ability to cope with pain since she has been out of work. She has provided an accommodation request from her employer which we will complete and send back. At this point, we recommend pt to plan for return to work after 12/03/14 at 4 hours per day for 2 weeks with accommodations which will be available per her paperwork brought to be filled out today and then we will re-evaluate her work status 2 weeks after that. [APA page 81, 83].

Pate returned to work at the Copy Center with these restrictions on December 4, 2014. Even with the restrictions, she called out on December 5, 12, 16 and 17. [APA page 307].

On December 22, 2014, Dr. Nolan continued the restrictions of 4 hour per day, 4 days per week, with "No bending, squatting or crawling, no lifting greater than 15 pounds, and no pushing or pulling heavy objects." [APA page 93].

On January 21, 2015, Dr. Nolan performed a Caudal Epidural Steroid Injection. This was

the first LESI performed since the injections were suspended due to the pulmonary embolisms. [APA pages 96-98].

On February 5, 2015, Dr. Nolan continued Pate on sedentary restrictions of 4 hours per day, 4 days a week. [APA page 101].

The Copy Center ultimately determined it could not accommodate Pate's restrictions. She was placed on LWOP (leave without pay) on January 29, 2015. [APA pages 308-309]. Pate remains disabled and unable to work.

ISSUES ON APPEAL

1. Whether the Single Commissioner on remand erred as a matter of fact and law in awarding 40% permanent loss of use of the back when the evidence shows Claimant is presumed permanently and totally disabled due to 50% loss of use of her back and there is no evidence to rebut the presumption.

2. Whether the Single Commissioner on remand erred as a matter of fact and law in failing to find Claimant permanently and totally disabled when her restrictions prevent her from obtaining suitable gainful employment.

3. Whether the Single Commissioner and Appellate Panel erred as a matter of law in finding this is a single member case when Claimant suffers from (1) radiculopathy affecting her left leg and (2) an SI joint injury which is an injury to her back and pelvis.

4. Whether the Single Commissioner and Appellate Panel erred as a matter of fact and law in denying psychological injury.