THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

R. Keith Kelly, Circuit Court Judge

Appellate Case No. 2017-002522
Case No. 2010-CP-5743

Gregory J. Feldman, MD, Joseph A. Boscia, III, MD, and Upstate Lung & Critical Care Specialists, PC, Appellants,

v.

Ray E. "Chuck" Thompson, and Charles M. Fogarty, MD, Respondents.

RECORD ON APPEAL
VOLUME X

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INDEX

ORDERS

PLEADINGS

MOTIONS AND MEMORANDA

TRANSCRIPT WITH EXHIBITS

OTHER MATERIAL AND DOCUMENTS

STATE OF SOUTH CAROLINA)
) COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG)

WILLIAM MARK CASEY,) TRANSCRIPT
)
PLAINTIFF,) OF
)
vs.) RECORD
)
GREGORY J. FELDMAN, M.D., ET AL)
) 06-CP-42-1728
DEFENDANT.)

May 19th, 2010
Spartanburg, South Carolina

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THE HONORABLE ROGER L. COUCH, Judge.

A P P E A R A N C E S:

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PAMELA E. GREEN
Circuit Court Reporter
Seventh Judicial Circuit

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INDEX OF WITNESSES

PROCEEDINGS

THE COURT: We're gonna continue with the trial of the case this morning.

The plaintiff can call its next witness.

MR. TURNER: May it please the Court, Your Honor.

The plaintiff would call Doctor Randolph Waid.

THE COURT: Sir, if you'd come forward to my left to be sworn please.

RANDOLPH WAID, being first duly sworn, testified as follows:

THE COURT: Have a seat, sir. Once you're seated, I'm going to ask that you state your name for the record.

WITNESS: My name is Louis Randolph Waid.

THE COURT: And, Mr. Turner, it's your witness now.

MR. TURNER: Thank you, Your Honor.

THE COURT: Yes, sir.

DIRECT EXAMINATION

BY MR. TURNER:

Q Doctor Waid, you traveled up here from Charleston, is that right, this morning?

A That is correct.

Q And your personal background, could you give the jury a little bit of insight into your personal background?

A Well, I have a Ph.D. in clinical psychology from the

University of North Texas that was awarded in 1982. I followed my internship here at the, the Medical University of South Carolina. I returned to the University in 1983 and have been on the faculty at the Medical University of South Carolina. I've been in the departments of psychiatry and neurology as my expertise area has been neuropsychology as well as clinical psychology, and I became the director of the assessment center at the Medical University of South Carolina, which is a clinic that, where we train neuropsychology fellow and interns as well as services throughout the hospital particularly in neurology and psychiatry because neuropsychologists deal with behavioral problems that stem from neuropathology, injuries to the brain, Alzheimer's, Attention Deficit Disorders, learning disabilities, these sorts of patients, and so we are particularly involved with that.

I remained at the University, but in '98 I did leave the faculty practice, continued my research, and established a private practice that actually is in Mt. Pleasant, South Carolina.

Q All right. So, prior to, you said 1998?

A That's correct.

Q Prior to 1998, you were a, on the faculty, a teacher, and a director at MUSC at the University?

A I was full-time at the University and now I'm just

part-time.
Q Okay. So, you're still teaching there?
A Oh, yes, indeed.
Q Okay. And teaching subjects that we just discussed here?
A I still do that. I'm still involved in research too, which is mainly been in the substance abuse area.
Q All right. And tell the jury what a neuropsychologist is, what that field encompasses please?
A Again clinical psychology is the study -- well, actually psychology is the study of human behavior. Clinical psychology is the study of, of abnormal behaviors obviously, psychiatric disturbances, and so forth. Clinical psychologist are involved in intervention, treatment, assessment, and research on the variety of the clinical syndromes.

Again, neuropsychology, clinical neuropsychology specializes in those type of problems that stem from pathology affecting the brain. So, we have additional neurology training as well as our populations, populations can stem from, you know, children that have a head injury or some type of developmental disorder. A head injury, very common population to deal with traumatic brain jury, toxic injuries, and also stemming to the late age, Alzheimer's.

And, so, we specialize in those populations and serve

in the same capacities that clinical, clinician in terms of evaluation, assessment, intervention as well as research. Clinical neuropsychologists have been very involved in understanding how the brain works because often studying damaged brains gives you a heck of a lot of input about how it works. And, so, they're also involved in that aspect.

Q And, and you are currently involved in those areas, you listed a lot of them, but your practice continues---

A Yes.

Q ---to develop?

A Yeah, my practice specializes in regular clinical psychology, but we do a lot of evaluations across the lifespan of people who have these sorts of neuropathology problems including, again, in children with learning disabilities and Attention Deficit Disorder.

Q And you're qualified to review diagnostic tests, but would it be a fair statement to say diagnostic test, such as an M.R.I. or C.T., those deal with the structure, if it was a, of the brain rather than what you deal with, with your testing, which is the output of the brain?

A Yes, to put it simply, I'm highly involved in a string of physicians. If you come into the emergency room and you have a brain injury, you're gonna see a neurosurgeon first. He's, he's an operative guy. He's there to fix your tissue. If you got an intracerebral bleed, a hematoma, or you need a

craniotomy. So, the analogy I say is like a car. The surgeons opens up the hood of the car and sees if there's anything to cut, fix, or so forth. He's a surgeon. Really in the second string is a neurologist. He also opens up the hood of the car and sees if he needs to throw some oil in there or something to treat some of the symptoms that that car is having.

The neuropsychologist, like psychology, we deal with behavior, and, so, we -- the analogy there, when we get into the passenger seat next to you, and see how you're driving the car. The behavioral outcome from whatever might of happened to the engine. And, so, we deal with that. And, so, many many of our referrals come from neurologists and neurosurgeons because we deal with the behavioral outcome of the pathology that might be hurting the brain or engine in the case of the description I gave.

MR. TURNER: Okay. Your Honor, at this point I would move to qualify -- I actually I left out one other question.

Your board certifications?

A I'm a licensed clinical psychologist and I'm a fellow in the American Board of Forensic Examiners and actually my board certifications seeking in forensic psychology. I also do criminal work, but that's where I'm at.

MR. TURNER: Okay. At this time, plaintiff would move to qualify Doctor Waid as an expert in the field of

neuropsychology.

THE COURT: Any objection?

MR. GUNN: No, sir.

MR. KING: No, sir.

MR. MANN: No, Your Honor.

THE COURT: Without objection he'll be so certified.

You may proceed, Mr. Turner.

Q All right. One thing that, Doctor Waid, and I hadn't planned to start with this, but would you agree you often call in a neurologist, is that what you said, or, or A neurologist is called in before you?

A It wouldn't be atypical for a chain of -- if the neurosurgeon's not gonna do surgery, often a neurologist might be next though sometimes if there's not symptoms like headaches, the neurosurgeon might refer right to us. But a lot of our referrals do indeed come from the neurologist who tends to be the next in line after a potential surgical procedure and there's no need for surgery, the neurosurgeon's done and ultimately the neurologist is more of a person dealing with medications that might help the brain.

Q Okay. And in this case, you're aware of two events, is that correct, from hospital, two events, and I'll just refer to them that way, at Spartanburg Regional dealing with William Mark Casey?

A I am aware of those, yes.
Q Okay. And you've reviewed or have you reviewed medical records regarding 5/28/2004 and 6/3/2004?
A That is correct. I did review those medical records depicting those events and trying to understand them as I involved with this man and evaluating him over a year after that.
Q And I, I think I heard you say, if you had a pulmonologist performing a procedure, and that was the treating physician for the, for Mr. Casey, that would be where the neuro-consult would generally be called in by the treating physician?
A It can eventually be called in by anybody who might be seeing the person in the hospital as it relates to mental status changes or problems like that. Obviously they're involved in their expertise level of care and they'll seek the consultation if they need to.
Q Okay. All right. And at the hospital, you've, you would be familiar, I would think, consults are called in fairly regularly to get a specialist involved if, if need be?
A Sure. That is correct.
Q And the, the specialist, if it's a neurologist that's gonna be called in, depending on the mechanism of the injury, if a neurologist is gonna be called in, that would

be done by the treating physician?
A Often it would be done by the primary care physician, I mean the primary treating physician in the hospital if they are other specialties needed to evaluate the patient.
Q Okay. And you're aware, from reviewing the records, Doctor Boscia performed a flexible bronch?
A I am aware of that.
Q And that Doctor Feldman performed the rigid bronch in the hospital?
A I'm aware of those events taking place.
Q Okay. And correct me if I'm wrong, did you see any neurological consult called in by either of the physicians?
A I don't believe I did see any of that.
Q In order to diagnose potential cognitive deficits in a, in a person, could you explain to the jury what sort of testing you utilize in order to, to make that happen?
A Yes, you know, when you have a impact on the brain, and you have a compromise in brain behavior functioning, you can think of them expanding from something that's rather mild and subtle to massive and severe. Neuropsychologists, quite frankly, are often called in to, on the cases where they're more mild to moderate because when you have a severe incident compromising the brain, you got a devastating injury, and, and, obviously, nothing's working. Motor won't work. They're devastated, and often that's, they're not

even testable.

So, when you look at evaluations, as they might have to do with milder forms, even like the Academy of Neurology wants you to use neuropsychology more there because bedside examinations, the most common one called a mental status examination, is relatively weak in being able to assess for deficits that might stem from this milder form of injury to the brain.

For example, on the mental status, which is the most common bedside examination, if you know what day it is, and who you are, where you're at, and if you can remember three objects after about a half a minute, you pretty much can get a 30 out of 30. That's basically the most common mental status examination used by doctors, even neurologists. Often, as the client continues to complain, then they'll be a referral to neuropsychology.

Now, again, on more severe traumatic brain injuries or neurological or even a hypoxic injury where you have anoxia, massive injury to the brain, the scan show it and the person's devastated, eventually they may end up in neuropsychology, but they'll have to be a recovery curve. So, again, you have to think of these as continuums from mild to just massive unfortunate events that can occur. And, so, basically a person on a mental status examination can, can look okay even though there could be deficits

present.

Q Okay. And you're familiar with the term emboli or air embolus, aren't you

A Yes, I'm very much aware of that and very much in my career have seen people post-surgery, even when surgery has gone well without an absolute event, who had cognitive changes, and neurologists will refer it and sometimes it's inferred that there's air emboli even when the procedure did not go negatively, so to speak, or in code. Other times the mechanism can be there in which there would be inferred some air emboli or some lack of oxygen, full oxygen getting to where it needs to get so.

So, obviously it can happen. Even in studies now, empirical studies on people who have heart transplants, the heart translates, they go well, those people have cognitive changes after successful heart translate mainly because they have to be on a machine for about eight to ten hours. It's a very long procedure. So, these sorts of incidents do occur and it can -- they range from, again, massive to subtle. But air emboli, or a lack of oxygen getting to, particularly the brain, is the mechanism for the injury.

Q And the big difference there, if you looked at it in terms of the spectrum with air emboli, micro bubbles or very tiny bubbles getting into the wrong place, and ultimately ending up in the brain, that can be on one end of the

spectrum, and macro or much larger bubbles getting in to the places where pulmonary, veins or---

A Sure.

Q ---or areas where they're not suppose to be, that may be on the other end of the spectrum?

A Sure.

Q And you would expect with macro, am I hearing you, that you're gonna have some immediate devastating injuries?

A Absolutely.

Q And gross motor para, paralysis and things of that nature?

A Much more greater the damage and it would be greater results from an acutely, that's obvious, with a greater event, an event where you have a much more devastating loss of oxygen to the brain. Obviously the worst event is death. So, ultimately, this is why, if you have a heart attack, minutes are very important cause essentially oxygen's not getting to the brain.

Q And, and that's something, you said minutes are important, if, in, I'm talking in reference to Mr. Casey, you come out of the operating room and you've reviewed the records you've stated, correct?

A Yes, that is correct.

Q And into the post anesthesia recovery unit, the P.A.C. Unit?

A That's correct.
Q They take you off the first ventilation system and put a mask, I forget what it's called, goes on your nose, around your ears?
A That's correct.
Q It gives you some oxygen and then you have to be re-intubated---
MR. GUNN: I object to leading, Your Honor.
THE COURT: I'll ask you not to lead the witness. I've been listening to the last couple of questions, and they're becoming more and more leading. I'll sustain the objection.
Rephrase your question.
Q When you reviewed the medical records of Mr. Casey from the ridge bronchoscopy, how was he -- was he provided ventilation?
A Basically at a level of this, there are experts involved in his care at this time who, and their, their expertise is their area. As a neuropsychologist, I know that an event took place that had a mechanism, potential mechanism of emboli or oxygen not getting there.
MR. GUNN: Your Honor, we object to that. That's outside of his area, area of expertise. He's not a, he's not a medical doctor. He's got---
MR. TURNER: Well, he mentioned hypoxia.
MR. GUNN: Might I, might I finish please, sir?

MR. TURNER: I didn't realize you weren't finished, Mr. Gunn.

MR. GUNN: Yeah, I wasn't.

MR. TURNER: I apologize for that.

MR. GUNN: If Your Honor please, this is, this is outside his area of expertise, and he's told us that in his deposition.

THE COURT: All right. Anything further?

MR. GUNN: No, sir.

THE COURT: All right.

MR. TURNER: All right. He's mentioned hypoxia and I think he's well qualified as a neuropsychologist. Be glad to proffer to the Court if we need to, but---

THE COURT: Well, I'm gonna ask that you lay---

MR. TURNER: ---hypoxia---

THE COURT: ---that you lay some foundation for the opinion.

MR. TURNER: Yes, Your Honor.

THE COURT: So, I'm gonna sustain the objection at this time and allow you to ask some additional questions.

MR. TURNER: Okay.

Q Doctor Waid, you first saw William Mark Casey, and you may need to refer your notes, can you tell the jurors what time, time period you first had contact with Mr. Casey?

A I first saw Mr. Casey on August 30th of 2005, and I

followed-up to complete the evaluation on September 10th of 2005. That constituted my evaluation of this man at that time.

Q So, two different dates, but one evaluation and one report resulting out of that --?

A That is correct.

Q -- those dates?

And you're familiar with the term hypoxia, are you not?

A I am familiar with the term hypoxia.

Q Okay. Can you tell the jurors what hypoxia is?

A It's a broad based term that insinuates that there's some reason or another a lack of full oxygen getting to the brain, a lack of full oxygen. Anoxia would be no oxygen, which is obviously gonna be much more detrimental. But hypoxia is basically a mechanism that we're aware of. Again, counsel's right, how that occurred or whatever, I'd leave that to other experts. But that is the potential causal factor that is of concern had already been expressed as a concern by other treating doctors. Thus he ends up with a neuropsychologist.

Q Okay. And from your review, anoxia is, is not an issue in this case where there's absolutely no oxygen whatsoever going to the patient's brain?

A That is correct. The term anoxia would mean absolutely no oxygen being there, and obviously that's a much more

critical situation.
Q Okay. But based on your expertise, hypoxia, where you have some oxygen, but it's an inadequate level of oxygen going to the brain, you could say, within a reasonable degree of medical certainty, that that applied in your first report to Mr. Casey?
MR. GUNN: Your Honor, I object. That's still not in his expertise, area of expertise. We've, we've got umpteen medical experts who all addressed that.
MR. TURNER: I---
THE COURT: Yes, sir.
MR. TURNER: Okay. On the anoxia, it's in the report, and if you want, Your Honor, I'll, I'll be glad to -- might be better just to proceed on. I'll strike that question.
THE COURT: I'm gonna, at this time, ask you again, you may refer back to other opinions. I don't know what, what he's relied on.
MR. TURNER: Yes, Your Honor.
THE COURT: And perhaps we should get into that.
MR. TURNER: Lay a foundation better.
THE COURT: Yes, sir.
Q All right. Would you -- when you met with Mr. Casey August the 30th and September 10th of 2005, you, did you administer testing on Mr. Casey?
A Well, yes, we eventually did administer testing.

Obviously we reviewed the records that led up to our event. We also -- and saw the other aspects of what was going on and what the complaints were and what other measures had already been applied. We did a rather extensive interview of this man to understand his personal complaints. We then do a rather extensive review of everything, make sure we've covered everything even if they don't, report, report it. It's very important to know all of those things even as history.

And, so, after that process then we get to what we call neuropsychological testing, which is the actual way of assessing the brain behavior functions to better understand what's going on behaviorally at the brain level, and what functional areas of the brain are maybe not working in the manner that they should based on models of how they should be working.

So, in essence, if you look at neuro-psych testing, it's a kind of a hierarchy of what we do. We get the simplest abilities that you hear, see, and smell, and we do these things first, and then ultimately we measure attention, concentration. Kind of like the key board before we get to the computer, very important. A lot of people who come to me complain about memory, but it, it can -- memory is involved in many tasks that constitutes whether you remember something.

So, attention, concentration, processing abilities, what we call executive functioning, very important frontal area of the brain. Then we measure true memory, the ability to hold information in the hard disk, retain it, and be able to go in there and retrieve it, and that can be poor visual memory on the right side of the brain in most people or auditory memory. We measure language ability. Visual spatial skills and then we measure also what we call higher integrative abilities, the way the brain comes together and interacts between all those systems to give you abstract thinking, problem solving, reasonings, and those advanced skills, the very integrated aspect.

We also measure people emotionally because things like depression, pain, sleep disturbance can interfere with one's brain definitely or add to the problem as well as measuring people from a point of view of why they're giving us good effort, faking it, bad effort, falsifying, malingering. When we put it all together, that's about six to eight hours of working with a client over the testing phenomena to understand their brain behavior functioning or, and/or their emotional problems.

Q And so, during what I'll call the first visit and evaluation with Mr. Casey, August 30th and September 10th of 2005, you performed these tests on Mr. Casey?

A We did. It's not unusual, even though he drove some

distance, to want to do it over two half days because it is fairly involved, and obviously, while I want to understand your fatigue, I don't want that to be the only thing I'm measuring. So, it's useful to be able to do that over two periods of time and we did in this case, and we were able to conduct a rather extensive evaluation of him as well as understand his complaints as well as review the medical records. Okay.

Q And you're not sure that or, or do you know if he drove or if he rode down to Charleston?

A Tell you, in 2005, I'd have to go back to my notes to check on that.

Q Okay.

A But he was on time. I remember that.

Q Okay. So, your first evaluation, how many months out from the rigid bronchoscopy procedure of 6/3/2004 was that approximately?

A Again, the occurrence of that was in late May and early June. And so, we're seeing him in August. So, it's about 14 months.

Q Okay. And could you tell the jury or the jurors is there some importance with the timing of the testing as far as whether you're expected to recover at a certain time or, or---

A Well, different sorts of neurological injuries have

timetables, but almost classically you'll see that most of us in the field want to give everybody a full year to recover as it relates to the brain behavior functions. Some of motor functioning issues can often take up to two years. So, if I was to see somebody after a traumatic brain injury, and saw them three months out, did an evaluation, I would actually anticipate they should get better cause you do recover from brain injuries.

So, we have different recovery curves that we expect. A stroke is a little different. But generally one would not be comfortable saying this is a permanent impairment without giving them a full year recovery as it relates to the brain. Obviously components that are reversible, like depression, pain, any time you can fix those you might get better functioning of the brain level cause they're interfering with the brain. They're not actually a tissue problem.

So, we saw him 14 months out. At some point we would say whatever brain recovery, tissue recovery he was making he would of made, but obviously, as is gonna be discussed there, this man also has other issues that are interfering with the brain like depression and pain and fatigue. So, those have been present at both evaluations.

Q And tissue recovery, is that neurons, dendrites, and things in the brain that take over for damaged ones?

A Well, brain tissue repairs. Not repairs so much as, as

recovers from an insult. If you come in, if you have a car accident today, and have a traumatic brain injury, if you don't die within 48, 64 hours, you're gonna get better. Your brain swelling will go down, function will return, and, quite frankly, if I measure somebody with a brain injury three months and they're not better by one year, then I have a question of why, they should get better because their brain swelling goes down. So, we understand these recovery curves as they relate to different sorts of injuries.

Q Okay. And jurors are probably gonna hear this, this term as we get into the report, and I think if you define it for them it might help a little bit, multifactorial, can you tell the jurors what that that means?

A Sure. Well, you know, basically when -- sometimes our, our job's a little bit easier if you just go out and have an uncomplicated head injury and don't hurt anything else. We can pretty much hold that accountable, that is the brain. But as often in the case, for example, in a motor vehicle accident, I have people who also have now spinal injury, live in chronic pain. Everybody can relate that when you have a headache, you're in pain, you're not focusing and concentrating as well. So, these are factors outside of the brain that can cause people to be forgetful, have memory problems that are not necessarily brain tissue. And, so, it can be very difficult to kind of isolate only what's not

working at the brain level versus what's interfering with the brain.

For the person, they're still forgetful. I mean don't get me wrong. They still have it, but sometimes there's a need to disentangle that and isolate which factor.

So, when we say multifactorial, we are saying, you know, yeah, this incident certainly could be contributing as well as this and this, and depression is certainly one that can do it, fatigue and sleep disturbance. Pain is a major player. So, when you say multifactorial you're talking about multiple reasons.

Now, that's for what happens with the person in their life. When we test them, we can observe that. I can see that a person's in pain during the testing. I can see that a person is too drugged up and they're toxic. I can see that a person is just depressed.

So, in the testing situation, we often can see that at work, and the reason I point that out is that's very important because testing often is better. People do better on testing often then they do actually in day-to-day life because the testing is ideal, one on one, generally a quiet place. Real world is multitasking, a lot going on, fatigue sets in. So, often test results are a little bit better than the complaints that the people have in real life, and there can be a, a, kind of a separation between those two.

They're actually having more of that here. So, the testing allows us to get a cleaner catch of how the brain is doing.

Q And they may do worse -- would you agree a patient could possibly do worse, such as Mr. Casey, if you add those stimulus back in, in the environment?

A Absolutely. You know, particularly multitasking, which people have -- the brain has a beautiful way of keeping up with multiple things in day-to-day pursuits. When you hurt a brain, that multitasking, the ability for me to be at a party and listen to one person, and then take half of my head off and hear somebody bad mouthing back here. When you deal with people after neurologic injury they'll tell you that's, that's what goes.

That also means they end up forgetting though actually it's not truly memory. It's more processing the frontal lobes that can keep up with multiple things. So, that's what a neuropsychologist understands, and that's what we bring to the situation where our patients to help them understand what's happening to them.

Q Okay. And you mentioned depression, fatigue, and pain are things in the multifactorial sense that can get in the way.

Are those three things that you, you saw exhibited by Mr. Casey?

A It was, in my opinion, that indeed Mr. Casey had a

contribution in terms of his compromise in life and day-to-day pursuits in terms of his complaints as they related to memory and attention, that the mood disorder and depression was a player, and, and certainly causes more problems for him in day-to-day pursuits. I also felt that he had some sleep disturbance and fatigue that was contributing also in terms of that, in both times that I saw him.

And, so, from time to time pain too. But, in the testing situation, we didn't see that so in the way on the days we saw him, and, again, we even tested him over two half periods to try to reduce the potential that fatigue would be contributing to our test results. But in his life, I assure you it, it, it is in the way.

Q And that testing plural, you, by agreement with the parties, we did a second evaluation of Mr. Casey, is that correct?

A That is correct.

Q Through you?

A Yes.

Q Okay. And can you tell us sort of the decision to do a second evaluation?

You'd done one in 2005?

A Yes, the decision came from a vantage point of this case going on for quite some time and being deposed and

ultimately kind of an agreement that, you know, I would like to have an updated evaluation of him to see where he's gotten to, how he's functioning, to see the consistency between that. Mr. Casey was being seen by a psychologist. So, we had some of his data over time and seeing there's been some concern that Mr. Casey had also gotten more depressed. And so, we did an updated evaluation to bring it all up-to-date to have a better understanding of him in 2009 since the last time I saw him was 2005, and allowed for greater comfort in, in providing of opinions.

Q Okay. And I think -- is that -- that's the date of evaluation, May 29th and June 2nd, 2009?

A Yes, we saw him on two dates in May and June of 2009.

Q Okay. All right. So, I'm gonna just call them the first evaluation and the second evaluation to try to keep it, it simpler.

A Okay.

Q And you mentioned the psychologist.

There was some testing also done by someone else, wasn't there, in this case---

A Yes.

Q ---that you were able -- were you able to utilize that testing to compare it to some of yours to see consistencies or inconsistencies?

A Yes, indeed. He was administered some I.Q. test as

well as before 2009 some memory testing. Those were standardized instruments, the same ones we used. So, obviously that data was utilized to understand Mr. Casey.

Q And the -- I always get this mixed up, I call it the, the WAIS-III, and I understand there's a WAIS-IV now, but tell me what the WAIS-III stands for.

A The Wechsler Adult Intelligence Scale III Edition is, for lay people, gives you your famous I.Q. test. But actually it's comprised of four factors of tests. It, it measures your verbal educationally oriented abilities, abilities that should not be too much negatively affected by any acute injury. It measures the right side of your brain, the visual spatial skills. It measures working memory, which is that ability to kind of hold information in the, and act on it and then overall processing speed.

However, for lay people, it gives you a full scale I.Q., which is everybody's -- what they refer to as their I.Q., a verbal I.Q., which tells you more of your left side of your brain educationally oriented skills, and a performance I.Q., which is more oriented toward your right side of your brain, visual spatial skills. It's a test that's been around just forever. We are now moving toward and using the Fourth Edition.

Q Okay. And in, in both times that you saw Mr. Casey in '05 and in '09, the first and second evaluation, would you

tell the jurors whether you noticed any toxic effects such as I think you said drugs, alcohol impairment?

A No, we didn't see Mr. Casey to be compromised by what's called toxic, but what I mean by that is sometimes, when you start a medication, use pain medication, these things, you look sedated. You look kind of fogged out. Obviously that's a drug effect. We look for that because, at some point, we're not sure if we want to evaluate that client because all that we're measuring is kind of that, that effect.

That was not his presentation at all. We thought he was mildly depressed, but not to the point that it was interfering. He did not look toxic or over sedated. He wasn't falling asleep. He got fatigued, tired during four or five hours, but that's when we broke it up a little bit. So, neither did he look like he was unduly compromised from a mental status point of view due to any toxicity or drug effect.

Q All right. And, and you also had the fortune of having some early records sent to you, didn't you?

A Yes, we had educational records from his educational pursuits and we did have those for review.

Q And do you -- recall what Mr. Casey's, I want to call it the P-A-C---

A Well, basically his education---

Q ---I.Q.?
A Yes, his educational records were good. He'd done well. He had some I.Q. quotients given, which would be I.Q. tests that are sometimes given in the school situation, can be done in group format. I reported in one that he had an I.Q. of 113. That was actually obtained in the sixth grade.

However, you need to understand, from their early TerMine studies at Stanford, you know, your I.Q., unless something happens, the one you get at eight or nine should be predictive of the one you have at age 30. I.Q. is a very well researched concept and it's very predictive. Now, if you don't gain or you hurt yourself or something happens, obviously it can change. But generally I.Q. is fairly consistent over time.

And, so, we have him -- we had some records that certainly indicated at least average intelligence if not a bit above that, and he did fairly well in school, and he didn't have any evidence of a learning disability or any other kind of pre-compromises in his brain as it might relate to his school years.

Q Okay. And did each of these evaluations take -- did you spend, did you say, eight to ten hours approximately on each of them?
A Yes, both of them would be about eight hours for his work. Obviously our additional work involved scoring and

reading records and so forth.

Q Okay. If you could, take the jury through the first evaluation that you did, and I realize it's rather lengthy, but summarize what you think are the important test results that relate to Mr. Casey's claim for cognitive dysfunction?

A Yes, again, using the hierarchy model about, you know, can you see and hear and all that, it's kind of interesting. He did basically have some difficulty with spine auditory on the left side, kind of a suppression. If you did this to him, he wouldn't, he wouldn't quite hear that. But hearing was grossly intact and all his senses were grossly intact.

Mr. Casey's performance and really implicated the primary cluster problems he was having was what we call these frontal executive abilities, attention, concentration, sustaining focus, speed of processing, multitasking, and when you have difficulties effectively encoding and processing information, you end up being forgetful. However, it's not a true memory problem like Alzheimer's. Ultimately what we saw in his testing was these difficulties there that were pronounced and clearly in the impaired range, generally found on most of them, occasionally he would do good on one. But that would also result in some reduced immediate learning.

So, if I read a story to him or some of these immediate learning kind of immediately he would be kind of diminished

on that. But he did not show loss of information meaning what he did get in was being reduced, but he didn't have rapid forgetting meaning 30 minutes later he had no idea what the story was. That was retained pretty well, which makes sense.

See, in Alzheimer's, which is more severe, very severe memory impairment, you can read a story and they do look pretty well, and then 30 minutes later you'll say can you tell me that story again, and Alzheimer's patients typically will say what story. They've actually forgot the source of the information. That's how bad their memory is.

His is more of an encoding problem, and it was found consistently as though he could profit on learning tasks where we would give him like the list five times. Then he, then he would correct that. So, his problem was mainly one of encoding or, again, analogous to a computer system keyboard to the hard disk. He had a problem keyboard to the hard disk, getting information in, not keeping up.

Now, that will result in people being forgetful. But, again, my analogy to y'all would be my wife telling me ten things to get at Harris Teeter, and about on the third object I'm basically over here looking at the Laker game and I come back with two of them. She thinks I forgot. I did not forget. It never got in. And so, you don't process. People come in and say they're forgetful, but the mechanism

is totally different.

And, so, this is the pattern we consistently saw in him. The problem with the attention concentration then is also it gets in the way of other tasks. For example, sometimes you do well or not well on a visual spatial task.

Does that mean a visual spatial impairment here?

No, it means, again, concentration of focus is variable, and, therefore, it gets in the way.

Q Would you explain visual spatial to the jurors?

A Sure.

Q I'm having trouble with that one.

A Visual spatial is the right side of your brain where you deal with information and that deals with spatial. From a memory point of view, for example, if all of you could kind of close your eyes and kind of see where you wanted to go and see you got to take a left turn by that white house on that corner, that's spatial visual memory. Very important, quite frankly. You don't appreciate it till it's gone. But, you know, it's loci. It's visualizing. It's working with shapes.

I got plenty of learning disabled carpenters who have great right side of the brain, but have, can't read and spell, left side of the brain. So, again, these are different abilities.

Left side is language, verbal. It's the side our

society uses more unless, unless you're a carpenter or an engineer. But, again, that's more language, and that's the way it is for all right-handed people and majority of left-handed people too. Some left-handed people are different and organized different.

But, generally, that's what we mean. Right, spatial, rhythm, music, language, analytic thinking, and very different sides of the brain.

Q And Mr. Casey, is he right-hand dominant or left-hand dominant?

A Mr. Casey is right-hand dominant.

Q Okay. Now, as you went -- the WAIS test, the WAIS-III test, that also has subtest to it, is that correct?

A Yes, it did.

Q Okay. And can you tell the jury what the subtests are designed to do and why you even have them?

A The, again, the subtest is because the WAIS itself is made up of ten to twelve subtests. Some of them are under what we call verbal, educationally, oriented abilities. If you did well in school you should know Shakespeare wrote Hamlet. If I have a brain injury today going home to Charleston again, believe it or not, three months from now if somebody asked me who wrote Hamlet, I will still know it's Shakespeare. That's not gonna be offended.

Perceptional organization, a little difficult. Though

you guys don't have that, it's ingrained. If I ask you to put blocks together to match a design, that's not an over learned task for any of you. So, it has a little bit more of a new learning. It's gonna show up more under neurological injury.

Working memory is the ability to kind of, for the frontal lobe to hold information. If I give you digits, increasing span, and ask you to give them back to me in either in the same order or even worse, hold them in your head and give them back to me in backward orders, that's more frontal, working memory. If you have attention deficit in your life, you'll already show a deficit in that. Attention deficit people don't do.

Processing speed is really not very intellectual. You got to do things fast. However, it's very sensitive to brain injury because that means all of the brain comes together to do something fast. And so, processing speed is a diffuse finding, but it really -- it's kind of like putting a certain symbol to a digit as quick as you can. It's not particularly intellectually demanding. But you got to do things fast. It tends to concentrate and remember.

So, those are the four factor scores that we look at as neuropsychologists. So, you can see a full scale I.Q. is just a summary score of all of that. And so, sometimes a full scale I.Q. can be down, but it's because, you know, you

can't hold digits in your head. Not because you're not dumb, smart. You just can't hold digits.

Q So, performance, did you say the performance speed, would you expect that to be relatively high for a coordinated person such as an athlete?

A Basically, you know, you would expect in an athlete, first of all, visual motor skills, visual spatial skills. Catching a ball and throwing a ball and hitting a baseball obviously involved good visual motor integration abilities, and you certainly would expect speed really to be up in most everybody unless they have some kind of reason for it not to be up. But, you know, ultimately you would expect particularly from athletes, time and time again, their visual motor skills are good.

Q Okay. Could you go through with the jury the sort of summary of what your finding -- well, let me ask you this first.

What area of the brain did you focus on or it appeared that the cognitive dysfunction was most prevalent in?

A Again, from a analysis of his performance, it was indicated that his frontal executive abilities, being able to process information, being able to encode it effectively, multitask, sustain his focus, concentration, even kind of an emotional control area of the brain, we thought he primarily had a, what we call a frontal executive compromise that then

contributed to some variable performance on other tests as well as decreased immediate learning though, again, when you gave him the information learned more than once he would correct, he would show a good ability to profit from hearing it. So, we thought his, the implication of the, the test results in terms of their functional are of the brain was these frontal executive abilities.

Q Okay. And, and one more thing before we get into the actual report, I forgot, you're always looking for people who are trying to cheat or get around the test, malingerers, is that a fair statement?

A Well, yes, anytime there's secondary gain, albeit money or just an opportunity to get any kind of gain in life, even not do something, we, we want to assess effort and we want to assess potential for falsification of the presentation. So, effort goes from literally giving us the wrong answer when you have the right answer, which is called malingering, which is random, not trying at all, to good effort to assured us that it's good effort. And, so, when you look at our measures, we're looking at those things.

We don't just look at measures either. I mean if any lay person comes in and does eight hours of neuropsychological testing, you don't have any idea what all we're measuring and whether or not it's consistent and holds together in terms of how the brain works. I had a man come

in last week, had no trouble finding me from Sumter, did beautifully, and then scored in the lower, less than first percentile memory.

How did you find my place?

You didn't -- wasn't consistent with how he was living. So, had, had, we had trouble with that.

And so, also, is it consistent with the potential of a known neurological injury?

Does it, does it fit with what you know about the neurological injury?

We can distinguish between Alzheimer's or vascular type dementia based on the type of performances on the test. Matter of fact, neuropsychology is often asked to make the differential. Alzheimer's looks very different than a vascular dementia, and that's a very important question in the elderly, quality of life issues.

So, that's another way we look. So, there's many ways that we can look at it, but we do have very specific tests that are designed to measure effort and whether or not we got appropriate effort.

Q And in both evaluations, can you, could you tell this jury whether you feel, whether you strongly believe that Mr. Casey gave good effort or did not?

A It is our opinion that he gave good effort and that the tests were valid and reliable assessment of where he's at,

both with regard to the specific symptom related to the test that are the test made, but also the consistency of his performance as it related to what areas seemed to be, what areas didn't seem to be implicated. For example, this is a man who thought he was forgetful, but he actually did forget information. He didn't effectively learn it.

Same complaint, but it made sense. That also makes sense with what the potential injury might of been. So, we, we thought that all held together on both occasions and I do not see Mr. Casey just falsifying or poor effort. He gave us good effort.

Q Okay. And you've not considered Mr. Casey a malingerer?

A Not based on our evaluations and the empirical data that we obtained.

Q All right. And in -- well, I'll wait till you actually get to the, to the TOM Test, but would you take jurors through the highlights and/or your summary of the evaluation of Mr. Casey's mental state approximately 14 to 15 months after the rigid bronchoscopy June 3rd, 2004?

A Well, it was our understanding of him, based on the testing, that he was a man of at least average intelligence. We thought intellectual and neuropsychological testing revealed him to be demonstrating slow mental and information processing speed. He had some compromise in his capacities

to effectively sustain attention, concentration. Assessment of memory revealed that his difficulties were with regard to immediate learning, memory, getting it right away. But he did not show rapid forgetting. He did not lose information if he could get the information learned. We thought that was there.

We thought the speed of processing difficulties were clearly there, and the reduced immediate learning and we thought those were the primary areas that were contributing to his complaints. We did not see specific impairment with regard to visual spatial skills or language skills. Higher reasoning was generally efficient, though, again, when you don't intent to concentrate sometimes, you don't quite do as well on that, and we also thought everything was okay from a sensory perception functioning.

Motor functioning was so much slow and weaker than we anticipated too.

Q Is that spatial sense, you---

A Well, I think that's below---

Q Played sports.

A Well, it's below his expected performance just for his age and gender, but also, yeah, obviously for somebody who has been active in sports, and you would expect them to have average dexterity and strength on those tests. He didn't. That could be due to a lot of reasons actually.

Q And you knew, when you did the first evaluation of Mr. Casey, that you weren't looking for Alzheimer's, that, that---

A No, we weren't looking for Alzheimer's, and if you performed like an Alzheimer's patient I wouldn't of believed it.

Q I guess what I'm saying is, from the beginning, you had sort of the guidelines of this is the type of -- you were provided -- let me strike that.

You were provided records and other materials I believe by both sides, and, so, based on those materials, you knew that, in general, what you were evaluating Mr. Casey for, is that correct?

A Yeah, we had some rationale for what might of happened, and that certainly guides our thinking about this evaluation. Obviously we reviewed our medical records. I count on my experts. I count on other physicians and radiographic studies.

MR. TURNER: Your Honor, may I approach?

THE COURT: Yes, sir, you may.

Q Now, on radiographic studies, like an M.R.I., C.T., something of that nature, could you tell the jurors the difference, if it shows up, something shows up, a black dot or a part of the brain's missing versus if it comes out, comes out impression normal?

A I count on the neuroradiologist report even though I like looking at this film. I'm not an expert. But obviously, if you're a neuropsychologist, you want to show, you want to understand what the neuro radiographic studies show. If you got a stroke in the left side of the brain, obviously that implicates certain functions are gonna be hurt and does it all make sense.

A normal C.T. scan, particularly on the day of an accident, and a normal M.R.I. would be my preference to have if I was injured, but does not mean uninjured. Particularly in the more subtle deficits. You have to understand mild hypoxia, or air emboli, whatever, if you have findings on M.R.I., you're devastatingly injured if it shows up on the M.R.I. because that kind of lack of oxygen will show up under the M.R.I. So, those kind of---

MR. GUNN: Your Honor, that's not -- he has no expertise in this area. That's for a radiologist and a neurologist.

MR. TURNER: He gave the spectrum earlier as for the difference between micro air emboli being on one end of the spectrum and macro emboli being on the other, and macro emboli had devastating results.

THE COURT: Yes, sir, you may though need to ask questions to see if he has reviewed M.R.I. findings in these type cases, whether or not he's relied on those type tests

before in reaching his conclusions. None of that information's been presented thus far. So, I'll ask that you set a better foundation for this information---

MR. TURNER: Yes, sir.

THE COURT: ---from this witness.

MR. TURNER: Yes, Your Honor.

THE COURT: Since he's not a medical doctor.

MR. TURNER: Yes, Your Honor.

THE COURT: You may proceed.

MR. TURNER: Thank you.

Q Doctor Waid, have you relied on diagnostic tests before in other cases and also provided in this case?

A When you do a neuropsychological evaluation you look at all the data that you can including the report of any radiographic studies as they relate to the brain and/or any place else in the body. So, those are obviously. The neuropsychologist is intimately involved with understanding neuro radiographic studies of the brain because they have implication for which functions have been offended. So, we do rely on it and try to understand the pathology so we can now measure, measure the behavioral manifestations or difficulties as a result of that.

So, we do. But we do not read those studies and I'm not an expert on reading those. But certainly I'm interested in know if the M.R.I. showed something or not or

if the C.A.T. scan showed something or not or we also, at the M.U. are involved in more advanced techniques like positive tron emission tomography. So, obviously neuropsychologist are aware of that, but, you know, we're not -- we don't do the reading of the studies.

Q And you were provided some diagnostic tests, at least one, in Mr. Casey's case?

A I was aware of an M.R.I. that was conducted some time later that was normal by reading of the radiologist.

Q Okay. And, and if it's normal, that does not rule out damage to the brain, correct?

A That is correct.

Q Okay. You were going through, and I may of stopped you, the first report and the, and the highlights. Did you---

A Yes.

Q Did you---

A Well, the other highlight that has to be brought out is that we're aware of emotional difficulties. Obviously our assessment revealed that, you know, both the review of the records as well after this event brought up concerns regarding post-traumatic stress, depression, he was in psychological treatment, fatigue, anxiety, fearfulness of returning to the hospital, being socially withdrawn and isolated as well as having some pain and sematic symptoms.

So, it certainly was our understanding that these difficulties persisted. He was still in treatment, both psychologically and psychiatrically as well as being involved in use of medications for those. So, you know, we, we need to understand those things cause they also can impact on brain functioning from outside the brain, interfere with the brain. So, we were aware that those are ongoing and thought they were, you know, actually quite evident as they related to his life. Didn't feel like those issues got in the way with the testing much, but obviously he's having problems with depression.

Q Okay. And the problems with depression, could a patient who was once fairly bright and now realizes what they have lost become more depressed as a result of that, in your experience, once they realize what they've lost?

A Fortunately or unfortunately neuropsychologist are often involved in traumatic incidents, and, basically, when you have everything functioning one day and you get in a car accident and you have an incident and then things don't function and you make errors, obviously you become depressed. You can become socially withdrawn and isolated, particular in head injury. This happens all the time.

In a, chronic pain patients, when have a accident, and you end up with spinal pain, the rate of major depression in chronic pain patients, it runs at about 40 to 50 percent

that they will get depressed particularly after several surgeries did not give them the hopeful fantasized relief.

So, when your life dramatically changes, getting depressed is not unusual and that occurs to a lot of people after any type of traumatic accident or incident. Certainly seemed to be the case here too.

Q And some of the, the conclusions that you made on the first report as far as problems with Mr. Casey, could, could you enumerate some of those for the jury and help them understand what, what you found?

My understanding, my understanding is you were measuring, trying to measure the output of the brain and see if it's normal, and, if not, where the deficiencies are, and that's part of the evaluation process.

A Basically the finding is put in a diagnostic nomenclature. As I've already explained to you, we, we thought there were neurocognitive impairments particularly effecting the frontal attentional executive abilities. We thought he had a mood disorder with depression as the features. We thought his mood disorder was due to the way that persistent sematic symptoms and neurological changes. We also gave him a diagnosis at that time of cognitive disorder not otherwise specified, and what that implies is that he has some change in loss and abilities, but not to the severity that we would call it a dementia.

A dementia is a major loss and that can be due to Alzheimer's and that dementia just means a more severe loss. We thought he had deficit cognitive changes and we attributed those to the interfering effects of his sematic symptoms, mood disturbance, sleep disturbance, and at that juncture, the potential that he had a permanent neurological deficit due to the complications of the surgery. We thought all those factors to be contributing to the experience he was having in day-to-day pursuits. We were less convinced that depression was in the way based on the day of the testing, but in terms of how this man was doing, we had no doubt that those were contributing to his complaints in day-to-day pursuits.

Q And you took that into consideration---

A We took---

Q ---in formulating your opinion that---

A Yes.

Q Okay. And could you say, within a reasonable degree of medical certainty, that, based on your evaluation of Mr. Casey, that his mood disorders, major depressive like episode, it's secondary to neurocognitive and sematic symptomology and within a reasonable degree of medical certainty more probable permanent neurological deficits due to complications of laser bronchoscopy?

MR. GUNN: I object to that, Your Honor. He, he added

that -- well, first of all, he said to a reasonable degree of medical certainty. We don't mind him asking questions within the reasonable degree of scientific certainty in his field. Secondly, he added that laser bronchoscopy. This, this witness is already told us he doesn't, he's not medical.

MR. TURNER: This may need---

THE COURT: Why don't you rephrase the question?

MR. TURNER: Okay.

THE COURT: Cause this, this gentleman's not been qualified in the field of medicine.

MR. TURNER: I'm, I'm---

THE COURT: He's qualified in the field of psychology. I'm going to ask you to rephrase the question.

Q Okay. Doctor Waid, under Axis -- tell the jury what the, I think it's the DMD-IV?

A DSM-IV.

Q DMS-IV?

A That's okay.

Q I got it backwards.

A That is our Diagnostic and Statistical Manual of Mental Disorders Fourth Edition. It's really our book of our diagnosis that we utilize and have to code by.

Q And it's broken down to five axis, isn't it?

A We have five multi-axis that depict clinical disorder,

whether you have longstanding traits or attitudes or personality behaviors associated with a personality disorder, Axis II. Axis III would be medical problems that are contributing to Axis I. Axis IV would be psychosocial stressors, other stressors ongoing in your life, and Axis V is a scale we use to give a global assessment rating of your functioning, kind of what level of impairment do you have.

Q Okay. And that global, that global level of functioning, what -- is that out of a -- what is the score based on, out of a hundred?

A Yeah, it goes up a hundred. It's based in our book. And, so, obviously, it's based on impairment and social and occupational and other functional roles you have. We gave him a score of 54, which would be serious impairment. Again, again, it's psychiatry. So, this is a little bit neurology, but we use it anyway.

You have to understand in the 40's, you probably have a very significant psychiatric disturbance, might even be hallucinating. But 50, in the 50 means you got a serious impairment with regard to, you know, role functioning as it relates to social, occupational, and then it can go, you know, moderate, mild, and then basically doing, doing well as the score gets higher.

Q And what did you find for the global, global, the GAF?

A I gave him a score of 54 cause of obvious serious

impairment, you know, in terms of social and vocational function.

Q All right. And as to Axis I, could you tell the jury what you, what your opinion on the report was on Axis I?

A Yes, on Axis I we gave a diagnosis of mood disorder with some major depressive like episode. It's based on a little bit a review of the records and work with his psychologist and concern that things had gotten worse as his life had gotten better. We thought that was secondary to the persistence of his neurocognitive and sematic difficulties as well as opinion and then, on 2009, the belief that more likely than not, based on neuropsychological data and evidence and review, that he had a permanent neurological deficit due to the events that transpired in the hospital.

We gave him a diagnosis of anxiety disorders with generalized anxiety. Again, due to having to cope with these symptoms as well as he's developed this kind of fear of going back to the hospital. It took an event to really get him back there, kind of a phobia about that, and we gave him a diagnosis of cognitive disorder not otherwise specified, again, due to the interfering effects of depression or psychological disruption, sleep disturbance, sematic symptoms, and, again, the probable persistent neurocognitive deficits as a result of the complications in

the hospital.

MR. GUNN: Now, Your Honor, we -- he's already -- he is testified he doesn't -- I mean we don't mind him connecting things up to a temporal basis, but he keeps saying as a result of what happened in the hospital and this witness is not qualified to say that. He's qualified to give the status of Mr. Casey before and after and that's fine. But, but not, not medical causation.

THE COURT: Mr. Turner.

MR. TURNER: Your Honor, they base it on the five axis, which is within his specialty, and Axis I is what he is just related to the jury, and it connects. Other specialties may be able to do it as well. But his specialty goes through the axis and the, the global functioning and Axis I---

THE COURT: Well, I understand what his speciality does now.

MR. TURNER: It deals---

THE COURT: My understanding of his testimony was he has relied on the opinions of other professionals in formulating his opinions, is that correct?

MR. TURNER: And, and -- that is correct, Your Honor, and he's also reviewed all the records and we could list the depositions, but---

THE COURT: Well, that might be a good idea---

MR. TURNER: He's reviewed medical records first hand.

THE COURT: ---to place that in the record.

Now, he has the right, Mr. Gunn, to rely upon---

MR. GUNN: Yes, sir.

THE COURT: ---opinions of other professionals in formulating his opinion.

MR. GUNN: Rule 704, yes, sir.

THE COURT: Yes, sir. So, I'm gonna allow that, that to go forward.

So, if you'd like to lay a foundation perhaps as to exactly what he has reviewed, and upon the things that he based his opinion upon. So, I'll allow you to proceed, Mr. Turner.

MR. TURNER: Yes, Your Honor.

THE COURT: I won't strike the last statement based on your future questioning. We'll see how that comes out.

MR. TURNER: I'll do a better job with foundation.

Q On the first report, Doctor Waid, did you -- you reviewed the medical records for treatment for the admission 5/28/04---

THE COURT: Just one second. We've got a juror with a problem. We're gonna take a little break at this time.

MR. TURNER: Yes, sir.

THE COURT: I'm gonna instruct the witness not to discuss his testimony with anyone during the break, and at this time I'll allow you to retire to the jury room. Please

don't begin any discussions until such time as I've advised you to do so.

You may retire.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: I'll inform the attorneys that this particular juror informed the bailiffs that he had an asthma attack last night and he's having, he's suffering from some issues in that regard, and I don't know if he's gonna be able to continue or not. He said he would try this morning and we'll see how it goes. I don't know what his particular problem is right now, but we'll find out.

We'll be in recess for about ten or fifteen minutes.

MR. KING: Is he an alternate or do you know?

MR. MANN: No, he's a primary.

THE COURT: He's a primary. He's a primary.

MR. TURNER: I'll try to do a better job with foundation.

(Whereupon, a short recess was taken at this time.)

THE COURT: All right. Gentlemen, I am going to release the juror from service. According to Rule 47(b), the juror will be replaced in the order in which they're called. Tina Craig will be the next juror.

Any objection?

MR. THOMPSON: None from the plaintiff.

THE COURT: Any objection from this side?

MR. KING: None, Your Honor.

MR. GUNN: No, sir.

MR. KING: No, sir.

MR. TURNER: Your Honor, will we -- did you again, or, he---

THE COURT: Beg your pardon?

MR. TURNER: I kind of got sidetracked, Pam may be able to tell, whether I started to make a proffer when he got sick or we were---

THE COURT: No, you were still -- you were in the process of asking questions.

MR. TURNER: Okay.

THE COURT: All right. If you'll bring that juror in. I'll excuse him and then we'll bring the panel in. But just bring him in at this time.

(Whereupon Juror Lamb comes into the courtroom at this time.)

THE COURT: Sir, I'll get you to state your name for me please.

JUROR: Charles Lamb.

THE COURT: I appreciate your effort to try to continue. I'm told by the bailiffs that's probably not going to be possible and would you confirm that as well?

JUROR: Not today at least.

THE COURT: All right. Well, we're gonna continue with the trial. So, I'm gonna excuse you at this point in time. The bailiffs will show you out. If you need an excuse from work the clerk will take care of that for you. Go by the Clerk's Office. You'll receive a voucher for your pay later on. I appreciate your efforts and your service in the case, but you're gonna be released at this time.

JUROR: Thank you very much.

THE COURT: Thank you.

(Whereupon, the juror leaves the courtroom at this time.)

MR. TURNER: Your Honor, before the jury comes in, I believe I---

THE COURT: Close the door.

MR. TURNER: ---may save some time if I proffer Axis I. That's what the objections, the last three have been about, and, and proffer that. That is Axis I in his report, and it deals with the---

THE COURT: Let me hear what they---

MR. TURNER: ---bronchoscopy.

THE COURT: Well, what's gonna be the issue on that?

MR. GUNN: I think the objection was misunderstood by counsel. My objection is not -- I mean he's qualified to go into these axises. No question about that. My, my, my objection was his relationship relating it to an event in

the hospital. That, that was the issue. Not---

THE COURT: And that was my ruling. Again, the objection is not to him, the opinion that he is formulated within his area of expertise, and he has the right, as an expert, to rely on the opinions of other experts that he is received and he, he can choose what he chooses to use for his opinion. They, of course, can attack what opinions he might use as a, as the basis of his opinions. But this witness is not a medical doctor and won't be allowed to give an opinion as to what he said was the cause. He could state that I took Doctor X's opinion concerning the cause and I used that in formulating my opinion as to what he, occurred. He can testify in that fashion.

MR. TURNER: Okay.

THE COURT: But he, he's not allowed to give an opinion as a medical doctor as to causation of the underlying injury---

MR. TURNER: Yes.

THE COURT: ---whatever that might of been.

MR. TURNER: Yes, Your Honor.

THE COURT: So, for the temporal issue, the only thing there is -- can we caution -- there's a list of what he reviewed in, in making both reports. The only -- I have an objection to the Massachusetts guys.

THE COURT: You have an objection to him using a

Massachusetts guy?

MR. TURNER: Well, no, it's listed there, and there's redactions and we still haven't worked that out yet. And so---

THE COURT: I'm not sure I understand what you're talking about. Maybe you can explain that to me.

MR. TURNER: I was gonna just remove -- well, I guess he could say -- okay. He, he, he didn't rely on it. Then he'll leave them out.

THE COURT: Okay.

MR. TURNER: Now---

THE COURT: But he has a right to testify as to what, what he's relied upon to formulate his opinion.

MR. TURNER: Yes, sir.

THE COURT: And that can even be information that's not necessarily admissible into Court, and -- but they have the right to attack the basis of his opinion, but the -- he had -- he can only offer an opinion within his field of expertise.

MR. TURNER: Yes, Your Honor.

THE COURT: And that's, that's -- if he goes into diagnosing medicals issues, then I'm sure I'll hear from Mr. Gunn pretty quickly there.

MR. TURNER: Yes, Your Honor.

THE COURT: You understand where we are?

MR. TURNER: I do.

THE COURT: And I don't know that a proffer is necessary at this point in time.

MR. TURNER: I would agree with you, Your Honor.

THE COURT: Okay. All right. Let's bring the jury in please.

(Whereupon, the following takes place within the presence of the jury.)

THE COURT: All right. Mrs. Tina Craig?

JUROR: Yes, sir.

THE COURT: You are now on the jury panel in chief. I have released, released the young man who was ill today. So, you no longer are an alternate. You are on the jury panel.

You understand that, ma'am?

JUROR: Yes, sir.

THE COURT: All right. When we broke the plaintiff was in the process of examining this witness.

You may proceed, Mr. Turner.

MR. TURNER: Please, please the Court, Your Honor.

CONTINUED DIRECT EXAMINATION

BY MR. TURNER:

Q Doctor, Doctor Waid, as to Axis I in your report, you -- did you rely on opinions of other physicians as well as documentation and medical records that were sent to you

by either the defense or the plaintiff's attorneys?
A Yes, I did.
Q Okay. And were you able to establish, based on reviewing all of those hospital records, deposition testimony of other physicians, and other documentation, able to establish the temporal aspect as to when Mr. Casey's symptoms that you've been describing, this cognitive dysfunction, first set in?
A Yes, I was able to establish a temporal relationship with an understanding of both cognitive complaints and difficulties, as well as emotional difficulties, subsequent to the event that we're discussing about the hospitalization.
Q Okay. All right. So, you were able to establish a temporal relationship with the event from the hospitalization, and that would be the ridge bronchoscopy of 6/3/2004?
A That is my understanding, yes.
Q Okay. Now, would you read for the jurors your opinion in Axis I as to whether -- let me, let me ask you a little bit different way.
The temporal relationship you were talking about as to the rigid bronch on 6/3/2004, in your opinion, is that causally related based on the physician opinions, documents and other materials that you received and reviewed, and any

weight that you put on it, if any, as to what is related in Axis I to an applied and acceptable scientific, scientific principle and recognized and acceptable principles of neuropsychology?

A Yes, it is, and both, again, related to the cognitive difficulties as well as the mood and anxiety difficulties.

Q Okay. And you said frontal lobes, subcortical, can you tell the jury what the subcortical region of the brain is?

A Yes, I can. From your neuro anatomy, you have higher cortical, gray matter, subcortical is the white matter. It's white because it's interrelated a little differently, and it's subcorticle and it has different functional basis of what it does. Higher cortical is the higher region of the brain having to do with much more sophisticated thinking and memory. The subcortical regions are much more innervated with small blood vessels, and, therefore, much more susceptible to events that might involve the lack of oxygen because of the amount of bloods vessels---

MR. GUNN: Your Honor, I object to this. This is, this is information to get from a neurologist. This is medical information. He's talking about the blood vessels in the brain and so forth.

THE COURT: He's, he's not offering an opinion. He's offering testimony he, I assume he has -- it appears that he's studied that. I'll allow him to testify as to what his

understanding of the brain's matter is. I mean -- I would expect he may of studied it, but at any rate, he can describe it if he knows it.

MR. GUNN: Okay.

THE COURT: He's not offering an opinion at this time.

A So this neuro anatomy is that way. If, ultimately, from a behavioral point of view, a neuropsychology point of view, we understand the brain and how it functions and the types of disorders and diseases that effect the subcortical region. For example, Parkinson's has a motor component. But we also know they have a frontal executive component because of the way of neuro anatomy has fibers that got to the frontal lobe.

So, often, when you have injuries in this white matter subcortical region, you'll get this frontal executive. But you do not get the higher cortical losses like the true memory and the skills. And, so, from a neuro anatomy and understanding neuro behavioral stuff, that's how we understand it and that's where you have much more expectation for the frontal executive finds, and when more severe, you'll clearly have motor problems with the subcortical as you do in Parkinson's with the kind of motor shuffle and motor problems or multiple sclerosis where there's a large motor component.

So, that's our understanding. We have, as

neuropsychologist, an understanding of anatomy function where it's mediated through and then the insult and what it could of done.

Q Okay. And you placed it in the subcortical region as one of the areas---

A That, that would be your concern and as it relates also to this frontal executive issue, again, owing that other things can contribute to the frontal executive problem also.

Q Okay. And you mentioned motor weakness, that's also in, in your report, isn't it, motor weakness with Mr. Casey?

A He did have some motor weakness or dexterity issues. But he ambulated well. Those are some changes that have occurred, and, again, some of those could be brain, but also, you know, he's got some back, back pain and other things that could be contributing to that too.

Q Okay. And the, in comparison with other testing that was done and your own, you, you reviewed other testing, exact same test, correct?

A That is correct.

Q And it was -- there were three months between the test given June of 2005 and the testing you gave to Mr. Casey?

A Yes.

Q Okay. And the -- do you remember what the full scale I.Q. differences were between the two?

A Doctor Grace got a full scare I.Q. of 97, a verbal I.Q.

of a hundred, and a performance I.Q. of 104. We got a full scale I.Q. of 96, verbal I.Q. of 91, and a performance I.Q. of 104. They were fairly consistent actually within various acceptable range as relates to those particular scores.

Q Okay. And I'm gonna take you back to the last page of your report, the neurocognitive deficits consistent with the subcortical injury, can you describe those for the jury?

A Again, they are what I've described. Ultimately this man's primary cluster of difficulties is with regard to attention, concentration, multitasking, executive functioning, attentional aspects of memory, being able to immediately take that information in. That's his primary cluster along with the slowness in his mentation. Those would be considered his primary cluster.

Obviously those can invariably interfere with performance in other areas, but those are consistently found and have been consistent across the evaluations conducted on him.

Q And reclusiveness, did you, did you note that with Mr. Casey outside of those symptoms as well?

A He definitely has some comorbid, emotional psychological problems coping with this, the changes in his life, not being able to do the things that he use to do, and, yes, we do see him as having mood and anxiety problems.

Q Okay. And you also administered the WTAR?

A The Wechsler Test of Adult Reading.
Q Okay.
A That's correct.
Q Okay. And that also dealt with executive function and sustained focus.
Can you tell the jury what the results of the, the WTAR test were?
A The Wechsler Test of Adult Reading is utilized to provide an objective measure that would predict or estimate what one's intellectual abilities were before an incident. And so, it's an actual measure we have, again, utilizing things that don't get offended much, and, and basically the WTAR predicted that Mr. Casey's I.Q. functioning should be more in line with a full scale of a 107, a verbal I.Q. of 108, and a performance I.Q. of 104. Again, consistent with some educational records and everything that would say that this man was well within the average rage, if not in the upper range of average.
So, it's another measure to try to get at whether there's a deviation there. It doesn't say why. But it does say that he should be performing better as it relates to those particular measures.
Q And that's important because you did not know Mr. Casey, did you, before June 3rd, 2004?
A That is correct. I did not know him and it's a rare

instance when I know any of my clients before an incident.
Q And the problems with immediate learning, would that also include lack of getting adequate oxygenation to the brain?

MR. GUNN: Your Honor, I object to that. This is medical. He's asking for medical. He's asking whether or not lack of medical or lack of adequate oxygenation to the brain causing that.

MR. TURNER: I'll strike it and try to make it simpler with an easier question.

THE COURT: Thank you, sir.

Q Problems with immediate learning, can you tell the jury what that encompasses?

Immediate learning specifically deals with an area if I'm not mistaken?

A Yeah, immediate learning has to do, again, with the ability to kind of take information from the keyboard, again, in your world, and effectively get it stored in the brain. It's learning. You have reduced learning, reduced ability. You read a page and you don't quite incorporate the information as well. If you go to school, you have to read it two or three times now rather than one. So, it's the ability to effectively get the information out here into true memory, and then that's part of the frontal executive issues that we're talking about in this man.

So, it shows up in those scores, but his retention rate is good meaning what he gets in he retains. Again, part of that cluster that we've already talked about.

Q And -- okay. And this may come up later, the TOM Test, it's called the TOM Test?

A (Witness nods affirmatively.)

Q That's the retention trial?

A The test of memory malingering is a symptom validity test that basically is there to assess the testing effort and it's given across two trials in a retention trial and certain scores are utilized to assure that good testing effort is provided. Mr. Casey's performance on that on both occasions as, as well as other symptom test was consistent with provision of good effort.

Q Good effort not.

And if it was one point lower or one point higher, is it quantifiable?

It'd still be good effort, wouldn't it?

A No, it's not quantifiable. You have a cutoff score. The analogy is basically very easy. You have a 50/50 chance of being right on the test on any occasion. It's like flipping a coin. If you go out and meet somebody today and flip the coin a hundred times and it comes up heads 82 times you need to check the coin. The same, the same principle used here, and by the second trial, we even expect you to

have 45 out of 50 correct. If you end up a little bit low, but 45, we'll give you a retention trial, and if, in your retention trial you improve, it's consistent with good effort. If you weren't trying at all, random, would be 25 out of 50. If you were falsifying, you would beat chance in the other direction.

So, if you come in and only get 18 out of 50 right on the Tom, you're giving me a wrong answer when you know what the right answer is. That's malingering. So, malingering is the worst scenario. Effort can certainly be effected in people even though they're not malingering. So, those are two different kind of strikes. But when you beat odds in the wrong direction, you need to check the coin.

Q Okay. I -- just a few more.

The memory, memory lapses, is that something that is associated with this cognitive dysfunction or depression in your expertise?

A In Mr. Casey's case, in his day-to-day life, there's no doubt that functional factors such as pain, fatigue, and depression add to the burden of his complaints as they relate to forgetfulness and attention problems. What we are stressing is that in the testing situation, we're able to observe and see it more often if a person's given depressionogenic (phonetic) behaviors and so forth. I believe Mr. Casey's cognitive abilities are definitely

effected by his functional factors like depression and pain.

I didn't see it as a major player during the testing situation, but obviously we believe he has a mood problem and that it contributes to the morbidity in his life day-to-day.

MR. TURNER: Okay. Your Honor, if I may approach the witness?

THE COURT: Yes, you may.

Q Doctor Waid, if you would, look at that and just see if that is a letter that you had, one of the documents that counsel had provided to you.

Do you---

A Yes, sir.

Q Do you recognize?

A Yes, it is.

Q Okay. And without dragging you all through it, would you read the third paragraph and tell me---

MR. GUNN: Wonder if you mind telling us what that is?

MR. TURNER: Yeah, Billy, be glad to.

THE COURT: Please show it to counsel.

Q This is, this is---

THE COURT: Just show it to him. Take it over and show it to him.

Q Doctor Waid, I'm going to refer you to what's been marked as Joint Exhibit 2, medical exhibits, Book 2 of 3,

and bates stamp is CT 0818. It's a three page letter and, and you recognize or do you recognize -- it's actually in reverse order.

A I---

Q Okay.

A ---do recognize it.

Q Okay. And this is Lung and Chest Medical Associates, and doctor, and the physician, those are -- this is a document you've reviewed, reviewed before?

A Yes, it is.

Q Okay. Paragraph 3.

A That's correct.

Q You've read it?

A Yes, I have.

Q Okay. Well -- all right. And would you read it to the jury and just tell them that you agree, either agree or disagree with it?

A With reference to the patient's difficulty concentrating, he undoubtedly had air emboli given his lengthy duration of anesthesia and laser perforation of the endotracheal tree with result in leakage of air---

MR. GUNN: Your Honor, I object to that, to, to his reading the whole thing about air emboli. He can, he can base it on what Doctor, Doctor Fogarty says, his opinions, as Your Honor ruled a while ago. But, but he's gonna be

asked now whether he agrees with the air emboli. He doesn't have that capability.

MR. TURNER: Well, if, if I'm not mistaken, that's exactly what Doctor Gonda, his family practitioner, did yesterday.

MR. KING: No, sir.

MR. GUNN: No, sir.

THE COURT: No, I didn't allow him to do that as a matter of fact.

MR. TURNER: Oh, okay. If he, if he---

THE COURT: So, I am going to allow you to ask this witness if he has utilized that opinion in formulating his opinion. But whether or not he agrees with that, he's not a medical doctor. I'll sustain the objection in that regard.

MR. TURNER: Yes, Your Honor.

THE COURT: So, if you wish to ask him if he's utilized that and how he's utilized that, I'm sure he'll tell us.

Q Doctor Waid, you reviewed that document?

A Yes, I have.

Q And you've utilized that in making and formulating the opinions that you've expressed to these jurors here today?

A Yes, I have.

Q All right. And do you agree with Paragraph 3 on, on bates stamp CT 0818?

MR. GUNN: Your Honor?

THE COURT: Sustained.

Q Okay. You relied on Paragraph 3 and reviewed it in formulating your reports?

A I did.

MR. GUNN: Asked and answered, Your Honor. He's -- I mean he said he---

THE COURT: He's already asked -- I'm gonna ask him not to ask the question again.

Q Did you rely on it in formulating---

MR. GUNN: Your Honor, that is the third time.

THE COURT: I am not gonna allow the question. He's already answered that he used it.

Q Okay. And, Doctor Waid, you still have your report with you?

A Yes, I do.

Q Okay. If you'd go to the last -- Axis I, I think this is where we got hung up before. If you would, let the jury or summarize Axis I.

It is -- let me make sure for the jury, Axis I, that's major disorders, right?

A That's clinical disorders.

Q Clinical disorders.

Tell me what your clinical finding was for Mr. Casey on Axis I.

A Mood disorder with depression, anxiety disorder with

generalized anxiety, and cognitive disorder, and O.S., not otherwise specified. I viewed those things as present, and due to the persistence of his neurocognitive and sematic symptoms, I viewed those as temporally related to potential mechanism that could of caused neurological injury.

MR. TURNER: Your Honor, that's all the questions I have for Doctor, Doctor Waid at this time.

THE COURT: Mr. Gunn, you may cross-examine.

MR. GUNN: Yes, sir.

CROSS-EXAMINATION

BY MR. GUNN:

Q Doctor Waid, I believe it's apparent by now, but you're not a medical doctor, are you, sir?

A No, I am not.

Q All right, sir. And you have not seen Mr. Casey to provide any treatment to him, have you, sir?

A I have not.

Q The only thing that you have done is done these evaluations of him?

A That is correct.

Q Is that correct?

A That is correct.

Q And these evaluations that you've done of, of him in the Year 2005 and 2009 were set up by his lawyers, were they not?

A That is correct.
Q You were first engaged, in August of 2005, by his attorneys at the time, Ken Anthony and Mr. Thompson?
A That is correct.
Q What is your fee for professional services?
A My fee for neuropsychological evaluations regardless is $150 on the hour for the evaluation at, per hour.
Q All right, sir. How about for depositions and coming up here?
A Travel time is also 150 since I'm out of my office, and I do get $320 on deposition hour and expert testimony hour.
Q All right. Do you know how many hours you have placed into this project?
A I have placed approximately ten to twelve hours the first evaluation, ten to twelve the second. I did a deposition with you guys also I believe and today.
Q All right. Now, the -- so, probably what, 30, 35 hours?
Would that be fair?
A I think that would be fair after today---
Q Yeah.
A ---when I drive back.
Q Plus any out-of-pocket expenditures?
A I don't have any. I just got up this morning. So, I don't charge for that.

Q Mileage?
A No.
Q Nothing?
A No.
Q Okay.
a Travel time's travel time.
Q Sure.
Okay. You, you indicated earlier that the second evaluation, the one that was done on August the 30th and September 2nd, 2009, that that was done by agreement of the parties.
Did I hear you say that?
A I don't believe I said that. I did discuss doing it at the deposition. That was May and June of, by the way, of 2009, and there was a statement made then that, that I wanted to do it and I was gonna do it. But I don't know that -- I'm not sure about agreement.
Q I think I was down there on May 15th, 2009, when that deposition was taken and may even of asked a question or two, and I don't remember making any agreement with you that I thought you ought to do that or not.
A I don't---
Q Is my, is my mind failing me?
A Potentially, but I wouldn't rate that at this point.
Q You think my mind's failing me?

A No, just being a joke. Just facetious. I'm sorry. My point to you is I'm not sure I made an agreement with you. I certainly told counsel I thought it would be a better idea for me to have a reevaluation and that would be the other attorneys.

Q Okay. You made, you made an agreement with plaintiff's attorney?

A Right.

Q Okay. All right, sir. Now, you told us in your deposition that was taken on May 15th, 2009, you told us, didn't you, that Mr. Casey, for his first appointment back on August the 30th, 2005, that he drove to Charleston?

A If I told you that I'll agree to that. I just, today, don't remember if I drove or not, yeah.

Q Sure.

Well, it might be important.

A Okay.

Q But that's what you told us.

A That's correct.

Q You got no reason to disagree with that?

A I wouldn't disagree with that.

Q All right, sir. We've been here about seven or eight days it seems like, and, and I want to try to do something that hadn't been done yet, and that's to ask some questions or maybe bring out some things that Mr. Casey can do.

Okay?

A Sure.

Q He can do some things, can't he?

A Yes.

Q All right. When he first came to see you on August the 30th, 2005, he drove to Charleston. We talked about that.

A That is correct.

Q He arrived on time?

A I believe so.

Q Kept his appointment?

A He did.

Q He was well groomed?

A He was.

Q Good personal hygiene?

A Yes, sir.

Q He was conversant?

A He was.

Q He handled himself well?

A He did.

Q So, we know that he can see people and this is the first time he ever met you?

A That is correct.

Q We know that he can see people, meet people, greet people and present well, don't we?

A That is correct.

Q All right, sir. And let me ask you this.

You said that you broke your evaluation up into two sessions, August the 30th and then again on September 2nd, 2005, in order to prevent fatigue, right?

A That is correct, yes, sir.

Q That's what you do with all your clients, is it not?

A No, it isn't. Unfortunately when you're Court ordered or I.M.E. you got one day you got to do it. We also made that decision based on him being, observed to be somewhat fatigued after lunch. So, made a decision then to -- sometimes when people come from the Upstate or other places, we try to get it done often. They're financially strapped a little bit. So -- but I do think it's ideal, if you're asking me, to kind of do it in two and a half days.

Q Well, especially if a fellow got a 210-mile drive down there and a 210-mile drive back, it's best to split it up, isn't it?

A I would even say coming down the night before would be ideal. You're trying to---

Q All right.

A ---not have that interference.

Q All right, sir. Insofar as your findings on that August the 30th and September 2nd, 2005, evaluation, let me, let me make sure I know about some of the things that you did find. Indulge me just a second if I could please,

sir.
A Sure.
Q You found that Mr. Casey had no evidence -- well, well, strike that. Let me go back and ask you, he could hear, see, and speak well?
A Yes, sir.
Q That's one of the things he could do?
A Yes, sir, in terms of gross, he could. Fine testing indicated some left auditory issues, but it didn't seem to interfere with him being able to hear.
Q He had no evidence of visual inattention?
A That's correct. He didn't have neglect to either side of space.
Q Tell the jury what that means.
A Sometimes when people have a injury to the parietal area of the brain, they end up having what we call a hematocoelia. They -- literally their vision will be cut off and can't see either to the right side or the left side. It's called a visual neglect. It's obviously a somatosensory impairment often because of injury back here. Wasn't anticipated on this type of incident, but when you get that, it's, it's a problem.
Q He doesn't have it?
A He does not.
Q He had total recall, recall score after five, five

administrations, which placed him in the 73rd percentile for his age peers?

A In 2009 it was 73rd, 50th the first time. That was where we gave him the redundant learning that I told the jury about where if you give it to him more than once he starts to gain. That is correct.

Q Well, that's a good thing, isn't it?

A That's -- I think so, sure.

Q Tells us he has a good learning curve?

A He has a learning curve. Basically beyond the immediate learning problem he starts to gain.

Q He had no evidence of dysphrasia?

A That's correct.

Q Dysphrasia is the loss of the ability to perform coordinated tasks?

A Basically it's a, actually fine motor drawing. Kind of basically if you show somebody an iron cross, can they draw it, or another one would be like a three dimensional design, can you draw it.

Q We know, from the medical experts in this case even on plaintiff's side, that Mr. Casey has no sensory or motor deficits, don't we, sir?

A That is correct.

Q All right, sir.

A Well, no, no gross motor. I did tests some of his fine

dexterity strength and it was off. But I, again, I don't think he has any gross motor deficits in terms of more significant deficits.

Q One of the items that you relied upon heavily was the deposition of Doctor Jantz from the University of Florida, who testified last week, didn't you?

A I don't know that I relied upon it heavily. I looked at everything and got everybody's opinions as they relate to this case.

Q Well, you saw where Doctor Jantz said he has no motor or sensory deficits, didn't you?

A That is correct, gross motor. I think a couple doctors said that, yeah.

Q For higher reasoning abilities, Mr. Casey was slow, but able to sequence find motor movements for no, for go and no go---

A That is correct.

Q ---test?

A Yes.

Q He performed in the average range on executive functioning test involving letter and category fluency?

A Yeah, they were a little bit in the low range of average, but they were within average limits.

Q He did not demonstrate an excess rate of errors in the Wisconsin, Wisconsin card sorting test, which put him in the

44 percentile or average?
A That is -- basically that's a finding where he did not have perceptorive (phonetic) errors, and that, that's correct. He didn't have that type of errors. He didn't do particularly well on the Wisconsin, but he didn't have what we call perceptorive (phonetic) errors, which is where you're continuing to use the same solution set even though we've given you plenty of information to change.
Q Not---
A He didn't have that type of error.
Q Okay. Not having perceptive errors is a good thing, isn't it?
A Perceptorive errors, yeah, would be much more expected in a more severe type of pathology, and he didn't have that type of error at a high rate.
Q In the tactual, tactual, tectorial performance test, which demands keen kinesthetic and proprioceptive abilities as well as organizational and planning skills he did well.
A He did within the average limits. He's a little bit deficient on his open second trial, nondominant hand performance, but otherwise within average limits.
Q His initial right-hand performance was average. That is---
A That is---
Q ---he was in the 49th percentile.

A That is -- technically, yeah, 48th percentile for that T score.
Q And on the nondominant or left side, 42nd percentile.
A That's about the 20th percentile, that's correct.
Q His, his total time performance, meaning, meaning just how he did speed wise, was in the average range?
A Yes, sir.
Q Your current evaluation showed Mr. Casey to function in the average range of intellectual abilities?
A That is correct. The data you use in 2000, he was still within the average range, in the low range of it, but he was in the average range.
Q All right, sir. Now, let me go over these axises with you if I could. Is there much -- is there any difference between these axises things or Page 9 of your report, on May, the last report, that is the, the May 2009 report and the 2005 report?
A In 2009 I added the anxiety disorder mainly because some of the anxiety and fearfulness that he has as it relates particularly to returning to the hospital and some of that, but otherwise the disorders were the same pretty much with the other two I've talked about.
Q Okay. Well, let's look at 2009.
A Okay.
Q Axis I, mood disorder with depressed mood secondary to

persistent sematic symptomology and potential permanent neurological deficit due to complication---

A Okay. That---

Q ---of laser bronchoscopy.

A That's, that's 2005 and that would be correct.

Q Well, that's 2009 too, isn't it?

A I don't believe so, but---

Q Excuse me. Let's look at 2009. I'm sorry. Mood disorder with depressed mood secondary to persistent sematic symptomology and potential permanent neurological deficit due to complication of laser bronchoscopy, bronchoscopy.

Okay. Depressed mood, the record in this case is clear that Mr. Casey suffered depression back in 2003 before this event, did he not?

A My understandinging he had pain and there was concern about comorbid depression, that is correct.

Q All right, sir. I mean Doctor Gonda's records are clear that he treated Mr. Casey for depression, and, in fact, gave him Paxil and he had significant depression at that time?

A Again, I'm not differing with you other than the fact that it was comorbid with the pain. Both were there and it's very common to use an anti-depressant in the pain/depression mode. It's a little bit different creature then depression by itself and very common in chronic pain.

So, yes, he did give him an anti-depressant, that is correct.

Q Well, the, the depression, as I recollect the records of Doctor Gonda, and we can look at them if need be---

A Sure.

Q ---the, the depression arose out of both the chronic back pain that I'll ask you about in a minute as well as family difficulties and financial difficulties that he had?

A That is correct and my understanding too.

Q All right. He, he was undergoing a divorce?

A Yes, sir.

Q And you will agree with me that even in a, even in a mutual divorce, when, when the parties have agreed for the divorce, it's, it can still be a weighty thing, can't it?

A I believe marital separation, divorce can be stressful, yes.

Q Yes, sir, I mean it's -- and these things that we see in Parade Magazine and everywhere, it's listed as a very very stressful episode in one's life, isn't it?

A Again, yeah, I would agree that it can be stressful.

Q And, and you saw that he complained about problems that his children were having?

A That is correct.

Q And financial stresses?

A I was -- I saw that, yes.

Q And a very very hard job?
A My understanding -- yeah, interfacing with his job.
Q All right, sir. And, and the back pain, the chronic back pain that Doctor Gonda treated him for, which contributed to his depression, that went all the way back to the late 90's, didn't it?
A Certainly was evident in the records I looked at about 2001. So, I would assume that late 90's is a fair estimate.
Q Well, did you see in Doctor Gonda's records where, on two, on February 1st, 1999, Mr. Casey told him he was trying to get an easier job at Michelin?
A I'm not sure if I saw that, but I wouldn't necessarily doubt that if you wanted -- you know, I saw that he was having some pain difficulties. Not just 1999, 2001. I'm pretty sure about 2001 in the records that I saw.
Q Absolutely no question but that he had significant chronic pain before any treatment by Doctor Boscia or Doctor Feldman, isn't there?
A That is correct. Low back pain was a chronic issue.
Q And there's no question but that he was on significant amounts of opioid medication before treatment by Doctor Boscia and Doctor Feldman?
A There was use of pain medication.
Q As well as after?
A That is correct.

Q Okay. Axis II, no diagnosis.

What, what is Axis II?

A Generally a cluster of different diagnosis. One of them being the personality disorders where you might have a pervasive pattern of behaviors added to some traits consistent with a personality disorder.

Q Okay. And you've, and you've made no diagnosis there?

A Yeah, I don't believe I saw any evidence for coming out of adolescence into his adult life that he had such a disorder.

Q Okay. Well, what are you talking about, preexisting stuff there?

A Sure. You come out of adolescence and you have personal traits that just compromise you socially and cognitively dependent histrionic antisocial. Those are the personality disorders. Didn't see any evidence for that.

Q Okay. Axis III, pain/sematic symptomology, motor weakness, now, the motor weakness we, we've talked about the fact that none of the medical doctors found any motor or sensory deficit, did they?

A Again, you're gonna go from gross and I'm gonna go to a finer way of measuring it, and, so, on strength measuring, since some of those are off, it's not gross. Gross would mean he can't walk and do those sort of things. But it's some of the testing we did from a dexterity and strength

point of view is off. I don't think it's a major issue and I'm not sure it's brain related either.

Q Well, let me ask you about that. On his right-hand you found him in the 49 percentile, that is his dominant hand, and the left, on the left, and the left-hand you found him at the 42th percentile on the screen?

A Sure.

Q Okay. So, that's well within the average range, isn't it?

A That's -- yes, on that one I saw the finger tapping was slow, but the grip strength was mild deviation bilaterally. Again, depending on which you -- that was 2005, and that's why I put motor weakness. In 2009, I added it, but motor weakness also is his complaint of just de, deconditioning.

Q Well, I -- in -- is the motor weakness out then in 2009?

A Not from the point of view of this guy just saying he's got diffuse deconditioning. He just doesn't feel as strong. It's a complaint. So, it's in there under that. But in terms of his, again, measurement on both times, his measurement was down for dexterity and down for grip strength particularly with guarded dominant right-hand.

Q All right, sir. Dexterity, would, would you agree with me, that being a pretty good golfer, maybe a ten or twelve handicap, would be evidence of some pretty good dexterity?

A I would think it's pretty good. It's evidence of good visual motor and motor planning and motor skills, yes.
Q All right, sir. Axis III, pain sematic symptomology, we've talked about that. We just discussed the motor weakness. Residual back pain.
The back pain has absolutely nothing to do with Doctor Feldman and Doctor Boscia, does it?
A That -- it does not.
Q Episodic chest pain, that has nothing to do with Doctor Feldman and Doctor Boscia, does it?
A Not making any opinion regarding that at all. I just know he has some episodic, but I make no opinion that it's related to this event at all.
Q Well, did you see in the October 10th, 2008, notes of Doctor Gonda where doctor, where Mr. Casey told Doctor Gonda that I don't have any chest pain related to my hospitalization?
A I may have, yeah. I'm just talking about -- these are just complaints. I'm not diagnosing anything. These are kind of complaints or difficulties he's having. So, he reports some episodic chest pain back in 2005, and I, and I would agree. I'm not necessarily saying it's related to the event or not, not making any opinion whatsoever regarding that.
Q Why don't we look at it just so, just so---

A Okay.
Q ---just so you know I'm being straight with you.
Okay?
A Fair enough.
Q I'm gonna show you CT 01020, and didn't he tell Doctor Gonda here, about a year and a half ago, on October 10th, 2008, he has no chest pain or shortness of breath from the collapsed lung?
A With due respect, I just have to say the sentence before. He continues with chest pain, which no one has ever been able to figure where it is coming from. Then the statement by doctors he has no chest pain or shortness of breath from the collapsed lung. So---
Q That's the patient's---
A I don't know that that's the patient's. That could be opinion. All, all I'm stressing for my records is he has some chest pain. I don't know the ideology, and I'm not an expert on chest pain. So, I'm just pointing out in the diagnosis that there is chest pain that episodically effects this man.
Q This is in evidence and will speak for itself, but I ask you, sir---
A Sure.
Q ---this record is clear in this case that Mr. Casey, what Mr. Casey was doing at the hospital on May the 28th,

2004, was seeking treatment for chest pain of several weeks duration, duration, was he not?
A I believe so, yes, sir.
Q Okay. And, and you've seen, you've seen nothing where Doctor Feldman, Doctor Fogarty or his group have been able to solve that chest pain, have they?
A I have not seen it clarified by those physicians.
Q And that's, and that's one of the things that you list in your diagnosis here?
A Again, I'm just listing the complaint.
Q Okay.
A That's correct.
Q Axis IV, Axis IV, what is, what is, what is Axis IV, what's the slot there?
A Other potential environmental stressors ongoing in his life.
Q Marital separation?
A Yes.
Q Not gonna blame that on the doctors, are you?
A I'm not blaming anything on the doctors. My point is these are other stressors that certainly might impact on Axis I, which is the mood disorder, which you've already brought out. So, the fact that he is going through a separation and a divorce back in 2005 is noted.
Q All right, sir. And that, and that happened -- well,

2005, that was going on before he sought treatment from Doctor Feldman and Doctor Boscia, wasn't he?

A Yes.

Q Okay. Disability/unemployment, worker's compensation litigation, you, you, you just put that in there?

A Those are all potential stressors. Not verifying to what extent, but those are ongoing stressors in his life, that's correct.

Q All right, sir. And you saw, and you saw -- one of the things that you saw and considered and reviewed in this case is the notes of Doctor J. Grace, a psychologist here in Spartanburg?

A I did review, review his records, yes.

Q All right. And you saw where Doctor Grace has seen Mr. Casey every couple of weeks?

A That is my understanding.

Q And insofar as this litigation things, did you see notations in there where a great deal of the time and effort that Doctor Grace has put into it is simply monitoring the litigation?

A I suspect -- I didn't see that personally. But I, I wouldn't have any doubt that it comes up in their interactions, but I wasn't aware of that.

Q All right, sir. Now, one of the things that you looked at and considered was Mr. Casey's school records?

A Yes, I considered them.
Q All right. Let me find them because I, I may have a question about them. I've got so much stuff up here.
Indulge me just a moment, Your Honor.
THE COURT: Yes, sir.
Q Now, I'm gonna ask you some questions about this and these are in the record as CT 1002, 1003, 1004, 1005, and 1006, and I'm gonna tread lightly because I don't want anybody rooting around out there at Spartanburg High checking on Billy Gunn. That'd be ugly.
Mr., Mr. Casey was a graduate of Dorman High School, wasn't he?
A Yes, sir.
Q Okay. And at Dorman High School, in 1977, he was 295th in a class of 455?
A Yes. Yes, sir.
Q And he had a G.P.R. of 1.80?
A That is correct.
Q Okay. Now, that's not all that great, is it?
A It's not a good academic performance.
Q And the year before that, in the 11th grade, he was 371 in a class of 551?
A Yes, sir.
Q With a G.P.R. of 1.625?
A That's correct.

Q Does that show you lack of effort?
A That's what it would be because his actual achievement measures and all that are very good and that's the brain.
Q A phenomena with which I'm familiar.
A One that I have dealt with myself with my children.
Q My experience is much more personal.
A I mean basically obviously non-elective factors come into performance, but you're looking at his attitude measures and all of that and they're really quite good.
Q Yes, sir.
Year before that, looks like 362 in a class of 571?
A That is what I read too.
Q With a G.P.R. of 1.667?
A That is correct.
Q All right, sir. To be more specific, to be more specific, during this year, and I don't, and I'm not, this is, this is ninth grade, English, C's, general math, C's, physical science, couple of D's and a couple of, whatever an E is.
A That is correct.
Q World geography, an A minus and a couple of B's?
A That's correct.
Q Latin II---
A That's---
Q ---E's.

What are E's?
A I suspect they're failure in this system. Yeah, failing, and, yeah, Latin II, got -- he got that. Got a C a Latin I, but that's correct.
Q Were you here when the testimony came in that after he got more interested in sports and girls that his grades went down further?
A Yeah, that's my understanding, and actually his grades up through the sixth grade were A's and B's. So, he got sidetracked in some form or fashion.
Q Okay, sir. All right, sir. Now, when you, when you tested Mr. Casey from an I.Q. standpoint, the test we just called an I.Q. or aptitude---
A Yes, sir.
Q ---score, what, what did you say -- did you say he functioned in the average range?
A Basically, in 2005, when we did the I.Q. in our office, he functioned in the average range indeed. Full scale I.Q. of 96.
Q All right. And in 2009, what was it?
A In 2009 he had a full scale I.Q. of -- it was lower. Full scale I.Q. of 90.
Q Okay. When did you graduate from college?
A I graduated from college in 1974.
Q Okay. Did you, did you have the fortune or good

fortune to serve in Vietnam, in the military?
A I did not serve in Vietnam.
Q So, you don't know about the military concept of the guys that came along that we called 6-7's, when they lowered the aptitude score?
A I know it actually very well. I've spent my first eight years in V.A. treating Vietnam veterans with posttraumatic stress.
Q Right.
A I know the war well.
Q Well, do you know, do you know who the guys we were that were 6-7's?
A Well, yeah, I have an understanding that it lowered requirements for the draft.
Q From 70 to 6-7?
A Uh-huh. (Affirmative).
Q And, and that, and that the guys that -- you could tell who those guys were because the first two digits of their serial number were 6-7, U.S. 6-7 or R.A. 6-7.
A Yeah, usually it was based on their performance on the Bata exam, that's correct.
Q Yes, sir.
And, and some of those, some of those men were flat performers, were they not?
They were good guys who would do what they were told

and, and were, and were brave decent men who could carry out orders and function well?
A Yes, I believe some of those could be good warriors.
Q And they have I.Q.'s of between 67 and 70?
A I would have -- I can't confirm that, but they did reduce it. I'm not sure that I would buy that, 67 to 70.
Q All right. When you first saw Mr. Casey, he was mildly depressed, but it did not compromise him?
A It did not seem to interfere significantly with his ability to meet the demands of testing.
Q All right. He was able to tell you the medication he was on?
A For the most part, yes.
Q And who had provided those medications?
A Yes, for the most part, yeah.
Q The Ateral had been discontinued?
A It was by the second contact with him in 2055.
Q All right. And you will agree with me that chronic pain can interfere with the testing process?
A Yes, chronic pain is definitely something that can interfere with testing or in the day-to-day cognitive functioning.
Q And, and this record is quite clear that Mr. Casey suffers, has suffered with chronic pain since the late 90's?
A Low back pain in particular seems to have been present

chronically.
Q You will also agree with us that there is a capacity for medications to interfere with the testing process?
A Again, use of medication, if it hinders you from clarity in your thinking, attention, makes you toxic, can interfere with testing.
Q All right. And I believe what you've told this jury is that Mr. Casey did not appear to you to be toxic and, and didn't appear to be---
A That is correct actually. We did not feel like we are having a great deal of drug interference due to the medications, both pain and other ones that he was having on the days of testing.
Q All right.
A I did say to the jury that that certainly can get in the way in real life, but it was not observed in the testing situation.
Q All right, sir. Now, now, let me, let me make, make sure that we understand.
Insofar as, insofar as -- when we -- I'm gonna use the term drug abuse.
A Okay.
Q Okay. And I want to have an understanding with you and with this Court that when I use that term I'm not talking about an immoral bad person. I'm talking about drug abuse

that relates to chronic pain.
A That's correct.
Q That, that kind of drug abuse in, in an, in an attempt to take care of chronic pain.
A Okay.
Q Okay?
A Yes, sir.
Q I don't want to, I don't want to put it in the context of a bad guy.
A Okay.
Q I mean out -- you know. But there is, there is, in this record, is there not, sir, significant evidence of the use of a lot of opioid medications, other synthetic opiates, a lot of drugs of different types prescribed for Mr. Casey over what, a ten year period, correct?
A There certainly is evidence in the records I read of 2001 to 2002 and in that area of indeed using the opiate based medication as well as some concern of running out of them too early and so forth and trying to, as we talked in deposition, you know, get control of that situation indeed.
Q And as a matter of fact, you saw in the records of Doctor Gonda where there were any number of several at least episodes that Mr. Casey ran out of medication early for his chronic back pain prior to 2004?
A Yes, I saw several episodes of that.

Q And an occasion where he told Doctor Gonda that his wife had taken his medication?
A I saw that on one instance, yes.
Q An occasion that he had purchased Percocet from friends?
A Purchased or at least got it from friends, yes.
Q Okay. And, and those are all red flags that would tell one that there was an overuse or abuse of medication on the part of the patient?
A There is a potential situation of that, potential situation of better control. As I talked with you, counsel, in deposition, even a better use of neuropathic pain medicines in my opinion should of been pursued at that time, which are nonaddictive and non-opiate---
Q Right.
A ---to give him more relief. So, it's a matter of getting patients the proper relief and finding a balance between use of opioids and non-opioids. In that situation, I thought he could of used a different approach, but he definitely was running out early and using the pain medicines more than they were prescribed.
Q All right, sir. And this record, this record shows in this case, does it not, Doctor Waid, that Mr. Casey has consistently, since about, since the early 2000's, before 2004, been on opioid pain medication, primarily Lortab,

sometimes Darvocet, maybe some Percocet, Tramadol, which I think is a synthetic---

A Yes, sir.

Q ---opioid or would we call that an opiate?

A No, it's a synthetic. It's not even as good as Darvocet quite frankly.

Q Okay.

A Generally not very useful quite frankly.

Q All right.

A But, yeah, he did get some of that too.

Q He's been on those. He has consistently been on antidepressants?

A Again, I was aware of antidepressants being used in that time period, yes.

Q He has been on -- and all of these at the same time?

A Again, the anti-depressant and pain pills at the same time, yes.

Q Okay. And as well as Ateral?

A Well, I was aware of Ateral. I'd have to check on the dates of when that started to help them focus and concentrate. I know that was used post-incident. I'd have to check about pre-incident.

Q And Ateral is a, is a salt mix amphetamine?

A Yeah, it's an amphetamine salts. It's just like Ritalin or Viavance. Very common use as for frontal

executive problems.
Q Known in street parlance as Speed?
A Back in, when I went to college in the 70's we actually got Speed. We didn't have as much psycho-stimulants around, but it is in the same ball park.
Q Okay. And, and to sleep, Ambien?
A He was given some medications to help him sleep, that's correct.
Q Okay.
A Again, definitely after the incident. I would have to check from before. But wouldn't doubt it because pain patients often have trouble sleeping too.
Q Now, now, over, over a period of years, that, that medication therapy there, that regimen, would be tough on a guy, wouldn't it?
A Basically the book on that is it's, it's interaction between a lot of years and your advancing age. That regimen's gonna be much more---
Q My advancing age?
A Well, anybody's advancing age.
Q Okay.
A I'm 58. My brain plasticity is not as good to handle these medications. In the 20's it's not doing anything that's gonna be harmful in the long run particularly once you get off of it. Substance abuse and those kind of impact

permanently on the brain are more age related than, than how much.

Q Well, in the, in the late 40's and early 50's it wouldn't be good for you, would it?

A In the late 40's not as much. But, you know, as you have advancing age, you need be weary of the amount of pharmacology you're using because your brain can't tolerate it as well.

Q But you're telling the jury now all of this, all this medication like that would cause no interference with the testing process, with the, the executive function, with the ability to carry out daily tasks and that sort of thing

A Be -- it would be my contention on several counts. One, I think pain's a bigger player. You need to get pain relief. So, you want to do that. It's a two edge sword cause if you leave a person out there in pain, they're gonna actually be more cognitively impaired than using the medications. Two, yeah, the data is pretty clear on this even as it relates to alcohol where I do research. It's an interaction between excessive use and also liver enzymes and other bodily things being effected.

So, amount alone doesn't do it, and, three, again, I would tell you, in the testing situation, you can observe that toxicity. So, I do not think he has any permanent neurocognitive impairments as a result of that. So,

obviously, if you continue to abuse over many years, the threshold for having some deficits gets lower.

Q The pain, the part the pain, the pain plays in it, the pain long since preexisted any treatment and care by Doctor Feldman or Doctor Boscia, didn't it?

A Yes, sir, he has a history for low back pain.

Q And he had depression and anxiety, those were part of his background before June of 2004?

A Well, I'll certainly agree with the depression. I'm not aware of the anxiety that I'm dealing with which is more fearful around hospitals and stuff. The depression, though, certainly seemed onboard with the comorbid pain as well as the family situation.

Q All right, sir. Well, when I took your, when I came down for your deposition, and your deposition was taken, you told us that anxiety was part of his background, didn't you?

A Yeah, but not when I was talking and telling you a little bit more about specific theories and phobias. Those seemed to be new. I wouldn't doubt he had some anxiety. Anxiety and depression are like brother and sister. They're together anyway.

Q All right. Now, I know you're not a medical doctor, but you're, you're aware of the distinction between objective symptoms and subjective symptoms in a patient?

A Yes, I'm aware of objective findings versus subjective

report.
Q Okay. Objective, objective findings are things that a physician can see, feel, touch, test by diagnostic methods in a patient?
A Yes, usually they show up more under the x-rays---
MR. TURNER: Objection.
A ---and stuff like that.
MR. TURNER: The same with a medical doctor.
THE COURT: I'm not sure the distinction between objective and subjective findings is a medical phrase. I'll allow him to ask about the difference between those two distinctions. I don't know where he's going with it, but we'll see how that works out.
MR. GUNN: Yes, sir.
THE COURT: Go ahead, Mr. Gunn.
Q And subjective, on the other hand, is based entirely on what the patient might tell the, the doctor or, or tell you?
A Yes, you know, there's a certain subjectivity. For example, pain and pain thresholds and, and its relationship to objective evidence. Some people complain more than others and so forth. So, we call that the subjective mode, that's correct.
Q All right. And you would agree with me that Mr. Casey's pain, back pain is subjective in nature?
A I would, I would say his complaints of pain come under

the subjective mode. It's him reporting it.
Q All right. Mr. Casey has demonstrated to you a good ability to remember things?
A Again, when it's effectively learned, yes, sir. The trouble is the learning process. Not the retention process.
Q Okay. You would agree with me that, in the testing process, anger, depression, and anxiety would be disruptive factors?
A I would agree that those emotions can be, again, as I've stated before, we didn't see them interfering. But we believe they interfere in his life and make his cognitive complaints more pronounced in day-to-day pursuits than what we obtained in the testing situation.
Q And you would agree with me that much of Mr. Casey's being down in mood, that is depressive mood, being down, is a result of other stressors in his life such as the financial condition he was in, the family situation, all that sort of stuff?
A Well, I wouldn't agree with that in 2009. A lot, a lot of stuff had worked out better. I think a bigger player is the change in his life and some of the things he can't do, and even finances and stuff like more so family in 2009. In 2009, a lot of things had rectified and gotten better as it related to the family situation.
Q Insofar as things he would be unable to do, one of

those things that apparently is very important to him, I think we had a witness the other day, Mrs. Crotts, said that, that golf is Mark's life.

Were you here when that took place?

You just came down this morning, didn't you?

A That's correct.

Q So, you didn't hear Mrs. Crotts say golf was Mark's life?

MR. TURNER: Asked and answered.

A I did not hear that.

MR. GUNN: Is that---

THE COURT: He didn't, he didn't really respond to the first question, and then he asked it again. I'll allow him to do that.

Go ahead.

A No, I didn't, I didn't hear her say that, but I was aware this is an avid golfer, and also reviewed in Doctor Grace's data, it's clear that a loss of being able to do a hobby or a pursuit that you have a fever for would be a downer for any of us.

Q Yes, sir.

And, and a little bit earlier I think we agreed that a ten or twelve handicap would be pretty good evidence of some manual dexterity, didn't we?

A Good coordination, dexterity, yeah, in terms of being

able to be a golfer like that, sure.
Q All right. And your first encounter with Mr. Casey was on August the 30th, 2005?
A That is correct.
Q Did, did you know that two days before that he shot an 87 on his home course?
A I knew he was still trying to play some, but I didn't know his particular score.
Q Okay. And did you know that on a couple days after that, on September 2nd, he went down and played 18 holes?
A I wasn't aware of what he did after my meeting with him on August 30th.
Q And that two days after that he played nine holes?
A Yes, I was aware he was still playing some. He wasn't scoring well, but he was playing well based on the report that I got from him.
Q And then, a few days after that, on September the 10th he came down for phase two of his evaluation?
A He did.
Q All right. And have you seen the report of Doctor Jeff Smith where Doctor Jeff Smith said that he was having difficulty, it was read in open Court the other day, the psychiatrist?
A Which report are you referring to?
Q Well, Doctor Smith -- let me find it.

Indulge me just a moment if Your Honor please.

THE COURT: Yes, sir.

(Pause.)

Q Where Doctor, Doctor Smith said he had major depressive disorder with reduced energy, sad mood, agitation, motivation?

A Yes, sir.

Q Okay. And that his -- he was unsatisfactory in dealing with customary work stresses?

A Yes, sir.

Q All right. Relating to co-workers and supervisors, unsatisfactory?

A I was aware he was having difficulties there, yeah.

Q Dealing with the public, he wasn't doing well?

A That's correct.

Q Okay. And that was, that was submitted on, this record will show from the witness the other day, on September the 15th and it was dated September the 12th, wasn't it?

A That is dated September 12th.

Q Okay, sir. Well, did you know that on September the 18th, just a few days after that, Mr. Casey went down and played 18 holes and then played what we call a, what people that play golf call an emergency nine? Hadn't had quite enough, and played another nine holes, so, he played 27 holes?

A I was not aware of that, but it doesn't particularly bother me.
Q It doesn't bother you?
A No, sir.
Q Okay.
A I would encourage him to actually do that and not be socially withdrawn---
Q Sure.
A ---and isolated. Kind of you get into the, this issue of being debilitated, that becomes part of the problem. In terms of treating his depression, I'd like for him to get out and play.
Q All right. Thank you, sir.
THE COURT: Mr. King.
Mr. Mann, you want to examine this witness?
MR. MANN: Yes, Your Honor.
THE COURT: All right.
CROSS-EXAMINATION
BY MR. MANN:
Q Doctor Waid, how are you today?
A Good.
Q And we previously met when we took your deposition down at your office.
THE COURT: Doctor, if you breathe into that microphone we get that sound.

WITNESS: I'm sorry.

THE COURT: You can get close, but not quite that close. There you go, sir.

All right. Go ahead, Mr. Mann.

MR. MANN: Okay.

THE COURT: I'm sorry.

MR. MANN: Oh, no worries, Your Honor. Thank you.

Q A couple of quick questions now.

You indicated that you are employed by the Medical University of South Carolina, correct?

A Well, I certainly was full-time and now I'm only a little, a little bit of research money now.

Q And the services that you're offering today are not affiliated with MUSC?

A No, they're not affiliated with the Medical University.

Q Okay. And if I recall correctly, your office where we met was not on the grounds of MUSC?

A No, it's in Mt. Pleasant.

Q And, so, you have an independent practice besides your teaching duties?

A Yeah, I went independent about two years, left what we call the University Medical Practice Plan in 1998.

Q And your meetings with Mr. Casey were not -- also -- they also were not affiliated with MUSC?

A No, they were at my office.

Q Okay. To ask an obvious question, but do recognize Mr. Casey?
A Yes, I do.
Q And this is the individual that came down and sat through the testing with you?
A Yes, it was.
Q All right. Have you had an opportunity to observe him today during the Court proceeding?
A Some. Not much.
Q All right.
A But I mean obviously I've seen him over there. But --.
Q And, and is his presentation today consistent with what you observed during his testing?
A Pretty much. I really haven't engaged with him much verbally or asking him to do any tasks. But he looks the same.
Q All right. And I'm simply putting this on the record. So, this is the basis of my questions.
But would you agree that he appears well groomed?
A Yes.
Q Consistent with what you saw during your testing?
A Yes.
Q All right. And he's had the ability to sit and take notes during the testimony that's been offered?
A Yes.

Q Do -- and, and this may be beyond what you've been able to observe, but has he appeared to be able to assist his counsel with this case?
A It's beyond what I observed, but I, even from a cognitive impairment point of view, I don't have any problem with him being able to do that. It's not a massive brain injury that would make him drool and sit in a wheelchair. This is the kind of subtle frontal executive. It's real. But it's far from the kind of patients I have to see that are massively injured. So, you know, obviously I would have trouble if he looked different cause it wouldn't make sense.
Q All right. And, so, again, then he's consistent with what you observed previously?
A Yes.
Q Okay. Have you ever, and I'm not sure if plaintiff's counsel asked you, but have you ever formulated opinions as to whether or not Mr. Casey could engage in employment?
A I offered an understanding that he was not able to return, but I do not offer that expert opinion. I sometimes have to rate such things for Social Security disability and so forth I'm asked to do it. My preference is to have a vocational expert do that as it relates to understanding all that and whether or not he can go back. So, I do some work on that, but I'm not here to offer that opinion is what I'm telling you.

Q And, so, this, again, I think you've answered it very clearly though---

A Sure.

Q ---you're not prepared today to offer opinions respecting his employability?

A That's right because, quite frankly, cognitively speaking, you know, that wouldn't stop him, but it would get in the way. But there's other issues here, pain and emotional and physical. So, I would leave that to a vocational expert.

Q Doctor Waid, I appreciate that. Thank you.

A Okay.

THE COURT: Redirect.

MR. TURNER: Just briefly, Your Honor.

THE COURT: Yes, sir.

REDIRECT EXAMINATION

BY MR. TURNER:

Q Doctor Waid, the, the name Debbie Goode, does that refresh your memory as to the friend that drove Mr. Casey down to the first evaluation?

A Again, my memory about how he got there is really gone. Ultimately, he arrives. I wasn't aware if he drove himself or not. I knew he didn't have a wife situation to drive him down. But I would have to defer to somebody else for accuracy on how he got to my office the first time.

Q Okay. If I told you his son, Travis, brought him down the second time, you wouldn't take issue with that, would you?

A I wouldn't take issue with that at all.

Q You were asked some questions I think by Mr. Gunn, in the 1990's, I couldn't tell you the record, 1990's, that's probably Gonda's records, but throughout the records you've reviewed, Mr. Casey was fully functional on the production line at Michelin?

A Yes, sir, actually some of the records indicated that part of why he was trying to get these medicines, he was trying to stay fully functional and doing a job that certainly aggravated his low back pain to a more disruptive level. So, he was really dealing with the interaction between low back pain and meeting the demands of his job which had a fairly significant physical capacity. And, so, he was trying to remain functional, as best I could tell, from the review of the records I had.

Q Okay. And one other thing, it caught me offguard, I didn't get to jump up, but when I think of Speed on the street, there's something about Speed, isn't that a slang name for a street drug?

A Speed is in the class of psycho-stimulants known as an amphetamine. You can have it made like meth or you can have Speed for diet pills. These psycho-stimulants used for

A.D.H.D. like Ateral are really a variations of that. Salts are not as strong as Speed or what we call, we call a methamphetamine. Ritalin is Merthiolate. It's a totally different chemical structure. They're just grouped in what we call the psycho-stimulants. They will enhance your concentration, your focus, won't sleep, appetite suppression as well as some people they might get too racy actually. But they -- definitely medications we use a lot in neurologic injury because they actually improve the frontal lobes and their ability to focus and concentrate. After a mild head injury or brain injury in my college students, we actually get them back to college, but they have to use this medicine to be successful.

Q Okay. You called it an M-Salt (sic)?

A The Ateral is really an, called amphetamine salt. It's not the full methamphetamine that is much stronger than is generally what people party with, but don't get me wrong, I'm -- certainly college kids can party a little bit with Ateral and things like that.

Q You know, Doctor Smith, he was prescribing it though to improve Mr. Casey's concentration according to his records you reviewed?

A Most, most definitely and it's not even a -- it's good. Mr. Casey was complaining of attention, concentration, memory problems and Doctor Smith gave it a shot, which is

totally understandable.
Q Okay. And so, the, the last question I asked you, the testing, the, the permanent impairment, once you take out and I know that there was some pain and some things before, they began after this 6/3/2004 procedure?
A Yes, my opinion they do and he has an acquired attention executive problem, and he, in my opinion, even if you get rid of the pain and depression he's gonna have to do something to improve that or deal with it would be my opinion.
Q And, at this point in the game, we're six years, well, I did poor math, from 2005, about four or five years, it's not likely to change, is it?
A No, I---
Q It's most likely permanent?
A I think prognosis is poor for change in that he's got to deal with this as a permanent situation.
Q Okay. No further questions.
THE COURT: Recross.
MR. GUNN: Yes, sir.
RECROSS EXAMINATION
BY MR. GUNN:
Q The Ateral, the Ateral, when, when a person is taking Ateral, and, and the Ateral begins to wear off, they have a pretty serious sort of coming down or crash and burn

situation, don't they?
A Not really. Basically you can have what we call a little bit of a drag effect as the medicine's half life wears out. It can renew a little bit of draggy feeling, maybe make you a little bit irritable. However, when you're already on an antidepressant, as this man was, and the use of it, that tends to guard against it. So, when we're dealing with college students who talk about this drag effect and be wary of it, also that's a good, a good time to go exercise and push it out.

So, you can get a little draggy effect, a little moodiness sometimes or if you have any underlying depression you can pull it out. When we have that real bad we just put a person on antidepressants and then it takes away that drag effect.

Q And you said that the crux of Mr. Casey's cognitive deficit is in the area of executive functioning?
A Attention executive functions, speed of processing, frontal executive abilities, yes, sir.
Q All right, sir. The, one of the things you considered in formulating your opinions was the negative M.R.I. that you saw on February 4th, 2007?
A Yes, sir, I was aware of the negative M.R.I.
Q That, that, that M.R.I. was indeed in the name of Mark Johnson, was it not?

A That is correct.
Q With a, with a date of birth other than that of Mr. Casey?
MR. THOMPSON: Your Honor, I have an in camera matter I'd like to take up.
THE COURT: Ladies and gentlemen of the jury, at this opportunity, at this time I'm gonna ask you to retire to the jury room while I take up something with the attorneys. Please do not begin any discussions until I advise you to do so.
(Whereupon, the following takes place outside the presence of the jury.)
THE COURT: Yes, sir.
MR. THOMPSON: Judge Couch, we had made a motion relative to Doctor Godwin and this brain M.R.I. that was made February of '07. It was my understanding that the Court ruled that the, that the M.R.I. itself could be used from medical purposes and medical purposes only throughout the trial, and that it could be used also for impeachment purposes if the opportunity rose, arose if Mr. Casey testified. But as to anything else concerning the background of the M.R.I., Doctor Godwin's involvement, any involvement on my part, that that was not going to be allowed in the case, and, in fact, it was done with an alias, which I would construe that as being apart of the

background as to how the M.R.I. was obtained, and would, assuming that the Court agrees that that is how the Court ruled, I would make the objection that that should be disallowed on this basis and move to strike that testimony.

THE COURT: Mr. Gunn.

MR. GUNN: Well, if Your Honor please, first of all, the document is in the record CT 0183 and shows the patient as Mark Johnson with another, another date of birth. Secondly, if Your Honor please, we have the transcript from the hearing April 29th. Your Honor ruled that, Pages 35 and 36, that essentially it would come in for the two purposes that outline, that were outlined by Mr. Thompson. But that if there was any evidence of intent to deceive, that all the circumstances would be allowed.

If Your Honor please, we, we, we've got a memorandum of law to hand up to the Court. At this point, at this point all we want to do is bring out the name, the name and the date of birth, and we have a memorandum of law we'd like to hand up.

THE COURT: As to what?

MR. GUNN: As to, as to the admissibility of the, of all of the circumstances.

THE COURT: I thought we've already had a hearing on that.

MR. GUNN: Yes, sir.

MR. TURNER: We did.

MR. GUNN: Yes, sir.

THE COURT: Are you asking me to reconsider my order?

MR. GUNN: Well, I haven't seen the order, sir.

THE COURT: Well, I made an order from the bench---

MR. GUNN: Yes, sir. Yes, sir.

THE COURT: ---as to the---

MR. GUNN: And we have it. I mean we, we've got the transcript.

THE COURT: Well, I'm looking at my ruling. We've got notes as to what I did. There were basically five specific things. I said it could be for the purpose of the information of the, in the, contained in the test, to attack the credibility of the plaintiff's prior inconsistent statements. As for deep, as for the details as to how the plaintiff's attorney went about conducting the test, it could not be used. So, to the extent to which it might be used at trial, I would have to rule on those things as to credibility et cetera at trial. So, that, that was basically my ruling.

MR. GUNN: All right, sir.

THE COURT: Now, I -- so far you've asked if he's aware of the M.R.I. and the name that was on it.

MR. GUNN: Yes, sir, that's, that's all. That's all I'm gonna ask him, the name, and the date of birth, being

some other date of birth.

THE COURT: And the test is already into evidence?

MR. GUNN: Yes, sir.

THE COURT: Okay.

MR. GUNN: That's all I want to do at this point.

MR. MANN: Your Honor, may I be heard?

THE COURT: Mr. Mann.

MR. MANN: May I be heard?

THE COURT: Yes, sir.

MR. MANN: May I approach with Doctor Waid's original deposition just in case it's needed during this cross-examination. I would like to also bring to the Court's attention, during Doctor Waid's deposition in Charleston, he was asked specifically about the M.R.I. and also because he is here to testify as to the cognitive abilities of the plaintiff, he was additionally asked as to whether or not Mr. Casey would have the ability to remember going over to Charlotte for the M.R.I., would he have the ability to remember laying down on a piece of equipment going through the M.R.I., and would he have the ability to tell the truth about it and recall these events. And Doctor Waid testified affirmatively that he would be able to tell the truth about these things.

That's all, Your Honor.

MR. THOMPSON: Judge Couch, you know, my understanding

that the Court's rule---

THE COURT: Well, excuse me.

Mr. Mann, at this time he's not denied that he took it.

MR. MANN: And, and I believe that's correct, Your Honor. However, I don't---

THE COURT: I mean if you had a prior inconsistent statement, if he admits that he made a prior inconsistent statement at trial, extrinsic evidence can't come in after he makes that admission.

MR. MANN: I would agree with that, Your Honor.

THE COURT: And I think -- have you taken his deposition since the M.R.I.?

MR. MANN: We not have, Your Honor.

THE COURT: Okay. Go ahead, Mr. Thompson.

MR. THOMPSON: Judge Couch, and, and maybe you, you can clarify this for me, but as I understood the Court's ruling, it was, you know, the door would be completely kicked open if there was evidence on the part of Mr. Casey as to being involved in the actual planning of the M.R.I. with an intent to commit fraud basically upon the Court, and---

THE COURT: Well, he hasn't testified.

MR. THOMPSON: Yes, sir.

THE COURT: The point I was trying to make is he's not testified at this point in time.

MR. THOMPSON: If I could, one, one matter.

THE COURT: And I don't know what his testimony is going to be on this point. That's the reason I asked if the deposition had been taken since that time that may reveal what his testimony would be on that point. So, I, and, again, my understanding of the rule is if you've made a prior inconsistent statement, if you admit that you made a prior inconsistent statement, the rule is pretty clear.

MR. THOMPSON: Yes, sir.

THE COURT: From that point forward, extrinsic evidence on that point can not come in.

MR. THOMPSON: Yes, sir.

THE COURT: Going by the rule. Now, if he denies he made prior inconsistent statements and he denies that, that he did that, then extrinsic evidence does come in. If he fails to admit is the way the rule works, works. He'd have to admit that he made a prior inconsistent statement.

MR. THOMPSON: And as to that---

THE COURT: Well, now, this, this document, Mr. Thompson, is already in evidence in that name. It's already in evidence.

MR. THOMPSON: Could I just make a very---

THE COURT: Yes, sir.

MR. THOMPSON: Your Honor, you know, we initially had a different medical book and we agreed to put together a Joint Exhibit. It didn't get put together, quite frankly, on a

timely basis and Mr. Gunn had it stamped, bate stamped with a copy delivered to us I think it was Tuesday morning, and I think it come out in the testimony where a number of documents that, that were part of the, part of the record to be included were not included, and the original notebook was some 500 pages and the one I've got now is 1,100 pages, and that M.R.I. apparently is what, ten by eleven now, and, quite frankly, I haven't seen it. I haven't been able to thumb through this 1,100 pages to see exactly what's in there, and I was, I was acting with the assumption that the, that the scan had been reduced in size, but consistent with, I understood the Court's ruling, that, that the name, wherever it is, if it's at the top, that that part would be redacted.

THE COURT: Well, again, all's I know is that I asked if that, if there was any objection, any objection to the documents. They've now been admitted is the way I understand it.

Am I---

MR. KING: You're correct.

MR. GUNN: Yes, sir, I mean---

MR. KING: Yes, sir.

THE COURT: It's in the record.

MR. MANN: Your Honor, if I may add---

MR. THOMPSON: It was admitted with the stipulation

that, you know, we, we could add documents and saw something that was missing---

THE COURT: Well, I don't remember that stipulation being put on the record. When it went in, I asked if there was any objection to the documents and there was none. It was admitted. It's in the record. If it's in the record in that other name, I'm gonna ask him if he understood that that test relates to this individual. That's as far as I'm gonna let him go with it at this point in time.

MR. THOMPSON: Yes, sir.

THE COURT: And I understand that's all you wanted to ask him.

MR. GUNN: Yes, sir, that's all I wanted to get in evidence.

MR. THOMPSON: Yes, sir.

THE COURT: And so, I'm gonna let him ask him if he understands that that test, even though it's in a different name, relates to this individual.

MR. THOMPSON: Yes, sir, thank you.

THE COURT: Now, later on, depending on the testimony concerning the, the test from your client, we'll see where it goes. I don't know what that testimony is gonna be.

MR. MANN: Your Honor, may I briefly be heard?

THE COURT: Certainly, Mr. Mann.

MR. MANN: Would we have an opportunity, before this

witness is released, because he is all the way up from Charleston---

THE COURT: We don't have to release him.

MR. MANN: But, but---

THE COURT: If he's under subpoena.

MR. MANN: I was, I was---

THE COURT: Let me finish. If he's not under subpoena, I don't have any hold over him. Now, you have the right -- Mr. Mann, I'm talking to you.

MR. MANN: I'm sorry.

THE COURT: And you -- if -- you have the right to have a subpoena issued for him if you wish to do that and call him at a later point in the trial.

MR. MANN: We will---

THE COURT: I think the testimony you just related to me just now, I don't know if it's relevant at this point in time in the issue that's before the Court other than credibility of the plaintiff if he testifies. Now, if he testifies and his credibility is called into question, that information may become relevant at that point in time.

MR. MANN: Thank you, Your Honor.

THE COURT: You certainly have the right to issue a subpoena for this gentleman and require his presence later in the trial. We're not through. You haven't presented your case yet.

MR. MANN: Yes, Your Honor.

THE COURT: We're not through with the case.

MR. MANN: Thank you, judge.

THE COURT: Anything else, Mr. Gunn?

MR. GUNN: No, sir, that's all I wanted to do.

MR. THOMPSON: Nothing from the plaintiff.

THE COURT: All right. Bring the jury in. We're gonna go till about 12:30 and then we're gonna break for lunch. I'll just let you know that. I don't know where you are in your questioning. Make you aware of it.

MR. GUNN: Just about through, Your Honor.

THE COURT: All right.

(Whereupon, the following takes place within the presence of the jury.)

THE COURT: You may proceed, Mr. Gunn.

MR. GUNN: All right, sir.

CONTINUED RECROSS EXAMINATION

BY MR. GUNN:

Q Doctor Waid, I was asking you about the M.R.I. of February 4th, 2007, that was negative that was among the documents that were given to you.

A Yes, sir.

Q All right. I'm gonna ask you about that. It's, it's in the, it's in this record as CT 01083, and is that the document that you looked at, the negative M.R.I.?

A Yes, it is.
Q And the conclusion was negative M.R.I. of the brain without contrast?
A That is correct.
Q And the patient's name shown there was -- and that was performed at Presbyterian Hospital in Charlotte?
A I believe that's correct.
Q All right. And the patient's name shown there is Mark Johnson?
A That is correct.
Q And the date of birth is 10/18/58.
What is Mr. Casey's date of birth?
A 11/3/58.
Q Different---
A Yes, sir.
Q ---dates of birth?
A Yes.
Q Okay. Do you understand that it's been stipulated, it was stipulated at the deposition that this is indeed a, an M.R.I. performed on Mr. Casey that was negative?
A I understand that.
Q All right, sir. That's all.
Thank you, Your Honor.
THE COURT: Mr. Mann.
MR. MANN: I have no questions.

* * *END OF REQUESTED TRANSCRIPT OF RECORD* * *

C E R T I F I C A T E

I, Pamela E. Green, Official Court Reporter for the Seventh Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for Spartanburg County, South Carolina, on the 19th day of May, 2010.

I do further certify that I am neither of kin, counsel nor interest to any party hereto.

May 22nd, 2010

_____

PAMELA E. GREEN, Court Reporter

10/20 - Requested that they Fed Ex back to us.

Dr Randy Waid

843-881-2778

Kathryn - Personal Asst.

Medical Notebook
Fed Ex Overnight
to us for corrections
and updates

222 W. Coleman Blvd.
Mt. Pleasant SC 29464

8/26 10am - Amy has not yet confirmed reservation w/CB later today w/ info -

lcrg.

FedEx Express. US Airbill

8550 3253 1235

0200

FedEx Retrieval Copy

1 From

Date 10/25/05 Sender's FedEx Account Number 1076906 89

Sender's Name Randolph Waid Phone 843 881-2778

Company

Address 222 West Coleman Blvd.

City Mt. Pleasant State SC ZIP 29464

2 Your Internal Billing Reference

3 To

Recipient's Name Karen Greer Phone 464 585-8166

Company Burts Law Firm

Recipient's Address 260 North Church Street

Address

City Spartanburg State SC ZIP 29306

4a Express Package Service

1 ☐ FedEx Priority Overnight 5 ☐ FedEx Standard Overnight 6 ☐ FedEx First Overnight

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Total Packages 1 Total Weight 4 Total Charges

8 NEW Residential Delivery Signature Options

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PLAINTIFF'S EXHIBIT 117 Waid

PENGAD 800-631-6989

THOMPSON 058207

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	C.A. NO. 2010-CP-42-05743

Gregory J. Feldman, MD, Joseph A. Boscia, III, MD, and Upstate Lung & Critical Care Specialists, PC,

Plaintiffs,

Versus

William Mark Casey, Ray E. "Chuck" Thompson, and Charles M. Fogarty, MD,

Defendants.

****

VIDEOTAPE DEPOSITION OF
WILSON P. SMITH, JR., M.D.

****

Pursuant to Notice of Deposition and/or agreement in the above-entitled case, the videotape deposition of WILSON P. SMITH, JR., M.D., was taken on the 5th day of May, 2017, commencing at the hour of 9:55 a.m. in the offices of Wilkes Law Firm, Spartanburg, South Carolina.

REPORTED BY: Rosalind Poole Walters,
Certified Verbatim Reporter-Master
VIDEOTAPED BY: Alan Metts,
Certified Legal Video Specialist

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INDEX

EXHIBITS:

*Note: Only cover page of exhibit attached to copies.

(THIS TRANSCRIPT MAY CONTAIN QUOTED MATERIAL. SUCH MATERIAL IS REPRODUCED AS READ OR QUOTED BY THE SPEAKER.)

STIPULATIONS:

It is agreed by and between the counsel for the parties as follows:

1. That this deposition is being taken pursuant to Rule 30 of the South Carolina Rules of Civil Procedure;
2. That this deposition is being videotaped;
3. That the deponent reserves the right to read and sign the deposition transcript.

VIDEOGRAPHER:

We are now on the record. Today's date is May 5, 2017. The time is 9:55. This is the video deposition of Dr. Wilson P. Smith, Jr. in the matter of Gregory J. Feldman, M.D., et al., versus William Mark Casey, et al. Will counsel now please introduce yourselves for the record?

MR. MANN:

My name Milton Mann. I'm here on behalf of Dr. Feldman, Dr. Boscia, and Upstate Lung and Critical Care Specialists. I am joined by Katelyn Owens who is a member of my staff. Thank you.

MS. CHEEK:

This is Ellen Cheek on behalf of Dr. Charles Fogarty. I'll also state for the record that Matt Henrikson who represents Chuck Thompson is not attending today because of a conflict. He has verbally

indicated that the deposition should proceed in his absence.

VIDEOGRAPHER:

And will the court reporter now please swear in the witness?

***** ***** ***** *****

WILSON P. SMITH, JR., M.D. being duly sworn to tell the truth, the whole truth, and nothing but the truth of his own knowledge concerning the matter herein, testified as follows:

***** ***** ***** *****

EXAMINATION BY MR. MANN:

Q. Would you please state your name for the record?

A. Wilson Pedrick Smith, Jr.

Q. Thank you, Dr. Smith. What is your vocation?

A. I'm a physician.

Q. How long have you been a physician?

A. Since graduating from medical school in 1976.

Q. Have you given a deposition before?

A. I have.

Q. Are you pretty comfortable with the normal procedures of giving or taking a deposition?

A. I am.

Q. If I can do anything to facilitate the process, please let me know.

A. Okay.
Q. Given that you're a physician, also, if you need to step out for any reason whatsoever, we will accommodate you however you need us to.
A. Okay.
Q. Thank you, Dr. Smith. Are you familiar as to the litigation as to why I've requested you to come today and give a deposition?
A. To be honest, not -- I'm not sure.
Q. Do you understand that previously there was a medical malpractice case that involved a patient of yours, William Mark Casey, that brought claims against Dr. Feldman, Dr. Boscia, Upstate Lung and Critical Care, and Dr. Shantha?
A. Yes, I am aware.
Q. And that litigation ended sometime, if I recall correctly, May of 2010.
A. Yes, sir.
Q. Is that your understanding?
A. Yes, sir.
Q. During that litigation you gave a deposition. Is that correct?
A. I did.
Q. Also in conjunction with that litigation, I believe you came to trial and testified, as well?

A. I did.
Q. I will represent to you your trial testimony was not typed up. So, to the best of my knowledge, that testimony has been lost. Is that your understanding?
A. I have no knowledge.
Q. You have no knowledge, which is fine. Let me do some housekeeping things first. You received a subpoena to be here, if I'm not mistaken?
A. That is correct.
Q. Okay. Let me -- I'm going to show and mark this just for, like I said, housekeeping purposes. Let me start with the subpoena. Would you please take a look at this for me, Dr. Smith, and we're going to mark this as Exhibit 118, please.
A. Okay.
Q. Would you let her put a sticker on it, Dr. Smith? That will help the court reporter.
A. Okay.
(Plaintiff's Exhibit Number 118 marked)
EXAMINATION RESUMED BY MR. MANN:
Q. And Dr. Smith, does this appear to be a copy of the subpoena that you had previously received, sir?
A. Yes, sir.
Q. And in an effort to comply with this request, that's why you're here today, sir?

A. Yes, sir.
Q. I appreciate it, so thank you. This also asked for you, for lack of a better term, to use a catch-all term, it asked you to bring a copy of Mr. Casey's chart?
A. Yes, sir.
Q. Counsel has agreed that given the fact that Mr. Casey is still a patient with Lung and Chest that the information that you brought today in compliance with the subpoena would be limited through the last day of the trial. Is that your understanding?
A. Yes, sir, it is.
Q. And in an effort to help us with this request, you have brought a chart with you today, sir?
A. Yes, sir.
Q. I'm going to get to that in a minute, and we're going to mark that as an exhibit, also.
A. Okay.
Q. Thank you. You also, I believe, received -- and Madame Court Reporter, could we mark this is as 119, please?
(Plaintiff's Exhibit Number 119 marked)
EXAMINATION RESUMED BY MR. MANN:
Q. Thank you. And Dr. Smith, let me ask you to please look at that, if you would be so kind.
A. Okay.

Q. And have you seen that document before, sir?
A. I have.
Q. Okay. And is that your understanding that that is the notice for us to be here today, as well?
A. It is.
Q. And, again, I thank you for your appearance. As we previously talked for just one second before we started the deposition, I have brought a copy of your previous deposition in the underlying medical malpractice case, and at this time I'm going to ask that it be marked as Exhibit 120, please.
(Plaintiff's Exhibit Number 120 marked)
EXAMINATION RESUMED BY MR. MANN:
Q. And let you take a look at it and see if you recognize it as to being your deposition in the underlying case, please.
A. Yes, this looks like my deposition.
Q. And Dr. Smith, have you ever read your deposition?
A. I may have read it. I usually read the depositions before approving them. So I probably did read that.
Q. Is it fair to say that that reading of the deposition would have occurred before 2010, either 2010 --
A. Yes, sir.
Q. -- or before?
A. Yes, sir, it would have.

Q. So in preparing to be here today, you have not reviewed your deposition?
A. I have not.
Q. Okay. Do you recall from your prior readings if there were any inaccuracies in your deposition?
A. I do not.
Q. Has anyone indicated to you that there is anything inaccurate in your deposition?
A. No, they have not.
Q. If that thought process changes that you feel that there may be an inaccuracy in that deposition, would you please alert Ms. Cheek so that she can alert me so that I would be aware of that?
A. Be glad to.
Q. Otherwise, if it is fair, if you think this is fair, I am going to assume that whatever you testified to previously in your deposition is accurate as to the best of your knowledge?
A. It is.
Q. Thank you, sir. Let's look at what you brought today. Can you please identify what this is that you brought with you?
A. This is the chart of Mark Casey.
Q. With your permission, I'm going to return these to the court reporter because I don't think we need those, but

Dr. Smith, I am going to give you your own copy of your deposition for whatever use you may see for it.

A. Okay.

Q. So you can take that copy with you.

A. All righty.

Q. But you were telling us what you brought with you today, sir?

A. It's Mr. William Casey's chart.

Q. Have you had an opportunity to look through it?

A. I have not.

Q. But, to the best of your knowledge, that is a complete copy of the chart?

A. It is.

Q. During your deposition before, you were requested to produce a copy of your chart. Is that your recollection?

A. I have to say I have no specific knowledge of that, but looking at the deposition, it looks like there's a copy of the chart. So I must have.

Q. Do you recall that the day of your deposition previously you did not bring the chart with you? Do you recall that?

A. I think they had a copy there for us, so I did not -- I did not have to produce our record.

Q. Do you -- do you remember at all if the copy of the

chart was produced through Mr. Casey's attorney, Mr. Chuck Thompson?

A. I have to say I just -- that's too far.

Q. Okay. Whatever your deposition says regarding that topic would be accurate because you have --

A. It would be more accurate --

Q. -- no knowledge?

A. -- than my memory at this point.

Q. And so we can just refer to the deposition, okay. Is that fair?

A. Mm-hmm.

Q. Thank you, sir. And you have to---

A. Yes.

Q. We have to do those yes and no, please.

A. I understand.

Q. Okay. And I get in the habit, too, because I'll nod and, you know, and give every other affirmation sign, but unfortunately for the court reporter she needs verbalization.

A. Okay.

Q. So at this point in time we did have a brief discussion before respecting the chart, before the deposition started. Do you recall that conversation?

A. Yes, sir.

Q. We're going to mark this now as Exhibit I believe it's

120. Is that correct?
A. 121.
Q. 121. Thank you.
(Plaintiff's Exhibit Number 121 marked)
EXAMINATION RESUMED BY MR. MANN:
Q. And we're going to request that the court reporter make a copy of this for us. Is that your understanding?
A. Yes, it is.
Q. And do you mind if I surrender it into her care and custody so that she can have that done for us?
A. Yes, sir, you can.
Q. Dr. Smith, let me call your attention to one thing in your deposition. There is a letter. Can you please tell me what this appears to be?
A. It is a letter from George H. Thompson stating that they represented Mr. Casey on a social security disability claim and that they had no information on him after a certain March 15, 2005 and thanked us for providing copies of any records after that date.
Q. And I think what I'm really -- the reason I'm asking you to look at this, I have some general questions, not necessarily specific as to this letter, but for the benefit of the record, the letter is dated September 6, 2005?
A. That is correct.

Q. Would you agree with that? And it appears that it was received or there appears to be a received stamp of September 8, 2005?
A. That is correct.
Q. Were you aware that Mr. Casey was attempting to qualify for social security disability?
A. I would be after that letter.
Q. And if information was provided to the Social Security office or things of that nature in conjunction with this, would you have had knowledge of that contemporaneously back in that time?
A. Yes, I would have -- we would have -- there's my initials here at the bottom of the page saying that I okayed the release of the chart.
Q. Okay. And was that customary that you would initial things for them to be released to various agencies?
A. That is correct.
Q. And if there are records that have that initialing and information upon it, may we assume that they are accurate?
A. Yes, to the best of my knowledge.
Q. And let me ask that question in a different way. Have you ever been alerted that there are records that exist that purport to have your initial on it that are inaccurate?

A. No.
Q. Okay. And I know that's kind of a catch-all question, but, again, I'm trying to streamline our time together, and instead of showing you --
A. Sure.
Q. -- a bunch of unnecessary -- not necessarily unnecessary, but instead of showing you a bunch of documents and having you confirm every single signature or notification, what I would like to do is just find out if you believe it's fair that if there are initials on medical documents respecting this particular case, then, to the best of your knowledge, you have never been alerted that anything is fraudulent or anything was done without your permission or express consent if you initialed them?

MS. CHEEK:

Object to the form.

EXAMINATION RESUMED BY MR. MANN:

A. Well, generally this would say that -- that the record was brought to me and seemed to be complete and I okayed that it be released.
Q. Okay. We're going to get back to this in just a minute, but -- and I think you have answered my question, and I think Ms. Cheek had a very good objection because that was a rambling question, but --

but to -- but for -- for my deference, you did understand what I was asking?

A. Yes, sir.

Q. And, again, to try to state that question a little bit differently is, to the best of your knowledge, you have never been told that there are records respecting this case that have your initials on them that were fraudulently sent or submitted to any agency or individual?

A. No.

Q. That's right. That's what I would assume, because I've never heard that.

A. Yeah.

Q. And, again, I'm trying to streamline our time together. So, in other words, I want to know if you know of any problems respecting the records and if we need to delve into those and have additional questions with them or can I just simply assume that the records speak for themselves.

A. Yes.

Q. Does that make sense as to my question?

A. Now, I have to say, to clarify that --

Q. Yes.

A. -- that Ms. Cheek did show me that there were multiple copies of one note from Dr. Fogarty. So I -- I was

aware of those as of last week. I was not aware of those prior to that date.

Q. That would have been my assumption, also, Dr. Smith, and I promise you I'm going to ask about those next. Okay?

A. Okay.

Q. And that's one of the reasons why -- and since you brought it up, I will represent to you in documents that were initialed by you to the Social Security there was one version of the note. Attached to your deposition and, to the best of everyone's recollection, your testimony at trial involved another version of that note that you're referencing.

A. Okay.

Q. And that was one of my questions, did you know that that had occurred, and it sounds like you did not.

A. (Witness shakes head).

Q. Okay. So let's -- we're about done here. So let's -- let's get specific as to those particular notes.

A. Okay.

Q. These notes have previously been marked in this litigation. That's why -- I don't know if you thought anything of it, but the exhibits that I've attached here, I think we started with 118. The reason is that from all the people that have given depositions, we're

not doing one through X number for one particular deponent. We're just keeping them all in order to make it easier for everyone to understand what note is what.

A. Okay.

Q. Also, in an effort to hopefully save a tree or two, we're not re-creating multiple copies of notes and things of that nature that have already been attached to a deposition. So with that said, I'm going to show you three notes that I believe you have indicated that you have seen. Oops, I'm looking at the wrong stuff here. And Dr. Smith, I will represent to you during the course of this litigation I'm going to show you these together, and these are previously marked exhibits to the depositions --

A. Okay.

Q. -- that have been numbered 5, 6, and 7.

A. Okay.

Q. And let me get them all out here so that we can have a brief set of questions respecting these. Okay?

A. Okay.

Q. I think you indicated to me that you've had the benefit of being alerted that there are multiple copies of what purports to be a 7/21/05 office visit note of Dr. Fogarty's respecting William Mark Casey. Correct?

A. Yes.

Q. And have you had an ample opportunity to look and compare them?

A. I have.

Q. All right. What is your understanding as to why these three different versions of this office visit note exists?

A. Well, let me just say that, again, I had no prior knowledge of these prior to Ms. Cheek bringing those to my attention. I can speculate for you what there is, but I have had no conversation with anybody about how they came about. It -- it looks to me like the note, the Exhibit 5, which I think is -- is the one that is unsigned by Dr. Fogarty --

Q. Okay.

A. -- is a draft that he would have perhaps reviewed, and we at that time, looking at the initials here, there is a transcriptionist, Nan Strickland, who did our transcription off of little cassette tapes, and they -- she would have returned those to us to review and correct if we felt there was something that came out wrong. And so it looks to me like that was the draft copy since it was never signed.

Q. Okay.

A. The second one is signed with some change in the three comment paragraphs, though not big changes, in my

opinion, and that copy is signed and a copy is to be sent to Dr. Gonda.

Q. Okay.

A. And then the third copy now---

Q. And which number is that, if you could help us?

A. I'm sorry. This is 7.

Q. Okay.

A. Exhibit 7.

Q. And you were previously talking about 6?

A. About 6, that is correct.

Q. Thank you, Dr. Smith.

A. So the order of the paragraphs is changed in the comments section, again, not a big difference in the content. And now there is two physicians that it's sent to, which would be to Dr. Gonda and to Dr. Grace, who was a psychologist that Mr. Casey was seeing, and Dr. Gonda was his primary care physician.

Q. Yes, sir. That's my understanding, also. Let's look back to Number 5, Dr. Smith.

A. Okay.

Q. And we're welcome to look if we need to. I've -- we've got a copy of your deposition here. But I will represent to you that when your chart was produced in conjunction with your deposition, this is the only note that was provided which is marked Exhibit 5. Would you

have any reason to doubt that, or do you need to look at the chart?

A. In -- in looking at the chart, that -- that's the note that's in there now.

Q. Yes. And so that note has remained consistent. In other words, it was the one produced with your deposition.

A. Right.

Q. That's your understanding. And it's also the one that's in the chart now. These other two notes are not -- not readily apparent, which you referred to as the two notes that appear to be signed.

A. Now, I have to say I don't specifically recall. Would we want to look in our deposition --

Q. Sure.

A. -- and see which -- which of these three notes ended up there?

Q. Let's take a brief off the record, please.

VIDEOGRAPHER:

Off the record at 10:16.

(Off the Record)

VIDEOGRAPHER:

Back on the record at 10:27.

EXAMINATION RESUMED BY MR. MANN:

A. Now---

Q. Dr. Smith, let me put a question before -- before you before you---
A. I mean, I -- just -- just before we -- this is the same, same one that I found, which was the one that's referenced to Dr. Gonda, but I swear that I saw that earlier, didn't we?
MS. CHEEK:
I think so. Shall I give it a go?
MR. MANN:
Please. Let's go back off, Alan.
VIDEOGRAPHER:
Off the record at 10:27.
(Off the Record)
VIDEOGRAPHER:
Back on the record at 10:30.
EXAMINATION RESUMED BY MR. MANN:
Q. Now, Dr. Smith, again, I want to make sure that we're accurate, and we've taken a few minutes to look through both your prior deposition and the chart attached to it as well as the chart that you've brought from us -- for us today. Can you please identify which versions of the notes that we were able to locate in the chart you've brought today as well as to your deposition?
A. Right. So there is a copy of Exhibit 6 --
Q. Okay.

A. -- which was sent to Dr. Gonda.
Q. Okay.
A. And then there is the unsigned copy which is Exhibit 5 --
Q. Okay.
A. -- in a different part of the chart.
Q. And, to the best of our efforts, we do not see a copy of---
A. Well, no, I'm sorry. Let me correct that. I see copy -- I see 7 here, Exhibit 7.
Q. Is it the one with the lines?
A. Yes, sir. Yes, sir.
Q. So you do not see 6?
A. Well, I see 6.
Q. Okay.
A. So I got 6 here. I got 7 back here.
Q. Okay. And do we have 5?
A. We're still looking for 5 then.
Q. Okay. While we -- while we look at what's here in your deposition, let me ask if Ms. Cheek can look in there for us and see if we can find a copy of Exhibit 5.
A. Okay.
Q. And Dr. Smith, now you've got a copy of the deposition that was marked --
A. Of the deposition.

Q. -- marked earlier, and, to the best of your searching ability---

MS. CHEEK:

Milton?

MR. MANN:

Yeah.

MS. CHEEK:

I'm sorry. I'm not -- I don't mean to --

MR. MANN:

Yeah. No, no, no.

MS. CHEEK:

-- interrupt your question, but---

MR. MANN:

Please, by all means.

MS. CHEEK:

I think between counsel we've got unsigned---

MR. MANN:

Unsigned is right there.

MS. CHEEK:

Unsigned.

WITNESS:

Okay. Where---

MS. CHEEK:

So we've got marked the unsigned, which I believe if you'll look, it's Exhibit---

MR. MANN:

It's Number 5.

WITNESS:

Five?

MR. MANN:

It is, mm-hmm.

MS. CHEEK:

And then we have back here, looking at the operative language and the signatures, I believe this is --

MR. MANN:

This is "complication."

MS. CHEEK:

-- 7.

MR. MANN:

Yeah, and that's going to be "complication," mm-hmm. Yeah, mm-hmm. So we've got 7. So we are missing 6 in the chart.

MS. CHEEK:

I am -- I have not found 6. I'm going to hand that back to you.

MR. MANN:

All right. Thank you.

WITNESS:

So here's 6.

MS. CHEEK:

The one you're referencing as 6 has---

WITNESS:

Is Gonda.

MS. CHEEK:

Is that signed or unsigned?

EXAMINATION RESUMED BY MR. MANN:

A. I'm so sorry. I am so sorry. It is the unsigned copy. I am so sorry.

Q. Not a problem.

A. I just saw the Gonda.

Q. Yes, sir.

A. And I didn't realize he had that on the unsigned copy. I apologize.

Q. Not a problem. And I think that, to the best of our best efforts, version or, excuse me, Exhibit 6 is not contained in that particular chart.

A. That's correct. We have version 7 and version 5.

Q. Thank you, Dr. Smith.

A. I am so sorry.

Q. And thank you, Ms. Cheek. Now, what versions do we have previously that were attached to your deposition back in 2009, I believe --

A. Okay. So---

Q. -- is when your deposition was taken?

A. So there we have Exhibit 5, the unsigned copy, and Exhibit 7, the signed copy to Dr. Grace and Dr. Gonda.
Q. Okay. So we don't have a copy of 6.
A. We do not have a copy of 6.
Q. And Dr. Smith, I think you've previously stated that you were not aware that there were multiple copies?
A. No.
Q. Okay. Looking at the front page -- now, I understand we've got deposition stickers. We've got streaks from what appears to be a printer or a fax machine. But if you were just looking at the front page, taking off the Bates stamp numbers, would you agree that they look pretty similar, just looking --
A. Yes, they---
Q. -- at the front page?
A. They look the -- the same.
Q. And would you also agree that you really have to do a pretty careful review to -- to tell that there are actually differences in these, between 5, 6, and 7?
A. Yes.
Q. Okay. I believe you stated earlier that respecting the medical diagnosis and/or treatment plans, all three notes are pretty doggone similar?
A. Yes.
Q. It appears that the bulk of the differences would

relate to the causation of an injury to Mr. Casey?
MS. CHEEK:
Object to form.
EXAMINATION RESUMED BY MR. MANN:
A. Okay. And if I could review those then, that would be okay with you?
Q. And -- and we can even -- we can even streamline it to a particular part of the notes.
A. Okay.
Q. And earlier you had mentioned the third paragraph of the comments section?
A. Right.
Q. And let me ask you to compare those three and see if you would agree with me that it appears that causation opinions within those three notes differ.
A. Okay. What would you like me to---
Q. Well, let me -- let me ask you as to note Number 6.
A. Okay.
Q. And that is Number 6. As to note Number 6, do you see where it states that air emboli have been reported as a common complication?
A. Yes.
Q. Let's take a look at what is marked as Exhibit Number 7.
A. Right.

Q. Do you see where air emboli have been reported as a complication?
A. Right.
Q. Versus common.
A. Common has been removed.
Q. Which would you agree, if you were describing a medical event of a patient, there is a difference between something being a common occurrence and simply an occurrence?
A. Yes.
Q. Okay. And then if we look at what was marked as Exhibit 5, I believe it has the term undoubtedly had an air embolism?
A. Correct.
Q. Okay. Correct me if I'm wrong, but those three statements in the three different notes appear to be talking as to the causation of an insult to Mr. Casey?
A. Correct.
Q. And would you agree that they are different?
A. Yes, in -- in their degree of certainty.
Q. Thank you. Let me think for a minute. We're going to go back off the record, but Dr. Smith, I believe I'm probably done.
A. Okay.
Q. Is that fair? And Ms. Cheek, of course, may have some

questions, but we can go back off the record, please Alan.

VIDEOGRAPHER:

Off the record at 10:38.

(Off the Record)

VIDEOGRAPHER:

Back on the record at 10:44.

EXAMINATION RESUMED BY MR. MANN:

Q. Dr. Smith, thank you so much. I have no further questions. I believe Ms. Cheek has some questions for you, and I appreciate your giving us your time today. So thank you.

A. Mm-hmm.

EXAMINATION BY MS. CHEEK:

Q. Dr. Smith, you had testified earlier that there are differences among the notes before you, notes 5, 6, and 7 as we've characterized them. Correct?

A. Yes, ma'am.

Q. And you had stated that the -- a difference that you've noted is the degree of certainty with which the causation opinion is rendered. Correct?

A. That is correct.

Q. Is there any difference among those notes with respect to the causation opinion itself?

A. No.

Q. That's all I have. Thank you.

MR. MANN:

Oh, before we leave, and I think we can be off the record for this one.

VIDEOGRAPHER:

This concludes the video deposition of Dr. William P. Smith, Jr.

WITNESS:

Wilson.

VIDEOGRAPHER:

The time is 10:45.

MR. MANN:

Wilson.

VIDEOGRAPHER:

We are now off the record.

(There being no further questions, this deposition concluded.)

CERTIFICATE OF REPORTER

I, ROSALIND POOLE WALTERS, a Notary Public in and for the State of South Carolina, do hereby certify that the foregoing 31 pages represents a true and accurate transcript of the videotape deposition of WILSON P. SMITH, JR., M.D., which was taken by me on the 5th day of May, 2017.

That the witness was first duly sworn to tell the truth, the whole truth and nothing but the truth of his own knowledge concerning this matter.

That I am not related to nor the employee of any of the parties hereto, nor related to or employed by any attorney or counsel employed by the parties hereto, nor interested in the outcome of this action.

_____

Rosalind Poole Walters, CVR-M
Notary Public for South Carolina
Commission Expires: 4/29/26

STATE OF SOUTH CAROLINA
ISSUED BY THE COMMON PLEAS COURT IN THE COUNTY OF SPARTANBURG

SUBPOENA DUCES TECUM

Gregory J. Feldman, MD and Joseph A. Boscia, III, MD
Upstate Lung and Critical Care Specialists, PC, and
Devendar T. Shantha, MD

Plaintiffs,

v.

C.A. No. 2010-CP-42-5743

William Mark Casey, Ray E. "Chuck" Thompson,
Charles M. Fogarty, MD,

Defendants.

TO: **Wilson Smith, M.D., Lung & Chest Medical Associates, LLC, 2030 N. Church Place, Spartanburg, SC 29303.**

YOU ARE COMMANDED to appear in the above named court at the place, date, and time specified below to testify in the above case.

Place of Testimony -	**Courtroom:**
	Date and Time:

PLAINTIFF'S EXHIBIT 118 Smith 5-5-17

[X] YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

Place: **Wilkes Law Firm** **127 Dunbar Street, Suite 200** **Spartanburg, SC 29306**	Date and Time: **9:30 am on May 5, 2017**

☐ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time below:

All medical records from your practice including, but not limited to, doctor's notes, nurse's notes, laboratory studies, pathology reports, pathology specimens, radiology films and/or reports, reports in your files from other healthcare providers, as well as any and all other medical records and parts of your medical file concerning treatment of and/or services provided through Lung & Chest Medical Associates, LLC and complete billing records for the treatment of and/or services provided to William Mark Casey, SSN [redacted], DOB: [redacted]1958 and complete billing records for his care, as well as, information listed in ATTACHMENT A.

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

Premises	Date and Time

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS SUIT IS HEREBY DIRECTED PURSUANT TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, AND SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED SHALL TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION.

ISSUING OFFICER'S NAME, ADDRESS AND PHONE NUMBER
F. Milton Mann, Jr, Esq.,
151 Harold Fleming Court
Spartanburg, SC 29303 (864/680-5079)

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45©(1) AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF ATTORNEY FOR PLAINTIFFS DATE: April 24, 2017

Attorney for Plaintiffs

SCCA FORM 254 (7/93) (See Rule 45, South Carolina Rules of Civil Procedure, Parts ©) & (d) on Reverse)

ATTACHMENT A

1. All records regarding treatment of and/or services provided to William Mark Casey through Lung & Chest Medical Associates, LLC.

2. All reports regarding your treatment of and/or services provided to William Mark Casey through Lung & Chest Medical Associates, LLC.

3. All notes, communications, memorandums including e-mails, to and from any third party related to this litigation or the underlying medical malpractice litigation, and/or the parties to this litigation or the underlying medical malpractice litigation.

4. Copies of all questions, memoranda and documents furnished to Defendants' counsel related to the depositions of other witnesses in this litigation or the underlying medical malpractice litigation.

5. All documents of any kind and nature related to this litigation or the underlying medical malpractice litigation.

6. If any records as described above have been destroyed, please provide documents with the dates of destruction, the name of the person who destroyed them, the basis for the destruction, and the reason for the destruction.

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Wilson Smith, MD
Lung & Chest
2030 N. Church PL
Spartanburg, SC
29303

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Patty Bailey ☐ Agent ☒ Addressee

B. Received by (Printed Name) Patty Bailey
C. Date of Delivery 4-25-17

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☒ Yes

2. Article Number
(Transfer from service label) 7012 0470 0001 7720 9007

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	SEVENTH JUDICIAL CIRCUIT
COUNTY OF SPARTANBURG	)	
	)	C.A. NO.: 2010-CP-42-05743
Gregory J. Feldman, M.D., Joseph A. Boscia, III, M.D., Upstate Lung and Critical Care Specialists, P.C., and Devendra T. Shantha, M.D.,	)	
	)	**PLAINTIFFS' NOTICE OF *DE BENE ESSE* VIDEOTAPED DEPOSITION OF WILSON SMITH, M.D.**
Plaintiffs,	)	
v.	)	
William Mark Casey, Ray E. "Chuck" Thompson, and Charles M. Fogarty, M.D.,	)	
Defendants.	)	

TO: WILSON SMITH, M.D.:

YOU WILL PLEASE TAKE NOTICE that the undersigned attorney for the Plaintiffs, will take the *de bene esse* videotaped deposition of the person at the time and place set forth hereinafter upon oral examination, pursuant to South Carolina Rules of Civil Procedure, Rule 30, before a Notary Public, or some other officer authorized by law to take depositions. Said deposition is to continue from day to day until completed. The deposition will be taken for the purpose of discovery, for use at trial, and for all other purposes permitted under the rules of this Court and all applicable statutes and laws.

Name of Deponent	**Place of Deposition**	**Date and Time**
Wilson Smith, M.D.	Wilkes Law Firm, PA 127 Dunbar Street Spartanburg, SC 29306	Friday, May 5, 2017 at 9:30 a.m.

The deposition will be taken before a notary public or some other person authorized by law to take depositions. The deposition will continue from day to day until concluded.

PLEASE TAKE FURTHER NOTICE that, pursuant to Rule 30(j)(8)of the South Carolina Rules of Civil Procedure, counsel for Plaintiffs hereby identifies and reserves the right to use any and all documents produced or made available in discovery by any party during this deposition, and hereby gives notice of the Plaintiffs' intent to question the witness regarding any and all documents produced or made available by any party during the course of discovery, as well as those obtained pursuant to records requests. The subject matter of inquiry will include all matters reasonably calculated to lead to the discovery of evidence admissible in the above-entitled and numbered matter.

By: _____

F. Milton Mann, Jr., Esquire (SC Bar #68250)
Attorney for Plaintiffs
151 Harold Fleming Court
Spartanburg, SC 29303
864/680-5079 – Cell
866/452-2276 - Fax

April 24, 2017

STATE OF SOUTH CAROLINA COURT OF COMMON PLEAS

COUNTY OF SPARTANBURG C. A. NO. 2006-CP-42-1728

William Mark Casey,

Plaintiff,

vs.

Gregory J. Feldman, MD,
Joseph A. Boscia III, MD,
Upstate Lung and Critical
Care Specialists, PC, and
Devendra Shantha, MD,

Defendants.

Deposition of ***WILSON P. SMITH, M.D.***

Pursuant to notice of deposition and/or agreement in the above-entitled case, a deposition was taken on the 2nd day of September 2009, commencing at approximately 3:18 p.m. attended by counsel as follows:

Appearances:

RAY E. (CHUCK) THOMPSON, JR. AND NOEL TURNER
Burts, Turner, Rhodes and Thompson
260 North Church Street
Spartanburg, South Carolina 29306
Attorneys for Plaintiff, William Casey,

H. **SPENCER KING, III**, Esquire
Ward Law Firm
233 South Pine Street
Spartanburg, South Carolina 29304
and

F. MILTON MANN, JR., Esquire
Law Office of F. Milton Mann, Jr.
1089 Boiling Springs Road
Spartanburg, South Carolina 29303
Attorneys for Defendants, Drs. Feldman & Boscia and Upstate Critical Care Specialists,

WILLIAM U. GUNN, Esquire
Holcombe, Bomar, P.A,
100 Dunbar Street, Suite 200
Spartanburg, South Carolina 29306
Attorney for Defendant, Dr. Devendra Shantha.

Index

Pursuant to notice and/or agreement to take depositions, the within deposition was taken by the above reporter, a notary public, as required under the code of laws of South Carolina, 1976, section 19-17-10, and circuit court rule 30, et al., by consent of all parties at the Ward Law Firm, 233 South Pine Street, Spartanburg, South Carolina.

WAIVER:

Counsel and the deponent **DID NOT** agree that both the reading over of and signing of the deposition are hereby dispensed with and waived.

** ** **

The deponent was duly sworn to tell the truth, the whole truth, and nothing but the truth of his own knowledge concerning the matter herein.

WILSON SMITH, M.D., being duly sworn, testified as follows:

DIRECT EXAMINATION BY MR. KING:

Q. Give us your full name, please.

A. Wilson Pedrick Smith, Jr.

Q. And you are medical doctor practicing in Spartanburg?

A. That is correct.

Q. And what is your medical specialty?

A. I am in pulmonary disease, critical care and sleep

medicine.

Q. Doctor, I have met you previously on other occasions, I believe?

A. Yes, sir.

Q. My name is Spencer King. I'm an attorney here in Spartanburg, and I am defending Dr. Greg Feldman, Dr. Joseph Boscia and their practice group, Upstate Lung and Critical Care Specialists in a lawsuit that's been brought by William Mark Casey claiming medical negligence. Milton Mann, who's seated next to me, also a lawyer, also is my co-counsel in this case. Billy Gunn, who is seated at the end of the table represents Dr. Shantha, who is an anesthesiologist. He's also a defendant. Mr. Thompson and Mr. Turner who are seated next to you represent Mr. Casey.

A. Okay.

Q. And in this deposition -- you have previously been deposed before? Let me ask that first. You've given previous depositions?

A. Yes, sir.

Q. So you know basically the rules?

A. Yes, sir.

Q. The purpose of this deposition is an information gathering session. It is my understanding that you

have seen and treated Mr. Casey at times?
A. Yes.
Q. And thus I'd like to discuss with you your care and treatment of Mr. Casey, discuss with you your knowledge about this case and whether or not you intend to render any opinions regarding standard of care by Dr. Feldman and Dr. Boscia in this case. If anytime I ask you a question that you do not understand my question, tell me you don't understand it and I will rephrase it. It is not a closed book test. That's why we ask you to bring your chart. You are certainly free to refer to your records. Memories sometimes fade, and I think we're talking about four or five years ago. And so certainly if you wish to look back in your chart, you are certainly free to do that.
A. Okay.
Q. Doctor, tell me about your practice?
A. Well, I'm in private practice. I have -- in a group called Lung and Chest Medical and we have four other pulmonary, critical care physicians in that group, and we share call and share expenses and share responsibilities.
Q. And in 2004 were the same physicians in that group?
A. No, at that time there were other -- a different

mix of physicians at that time.
Q. Who were the physicians in 2004?
A. It would have been -- that are not there now?
Q. Well, just name who's there ---
A. Oh, okay.
Q. --- and then we can change them?
A. All right. Well, in 2004 there would have been Dr. Bert Knight, Dr. Mary Lou Applebaum, Dr. Charles Fogarty, and Dr. Doug Clark and myself.
Q. And Dr. Knight is no longer there?
A. That is correct. Nor is Dr. Applebaum.
Q. And has anyone else joined you?
A. Dr. Rico Mendoza and Dr. Raul Cruez.
Q. And do you have physician assistants?
A. We do.
Q. Do you know a Beth Edwards?
A. I do.
Q. What was Ms. Edwards?
A. She was a nurse practitioner that worked with us during that time.
Q. Is she still employed?
A. She is not.
Q. When did she leave, if you know?
A. I want to think she would have left in 2005.
Q. And do you know where she is now?

A. I do not.
Q. Doctor, would you give us kind of a capsule of your educational and medical training?
A. I went to college at Villanova University in Philadelphia. I went to medical school at West Virginia University in Morgantown. I went -- I did an internal medicine internship and residency at the University of Alabama in Birmingham, and I did a pulmonary fellowship at Duke University.
Q. And when did you complete your pulmonary fellowship?
A. I completed that in 1981.
Q. Now, you told me that you also, if I understood for -- had a designation in critical care?
A. Yes, sir.
Q. Okay, and sleep medicine?
A. That is correct.
Q. Did that require additional training and education?
A. It does, but those boards were not available at the time that I completed my training, so I did that additional training and examinations after my formal training was completed.
Q. When did you do your critical care training?
A. Well, critical care is a part of pulmonary, so I qualified to be able to take those boards based on

my pulmonary specialty and passing the board.
Q. Okay, without having any additional training?
A. Without having any additional training.
Q. And is pulmonology not also a subspecialty of internal medicine?
A. That is correct. You have to do your internal medicine to be able to qualify to do that additional training.
Q. Help me with this, is sleep medicine a sub specialty, or are they both sub specialties of internal medicine?
A. Well, no. Sleep -- sleep medicine actually has -- at least at that point had several different roads in; neurologists, psychiatrists, internists, pulmonary physicians, all had the opportunity to do additional training and take the board examination in that.
Q. But you have since -- when did you become board certified in internal medicine?
A. Golly, probably '80 or '81.
Q. And when did you become board certified in critical care?
A. The first time would have been 1989.
Q. In pulmonology?
A. In critical care, you asked.

Q. I did. And in pulmonology?
A. In pulmonology would have been, I believe, in '81.
Q. And is the organization that you are boarded in The American Board of Internal Medicine?
A. That is correct in everything but sleep. Sleep had its own board up until this time, at which time they've come under The American Board of Internal Medicine.
Q. Doctor, I looked you up on their website. Does that appear to be accurate?
A. Oh, okay, well you -- yes. So I was mistaken about the date for -- for my internal medicine and pulmonary, if you'll correct those to '79 for internal medicine, and '82 for pulmonary disease.
Q. This is accurate?
A. Yes, sir.
Q. Now, ---
A. I don't -- just a second. And -- and understand the sleep doesn't fall under this board. It's a separate board.
Q. You told me that, okay. And your critical care medicine board is valid through December 31st, 2009?
A. That's correct. I'm in the process of redoing all that.

Q. So you will have to take that board again?
A. I have to take that board again.
Q. Now, the other two boards covered by The American Board of Internal Medicine, i.e. the Pulmonary Disease Board and the Internal Medicine Board, you're quote "grandfathered in." You're certified in those fields indefinitely?
A. Well, not grandfathered in. I'm -- I'm free from having to recertify in those.
Q. Because you did take a test?
A. Well, the contract with you at that time was the board was yours for life. They subsequently changed that. And you can see when they started the Critical Care Boards, they didn't allow that possibility. You had to recertify every ten years.
Q. And board certification, Doctor, is something over and above attendance at medical school, internship, residency and fellowship; is it not?
A. Well, there's -- yes, there's usually additional testing that's undertaken to be able to have those qualifications.
Q. Is there both an oral and a written test?
A. No, there's only a written exam.
Q. And so you would have taken a written exam for pulmonary disease sometime prior to November 9 of

1982.
A. Yes.
Q. And the critical care you would have taken it sometime prior to ---
A. I assume they probably date you to when you took -- the date of the exam. Having passed the exam qualifies you for the board.
Q. And in critical care you've had to have been certified ---
A. I'm now going ---
Q. --- by the board --- .
A. --- for my second ---
Q. Second time?
A. --- second recertification. I certified, recertified, and now this is my second recertification.
Q. Okay, but to be boarded requires an extra effort by the physician?
A. It does.
Q. And why do you need to be boarded?
A. Well, it just -- it is a reflection of you having completed that specialty area of training that you are particularly interested in -- in setting yourself forth as an expert in that area.
Q. To maintain your boards do you have to complete any

continuing education?
A. Yes, you do.
Q. In that field?
A. Right, and to maintain your license in South Carolina you have to have a certain amount of ---
Q. And do you actually have to practice in that area? Do you have to have patient encounters or case loads within that field of medicine?
A. To maintain your hospital privileges you do. Now, I'm not sure that you do to maintain your board eligibility, but your board eligibility now requires some clinical evidence of proficiency, so to some extent you do have to have some practice to be able to continue to take your boards.
Q. You're on staff at the Spartanburg Regional Medical Care Center?
A. That's correct.
Q. Any other hospitals?
A. Yes, at Spartanburg Hospital for Restorative Care, the Village Hospital in Greer, and Mary Black Hospital.
Q. And are you actually the medical director at Restorative Care?
A. I am.
Q. Is there any requirement to be on staff at

Spartanburg Regional Medical Center that you be boarded?

A. Yes, if you are going to be in a specialty then you have to have board certification in that specialty.

Q. Now, doctor, do you have any neurological training past basic training in med school?

A. Well, again, just those areas that would pertain to my board certification. Sleep involves some neurologic training. For instance, I can read EEGs, which is not something that a pulmonary physician would be able to do. There is, of course, certain parts of critical care that tend to neurologic problems. So I have some additional training though I certainly wouldn't put myself forth as a neurologist or neurosurgeon.

Q. Or a neurosurgeon, okay. But you do not treat diseases or disorders of the nervous system?

A. For the most part, no.

Q. Now, you ---

A. By myself, no.

Q. But I do understand that your work in sleep disturbances may play into it?

A. Right, and again, in critical care we may participate in the care of someone with neurologic problems, but we would always, for the most part,

do that with the assistance of a specialist in that area.

Q. Such as either a neurologist or a neurosurgeon?

A. Neurosurgeon; right.

Q. And I asked you -- I knew, and you confirmed that you are the medical director at Restorative Care?

A. Right.

Q. How does Restorative Care differ from an acute care hospital such as Spartanburg Regional, and differ from a skill care nursing home? How do those three facilities -- what's the difference between them?

A. Okay, well, a long-term acute care hospital was established by the government to take care of those patients who were going to require at least 25 days of hospitalization, on average, and who have an acute condition that still requires hospitalization. Therefore that's where they differ from a nursing home where the patients in a nursing home do not require acute hospitalization. It differs from the acute care hospital in that the patients, on average, who are Medicare patients have to maintain an average length of stay, you know, of greater than three weeks. So we generally take patients who have chronic conditions on transfer from acute care hospitals who are

anticipated to need prolonged hospital care.
Q. And how long may a patient stay at Restorative Care?
A. As long as they need. I mean, we've had patients for two years, three years.
Q. You would have patients at Restorative Care that have neurological issues ---
A. We do.
Q. --- and need neurological treatment; correct?
A. Yes, sir. Yes.
Q. And you would involve in their care if they did not already have a physician, a neurologist or a neurosurgeon?
A. Yes, we would -- we would get a, for the most part a neurologist and psychiatrist to help us with managing those issues.
Q. Doctor, according to our records you have seen and treated Mark Casey?
A. That's correct.
Q. And we asked you to bring your chart with you today. Did you do that?
A. I did.
Q. Would you let me look at that, please, sir?
A. Yes, sir.
Q. And this is the chart maintained by Lung and Chest

Medical Associates on Mr. Casey?
A. Yes, sir.
Q. Do you know of any other records that Lung and Chest Medical Associates has on Mr. Casey?
A. We had gone to an electronic medical record, and I glanced in there last night and I didn't see any office visits there, but it is possible there's something in that electronic record, but I do not think there is.
Q. When did you go to electronic records?
A. Well, I looked at that yesterday.
Q. But, are there any ---
A. I can make a phone call and just answer that question if you'd like?
Q. That's fine. While he's doing this I'm going to mark this as Defendant's Exhibit number 1.
A. But I have myself not seen him since we've gone to the electronic record.
Q. Okay.
(COURT REPORTER MARKS ENTIRE FILE OF DR. SMITH AS DEFENDANTS' EXHIBIT NO. 1; ATTACHED TO DEPOSITION).
BY MR. KING:
And what we're going to do, we agreed we will copy this, substitute the copy ---
BY MR. THOMPSON:

Yes.

BY MR. KING:

--- for the exhibit and give ---

BY MR. THOMPSON:

Dr. Smith back his records.

BY THE WITNESS:

Hey, Crystal, this is Dr. Smith. Can you do me a favor? Would you look up and see if we have any electronic medical record on William Mark Casey. He's about 50 years old.

BY MR. GUNN:

11/03/58.

BY THE WITNESS:

Birth date's [redacted]/58. We do. How many visits? All right, do you want me to have them make a physical copy of those?

BY MR. KING:

First question, what are the dates -- the span of those visits?

BY THE WITNESS:

What's the span of the dates of those visits, the first to the last? July 7th 2006. December the 8th of '08. And can you see if any -- were any of those mine, or are they all somebody else's? None of them were mine.

BY MR. KING:

If she could reproduce those.

BY THE WITNESS:

Would you make a physical copy of all those for me? We'll deliver those to you tomorrow?

BY MR. KING:

That's fine.

BY THE WITNESS:

Thanks. Appreciate it, Crystal. Bye.

BY MR. KING:

Was that on the record?

BY COURT REPORTER:

Yes.

BY MR. KING:

So on the record we have that there are some electronic records from the span of July 7, 2006 to December 8, 2008. Dr. Smith's going to get us copies of those, but none of those were visits where Dr. Smith was involved in the care; is that a fair statement?

BY THE WITNESS:

That's correct.

DIRECT EXAMINATION RESUMED BY MR. KING:

Q. Doctor, the first visit that I have that I believe that you recorded when you saw Mr. Casey first

time, July 14, 2004?
A. Yes.
Q. And was he referred to you by anyone at that time?
A. No, he was a self-referral.
Q. And you take self-referrals?
A. Yes.
Q. In the chart there is a medical history. It says, "Medical History Information Sheet." Do you see that?
A. Yes, sir.
Q. And in 2004 was that a form that your practice used for new patients?
A. Yes, it was.
Q. And the information, is that recorded in the patient's handwriting? Do you ask the patient to complete that?
A. Yes, though I had made notes as well in the -- to the side.
Q. Doctor, would you talk me through your notes?
A. Okay. "Sleep well, fatigue, Michelin, swing shift, very physical job for several years, 2000 had a stress test and a cath which was normal." And follows over there in the ---
Q. And are these notes that you made during your first visit with him?

A. Right, during -- during my discussion with him.
Q. Okay, and what were his complaints when he first saw you?
A. In his writing, "Not happy with current care provider, post operation for chest pain." And I should amend that there is additional writing from me. There was "anxious, haven't slept well," instead of "slept well."
Q. Okay, so interpret that for me? So he is anxious and hasn't slept well; is that what you recorded?
A. Right, yes.
Q. All right, go ahead. And you said he "wasn't happy with his current position"?
A. Right.
Q. Continue on with his reason for seeing you.
A. That he had "had this problem for a month." And those were the main things that he had given as his reason for being there.
Q. And your first visit is a -- I believe a two-page typed report?
A. Yes, sir.
Q. Okay, do you have that in front of you?
A. I do.
Q. And if you would, kind of summarize for us the history that you were given on that visit?

A. Okay, well, at that time he was 45 years of age. He complained of some chest difficulties that had begun in May "when he presented to the emergency room at Spartanburg Regional with a complaint of chest pain. A PA chest x-ray at that time suggested the possibility of a foreign body. He underwent a bronchoscopy which was felt to be abnormal, but no foreign body was identified. A subsequent CT scan done the same day did not confirm any abnormality. However it does mention there is a left anterior descending coronary artery calcifications. In 2000 he had a stress test and catheterization was normal. He underwent a rigid bronchoscopy in attempt to identify foreign body and remove it during that procedure. He had a perforation of the bronchial wall by a laser, which resulted in a pneumomediastinum and respiratory distress. He required intubation and heavy sedation and was able to be extubated the following day. Since that time, he notes fatigue during the day. He continues to have dyspnea and chest pain with exertion. He has become very anxious. His sister accompanying him for the interview notes that he seemed to experience a change in his ability to tolerate stress and appears much more

anxious and restless than she has known him to be in the past. He is a previous smoker for about 12 years, but has not smoked in the past three weeks. He does snore, but feels he sleeps well. He denies any hemoptysis, chronic cough or weight loss. He still has the chest pain."

Q. Okay, and there's a list of medications that you asked him to give; is that correct?

A. That's correct.

Q. Are there any opiates listed there?

A. No.

Q. Doctor, we have in discovery procured drug records on Mr. Casey for some time before and after the 2004 events. Let me ask you to take a look at this, Doctor.

A. (Witness review document). Okay.

Q. And looking back prior to late June of 2004, do you see where he was taking opiates?

A. Yes, it looks like at one point he was taking Hydrocodone.

Q. Which is Loratab?

A. Yes.

Q. And that's Dr. Gonda that prescribed that?

A. That is correct.

Q. Did you know that Dr. Gonda was his primary care

physician?
A. I don't know whether I knew that or not. I don't think we had a place to list that on our sheet, so I -- oh, no. Yes, "Who's your family doctor? Frank Gonda."
Q. And so, if you look at the records, Dr. Gonda was prior to May/June of 2004 giving him Loratab; correct?
A. That is correct.
Q. Did you ever learn that, during the time that you were treating Mr. Casey, that he took opiates?
A. I don't believe so.
Q. And you assume the accuracy of the information that Mr. Casey gave you so far as his history?
A. Pardon?
Q. You depend upon the accuracy and the honesty ---
A. Sure.
Q. --- that your patient had given you an accurate history?
A. Sure.
Q. And you conducted an examination?
A. I did.
Q. And what did you find in your physical examination?
A. His physical examination was basically normal.
Q. And you also did some diagnostic studies?

A. I did.
Q. What diagnostic studies did you do?
A. I did pulmonary function tests and those -- those were normal.
Q. And what would a normal pulmonary function test tell you, a pulmonologist?
A. What would a normal -- well, just that the resting parameters of pulmonary function appeared to be normal.
Q. And you've told me that in the history that you were given ---
A. Uh-huh (affirmative response).
Q. --- Mr. Casey underwent, and I believe that Dr. Feldman performed a rigid bronchoscopy which resulted in a pneumothorax; did I understand you to say there was a perforation of the bronchial wall at that point?
A. Yes.
Q. Now, finding that his pulmonary function studies are normal, and no evidence of airway obstruction, do you conclude that he has no permanent injury to his lung?
A. I did.
Q. So there was no injury as a result of the procedure or the complication?

A. No injury to the lung.
Q. To the lung?
A. Right.
Q. As a result of that procedure?
A. Yes, sir.
Q. You told us that his sister, Carol, accompanied him to the visit?
A. She did.
Q. Is Carol a patient of yours?
A. No.
Q. Do you know her?
A. Yes, I do. She worked in the cafeteria for a long time at Spartanburg Regional.
Q. And is that a bit unusual for a 45-year-old man to have his sister accompany him to a visit with his physician?
A. No, I mean, we allow the patient to bring family members as he would like into the exam room with him. So it's not uncommon for me to see a patient with other family members.
Q. And he gave you a history that he was having difficulty sleeping?
A. Right.
Q. Did he complain about being moody, frustrated?
A. I don't have a specific mention of that. Like I

said, what I wrote down was that he was anxious, he wasn't sleeping well, and that she said, you know, he -- he seemed to have changed somewhat in terms of being more anxious and restless since -- since he'd been hospitalized.

Q. Let me ask you to look at a note. And these come from Dr. Gonda's records, June 23rd, 2003. Let me ask you to read that, please, sir. You don't have to read it aloud, but just review that.

A. And the note I want to read is the 6/23/03?

Q. That's correct.

A. (Witness reviews document). Okay.

Q. Are those similar complaints with complaints that were being expressed to you on your initial visit?

A. They are.

Q. Now, both on your physical examination and your diagnostic examination, you did not find any pulmonary function injury?

A. Any what?

Q. Any limitation in pulmonary function, and you did not find any pulmonary injury to the lung; is that correct?

A. Correct.

Q. He gave you a history that he was a smoker, I believe, for like 12 years, but had quit in recent

weeks?
A. Yes.
Q. From a pulmonary standpoint smoking is of significant concern; is it not?
A. It is.
Q. And what was your conclusion of the basis of Mr. Casey's complaint?
A. Well, it was not that -- I didn't feel that his chest pain at that point had been explained since he still had that complaint, and there was not any pulmonary abnormality to explain that. And the CT scan which had been done, they incidentally noted that he had calcification in his left interior descending artery, which is an important coronary artery. And so I felt that further evaluation to exclude a possible cardiac condition was warranted.
Q. And did you do that?
A. We did.
Q. And what were the -- with -- through diagnostic studies?
A. Yes, he had a -- another stress test, which did not show any changes suggestive of cardiac ischemia.
Q. And did he have an EKG?
A. Yes, he did.
Q. And was that also normal?

A. Yes, it was normal.
Q. Did he have a chest x-ray?
A. I'm not sure he had had -- that he had another chest x-ray, but I had the recent CT scan which was completely norm.
Q. So, did you conclude the likely cause of the chest pain?
A. Well, again, as I said, I was concerned -- are you speaking of at my initial visit or after further ---
Q. No, after you did these diagnostic studies, did you conclude what the cause of the chest pain likely was?
A. Well, I thought it most likely is chest wall pain.
Q. Muscular?
A. Muscular, skeletal pain.
Q. Okay. And that would be treated by -- how?
A. Pain medications or, you know, trying to identify a specific area that was abnormal.
Q. Did Mr. Casey give you any history or complaints of back pain?
A. Well, he had mentioned that he had some arthritis and that he used -- sometimes used Bextra, an anti-inflammatory drug for that. And he mentioned some disc problems and arthritis in his lower back.

Q. Now, what other conclusions did you reach with regard to Mr. Casey at that initial visit?
A. Well, that he had some psychiatric issues at that point that I felt needed further investigation beyond my abilities.
Q. You're not a psychiatrist and don't treat psychiatric issues?
A. That is correct.
Q. What psychiatric issues did you think that he might be suffering?
A. Well, again, they talked about his anxiety, his difficulty sleeping, his restlessness, so I thought that a referral to a psychologist or psychiatrist would be appropriate, and so I referred him to Dr. Jay Grace.
Q. He is a psychologist?
A. He's a clinical psychologist that works over at the Regional.
Q. And in your impression -- I'm going to read this, "But I wonder if he suffers from post traumatic stress disorder related to his injury in intensive care unit experience." Did I read that correctly?
A. Yes.
Q. And what is the basis for you to put in there, "I wonder if he suffers from post traumatic stress

disorder related to his injury in intensive care unit experience?" What was ---

A. Well, just, again his complaint that those -- from his sister and he that he felt that he was worse since he had been in the hospital.

Q. Are you making that as a definitive diagnosis?

A. No, sir.

Q. Okay.

A. No, sir. Again, like I said, I identified that that was something that I was not qualified to help him with and that I tried then to send him on to somebody that I felt that was; that could do a proper evaluation of that and treatment.

Q. And so you would be deferring to someone other than a pulmonologist or critical specialist for that diagnosis?

A. That's correct.

Q. When did you next see Mr. Casey?

A. I guess he came back for a follow-up visit on the 29th.

Q. And at that visit did you discuss -- July 29th?

A. Yes.

Q. And at that visit did you discuss with him the result of the diagnostic studies, the stress and the ---

A. I think that it was at that point we sent him up to go have the Cardiolite stress. And I did some additional things. I think I did do a chest x-ray that day, again just wanting to be sure because he still was having the chest tightness that he described.

Q. And on that visit, Dr. Smith, you gave him a leave of absence from work through August 16th of 2004?

A. Yes, I did.

Q. Doctor, looking through your chart I cannot find any other leaves of absence that you authored, nor can I find any statements of disability to any third party that you authored? Would you like to look through your chart and see if that is a true statement?

A. Right here -- well, he had two subsequent visits with me. He had one in August, and that was where we actually talked about the results of the stress test being negative. But at that time he said the chest pain had resolved. And then I saw him once more in November of 2004. November 10th of 2004. And at that time he had been to see Dr. Grace, who at that point did not feel he was ready to return to work. And so I assume at that point, any further work-related releases would have come from

him.

Q. So my statement was correct, other than the statement we referred to of July 29th. That is the only statement where you took him out of work?

A. Yes.

Q. And I do not see any statements there where you authored that he was disabled.

A. Again, from a pulmonary standpoint, you know, there was no evidence of pulmonary disability.

Q. But from any other standpoint, you would not have authored a disability statement.

A. Correct.

Q. On the visit of July 29, 2004, ---

A. Uh-huh (affirmative response).

Q. --- in the upper left corner there are a series of conditions that are marked or checked. Can you look at those, please?

A. Yes, sir.

Q. And I take it that if there's a marking there, which looks to be like a circle with a stripe through it?

A. That means that that question was negative.

Q. That he did not have that?

A. Did not have that complaint.

Q. And on this one he was not coughing; correct?

A. Correct.
Q. Can you help me with the next one? What's it -- is that ---
A. He was having some shortness of breath on exertion, just, you know, on exertion.
Q. Okay. No wheezing? Is that edema?
A. No wheezing, no edema, no new allergies, no fever or chills, no nausea, vomiting or diarrhea.
Q. Okay.
A. He was smoking four to five cigarettes a day. And said that he did consume some alcohol.
Q. And he was oriented?
A. And he was oriented.
Q. And down at the bottom, Doctor, could you help me with what's recorded there?
A. Well, I just said that he had post traumatic stress, and that there was costochondritis, was what I concluded was ---
Q Chest -- was chest wall?
A. Right.
Q. And the statement post traumatic stress; is that a diagnosis that you were making or is someone else making that diagnosis?
A. At -- like I said, at that point he's seeing Dr. Grace. I have written him at that point for some

Zoloft, and I can't remember whether that was at the request of Dr. Grace or not. Do you happen to have records from him?

Q. I have no records in your chart. We have records from Dr. Grace, but we do not have any records in your chart from Dr. Grace. We do not see any communication other than the -- and I was going to ask you what the nature of that communication -- you told me ---

A. I may have spoken with him, but I have to say I didn't record that.

Q. You told me a minute or two ago that there was a communication of some type from Dr. Grace to someone that he did not feel that he was ready to return to work; that being on November 10th, 2004?

A. Right.

Q. And your memory is that you may have spoken ---

A. I may have spoken to Dr. Grace about that, because it's also possible that he, as a psychologist can't write prescriptions. So I think that I would have written that at his request, perhaps.

Q. And so Zoloft is a prescription that you perhaps wrote?

A. Well, I know I wrote it.

Q. Okay. But you may have ---

A. The question would be whether it might have been at the request of Dr. Grace, who wouldn't be able to write for medications as a psychologist, but usually would work with a physician to write those medications.

Q. And what is Zoloft?

A. It's an antidepressant.

Q. And the dosage?

A. Is 150 milligram.

Q. And that would have been how many per day?

A. One a day.

Q. That is not a pulmonology medicine?

A. No.

Q. And the next visit, when is that, Doctor?

A. The visit that I'm telling you about? That's 11/10/04.

Q. And that's the last visit that you had with him?

A. I believe that is the last time that I saw him in the office.

Q. Doctor, there's a period that looks like about eight or nine months from August 12th of 2000 -- I'm sorry, excuse me. I'm showing a visit of July 19th, 2005; is that yours?

A. What's that?

Q. Visit of July 19th, 2005. That is not yours?

A. No, that's -- it looks like that's Dr. Mendoza's signature and writing.
Q. Let's see, your last visit again? I'm sorry I confused that, because I thought that was ---
A. Was 11/10/04.
Q. And that is your handwriting?
A. 11/10/04; yes, sir. All except the handwriting up in the corner that the nurses do that little checklist and anything there up in that left-hand corner.
Q. And do you know who that nurse would be?
A. Joan Floyd.
Q. Joan Floyd?
A. Joan Floyd.
Q. Is she still with you?
A. She is.
Q. Could you read for me the verbiage that is kind of on the right side?
A. Okay. "No dyspnea in the -- in the yard working or walking. Walking stops and pain is relieved." I think that refers to the chest -- the chest pain is only with exertion, so I've added to there, "There's no shortness, dyspnea when in yard working or walking. He stops and the pain is relieved. Dr. Grace does not feel ready to return to work.

Not ready to return to work. Does not want to go. Pain begins after working two to two and a half hours. He's tender along the sternum margin."

Q. And would these notes have been made contemporaneous with the visit?

A. Yes.

Q. And do you know what time the visit was?

A. What time of day?

Q. Yes, what time of day?

A. No, sir.

Q. How would we find out what time of day it was?

A. Well, I guess we could go back to our log for patient visits.

Q. Would that be a patient log, or would it be your log?

A. Well, I mean at our -- at our office if we still have them back that far to know what time.

Q. And it would be called the patient's log?

A. Well, I mean, we keep a record of the patients' scheduled appointments, so we would know what time he was scheduled to be seen that day.

Q. But what would that document be called?

A. I have to say I don't know that we have a specific name for it. I mean, just our patient appointment record.

Q. Okay, and who maintains that? Who oversees the keeping of those records? Do you have a practice manager?
A. Yes, but she would not have been the practice manager at that time.
Q. But the position would be practice manager?
A. Yes.
Q. And then the next visit to your group is the one of July 19, 2005?
A. That is correct.
Q. So there's a period of about eight or nine months that he did not see you and your group; is that your understanding?
A. Yes, sir.
Q. And do you know why?
A. Well, again, we hadn't identified any pulmonary issue for him to continue to need me.
Q. Okay.
A. And Dr. Grace was seeing him in terms of the issues that I had referred him for, so I didn't probably feel that I needed any -- you know, that he needed me any further.
Q. Doctor, some of your physicians, I believe, are involved in a research center?
A. That's correct.

Q. Are you?
A. Yes.
Q. In Dr. Mendoza's visit of 7/19/2005; can you switch to that, please, sir?
A. Yes.
Q. There's a notation, again at the top, "Saw Dr. Forgarty at research several years ago." Did I read that correctly or can you better interpret that for me than I did?
A. Yeah, "I saw Dr. Forgarty at" -- I think that's research several years ago. "Sister still patient there."
Q. And do you know whose handwriting that is?
A. It probably would have been whichever nurse or assistant was working with Dr. Mendoza ---
Q. Mendoza?
A. --- that day, because it's clearly not Dr. Mendoza's handwriting which is pretty recognizable.
Q. And where is the research facility located?
A. It is located just off of I-85 on -- oh, I'm sorry, it -- I'd have to look up the address, but ---
Q. Does it a separate name other than Lung and Chest Medical Associates?
A. Yes.
Q. What is the name?

A. I believe it's Spartanburg Pharmaceutical Research.
Q. If a patient is seen at the research center are there records maintained on that patient at that facility, not maintained at Lung and Chest?
A. Yes, that's correct.
Q. Have you discussed this litigation with anyone? Litigation against Dr. Feldman and Dr. Boscia?
A. Yes.
Q. And with whom have you discussed it?
A. Well, Dr. Fogarty has told me that he was involved in the deposition with this regard. And Mr. Thompson's wife used to work for us, and she had mentioned that she knew Mr. Casey and that he was involved in a suit against Dr. Feldman and Dr. Boscia.
Q. If you are called as a witness in this case, Dr. Smith, what would be your testimony as you understand it? You would testify as to the visits and your treatment of him; correct?
A. I'm -- I will testify to whatever ---
Q. Whatever questions are asked ---
A. Are asked.
Q. --- but, I mean, would you -- you would answer questions as to your treatment?
A. Sure.

Q. And what other areas would you feel that you are knowledgeable to give information and evidence of?
A. Well, I am a pulmonary board certified, and so I would think I would be able to answer questions in that area.
Q. Would those areas include comments regarding care and treatment rendered by Drs. Boscia and Feldman?
A. Yes.
Q. Any other areas that you think that you would be qualified to render evidence -- into evidence?
A. Not that I can think of in this particular case.
Q. The procedures that were -- the operative procedures that were done in this case was a flexible bronchoscopy by Dr. Boscia; do you do that? Do you flexibles?
A. Yes, I do.
Q. And the procedure done by Dr. Feldman was a rigid bronchoscopy. Do you do that procedure?
A. I have done those.
Q. When did you last do those?
A. It'd be years and years and years ago.
Q. Do you consider yourself qualified to render opinions about a rigid bronchoscopy?
A. I do.
Q. Okay, and do you do lasering?

A. I have.
Q. When did you last do lasering?
A. Probably several years ago.
Q. And what type laser did you use?
A. I used the YAG laser.
Q. Was it gas operated or water?
A. I have -- I'm not sure.
Q. Do you know whether you've ever used a water cooled YAG laser?
A. Again, I used whatever YAG laser we have at Spartanburg Regional. I was the one that started the laser program there.
Q. When did you last use a YAG laser?
A. I would guess four or five years ago.
Q. Do you have any criticisms of Dr. Boscia and his treatment of Mr. Casey?
A. Yes, I think that -- that it could have been handled differently.
Q. And tell me how you feel it could have handled differently?
A. Well, the chest x-ray that was taken shows an object. Because that chest x-ray is one view, you cannot tell the location of that object in relationship to being inside or outside the body, or if it is an artifact.

Q. Okay.
A. I believe that that would have been prudent to have established by x-ray whether that object was in or outside the body or an artifact.
Q. So additional diagnostic x-rays should be taken; is that your testimony?
A. That's correct.
Q. Plain film x-ray?
A. A plain film would have been helpful or a CAT scan would have been done in place of that.
Q. Okay, do you think that reaches the level of a breach in standard of care?
A. I think it would be -- have been prudent to have done in this case.
Q. I heard that ---
A. Right.
Q. --- but my question is, in your opinion, does that reach the level of a breach in standard of care?
A. Yes.
Q. Other criticisms of Dr. Boscia?
A. He ordered a test which it's not apparent that he followed up the result of.
Q. And that is?
A. The CT scan.
Q. Okay, and that CT did not show a metallic body?

A. That is correct.
Q. What is your criticism of Dr. Boscia in respect to the CT?
A. Well, having ordered the test, he was responsible to know the result of that and to communicate that then, since that would have likely changed the care of this patient. The working diagnosis was a foreign body, and the CT failed to confirm that. Therefore, he had a responsibility to communicate that if he was not going to continue to be the physician in charge.
Q. But Dr. Boscia did a flexible bronchoscopy and was not able to find a metallic body; correct?
A. That's correct.
Q. So the CT confirmed what Dr. Boscia had found by his procedure; correct?
A. That is correct.
Q. And did Dr. Boscia -- do you know, did he not communicate to Mr. Casey his negative finding of a metallic body?
A. Again, I do not find evidence that that was communicated prior to the laser bronchoscopy.
Q. That Dr. Boscia's not finding a metallic body was not communicated; is that your testimony?
A. Again, that the finding on the CT scan was not

communicated.
Q. But if the flexible bronchoscopy finding was the same as the CT reading, i.e. no metallic body, that was known to Dr. Boscia when he did his procedure; correct?
A. Yes.
Q. Okay, and is it your testimony that Dr. Boscia did not communicate that he did not find a metallic body to Mr. Casey?
A. No, it is that as far as I can tell, the results of the CT scan were not made aware to either Dr. Feldman or Dr. -- or to Mr. Casey prior to the laser bronchoscopy.
Q. But if the same fact is obtained in another method, further than diagnostic study, it's determined in a procedure ---
A. No, you're -- you're incorrect. The negative finding on bronchoscopy would make me more want to see what the CT showed, because now I have not confirmed my initial impression. I didn't find any foreign body. I thought I saw one on the x-ray. What -- what's going on? Did I miss it at the bronchoscopy or was it never there in the first place?
Q. And does that reach the level of breach of standard

of care, in your opinion?
A. I do think, again, this is -- as we can see the results of not communicating that have important consequences. I do think that that was a mistake on his part, yes.
Q. And you think it reaches the level of breach in standard of care?
A. I think if he had knowledge that they were proceeding to the laser bronchoscopy, and I don't know that, but I -- but if he knew that they were proceeding on to this other step, then yes, that was a breach. If -- if ---
Q. All right, other criticism -- go ahead. I'm sorry. I didn't mean to cut you off there.
A. Well, I was just going to say, if at that point it had ended, if he said, I didn't find a foreign body. There's not a foreign body. Then that wouldn't have been -- it wouldn't have resulted in any harm not to have seen the CT.
Q. Okay.
A. But since he did not find a foreign body, and he didn't communicate that the CT had been done, nor that it did not show anything, then that is a breach. If -- if ---
Q. Any other criticism -- I'm sorry. Cut you off

twice. Excuse me.
A. Like I said, if he knew that there was going to be a subsequent procedure that involved the risk that a laser bronchoscopy does.
Q. Other criticisms?
A. Again, just that there wasn't a clear handoff of this patient to Dr. Feldman, that would have given Dr. Feldman all the information he needed to make decisions about his subsequent procedure.
Q. Okay, that's not a separate criticism?
A. No.
Q. Other criticisms of Dr. Boscia?
A. None.
Q. Criticisms of Dr. Fogarty? Excuse me, Dr. Feldman? Excuse me. I'm sorry.
A. Well, it's not apparent that he examined all the clinical material available to him before proceeding with this procedure.
Q. And what material would that be?
A. Well, again, the presence of the CT scan, which would perhaps have changed his thinking about the need for that procedure.
Q. Is that a breach of standard of care, in your opinion?
A. Again, to -- it certainly would be for this

procedure to not have again, done those things which would have confirmed that this was an object in the lung.

Q. Okay, and again ---

A. So -- so if -- if he knows Dr. Boscia hasn't seen an object, and if he knows the x-ray is only a PA film, even if he doesn't know that the CT exists, he should have wanted to get another chest x-ray to confirm the presence of this object or to have ordered a CT scan himself to know, was this object where I think it is?

Q. Okay, now you're assuming that Dr. Feldman knew that the plain AV film showed a metallic body; correct?

A. Right. My understanding is that he had looked at that in the emergency room when Mr. Casey first appeared.

Q. And he had information from Dr. Boscia that Dr. Boscia had done a flexible bronchoscopy and had not found a metallic body?

A. That is correct.

Q. That Dr. Boscia had found abnormal tissue?

A. He had seen something on the bronchial wall; correct.

Q. And based upon knowing that -- those facts and

proceeding with the rigid bronchoscopy, your opinion is that Dr. Feldman breeched the standard of care?

A. Well, again, there was -- without the object, there's no need for rigid bronchoscopy. The -- you may want to again repeat the bronchoscopy to confirm the abnormality and perhaps obtain biopsies of what Dr. Boscia saw. That would be reasonable. But there was no need to do a rigid bronchoscopy and no need to have done a laser.

Q. And so the bronchoscopy -- the second bronchoscopy would have been a flexible?

A. Again, if we say there -- and Dr. Boscia says, I saw something abnormal but I didn't biopsy it so I don't know what it is. Then the prudent course would have been to say, well, let's repeat your bronchoscopy and go back and biopsy that place.

Q. And that would be a flexible?

A. That would be a flexible.

Q. Other criticisms of Dr. Feldman?

A. That would be my main criticism. It just didn't seem that he had reviewed the clinical material available to him, and went in not assured that there was a foreign body to be found and removed.

Q. No other criticisms you have of Dr. Feldman that

reach the level of breach of the standard care?
A. Again, at this point I haven't reviewed the whole clinical record, but of those are the things that I know that I -- I felt were wrong.
Q. And, Dr. Smith, I'm going to ask you if you -- if you form any additional opinions with respect to Dr. Feldman and Dr. Boscia, if you would tell Mr. Thompson or contact us and let us know that you have additional opinions, we'd like to talk to you about that.
A. Okay.
Q. Have you reviewed any information materials other than the records created by your group?
A. I looked at the x-rays that were available on -- through the PACS system at Spartanburg Regional.
Q. Would that include the AP taken on May 28th, 2004?
A. The -- no, I have -- I had looked at that chest x-ray, because at that time the emergency room was not on our digital system, and of course, Dr. -- or Mr. Casey had brought that with him the first time he came to see me.
Q. Because that's the AP plain film, May 28th that shows the object you have seen?
A. Yes, sir.
Q. And then you've looked at the films that were

available on the PACS system?
A. That is correct.
Q. Would that include the CT?
A. The -- yes.
Q. Would that include post-operative ---
A. I just briefly looked at the initial films in the recovery room and with the insertion of the chest tube.
Q. Anything else you've reviewed?
A. No, just our record here.
Q. Have you reviewed Dr. Fogarty's chart?
A. I did not.
Q. And Dr. Fogarty took over his care? He saw Dr. Mendoza one time and then Dr. Fogarty has seen him since then; is that a fair statement?
A. Correct.
Q. There have been allegations raised by the plaintiff that Mr. Casey suffered an air embolism to the brain and suffers cognitive dysfunction. Are you qualified to render opinions regarding the nature of the mechanism that would result in that injury?
A. Yes.
Q. And how so?
A. Well, because I have done training for laser bronchoscopy, and because I began the Hyperbaric

Chamber Program which is a treatment for air embolism.

Q. Do you have an opinion as to whether or not Mr. Casey suffered an air embolism to the brain?

A. Well, now, that's a different question than you just asked. What -- if you're asking, is it possible to -- for the injury he sustained to produce such a problem, then I can talk to that. As far as for Mr. Casey individually, I have not reviewed his subsequent evaluation in regards to that question.

Q. Okay, and what evaluation would that be?

A. Well, you said that he had had further neuro-cognitive testing. There's -- there is the first page in our chart on this side shows that he's had a neuro-psychological evaluation.

BY MR. THOMPSON:

Spencer, if I could just add one thing I had delivered to Dr. Smith yesterday morning. It's very similar to the same notebook that I provided to you and Mr. Gunn at the beginning of the litigation. This had some additional updates as to physician records. Then it had certified hospital records that were separated into the two hospitalizations. And it did have Dr. Wade's

report. You know, all the physician reports ---

BY THE WITNESS:

Yeah, I'm sorry if I left that out that I did review the depositions -- some of the depositions in relationship to this.

BY MR. THOMPSON:

I don't know that he's had time to work his way through that.

DIRECT EXAMINATION RESUMED BY MR. KING:

Q. Let's go back. You've told me that you're not a neurologist and you're not a neurosurgeon?

A. Right.

Q. And if I understand, the brain is normally treated by a neurologists and neurosurgeons?

A. Correct.

Q. Tell me your qualifications to render an opinion as to an air embolism to the brain from a bronchial injury?

A. Well, as I said, because I have had training and have done laser procedures and because as a physician who started the Hyperbaric Chamber Program at Spartanburg Regional, that is the treatment that one renders potentially for those problems. And so I am aware of that through my training for that.

Q. And what would be the mechanism as to how a rigid bronchoscopy and laser would result in an air embolism to the brain?

A. Well, you just have to create a communication between an air-containing space and a vein, that would result -- or artery that would result in the carriage of that air to the brain.

Q. And would that be either the pulmonary vein or the pulmonary artery?

A. Well, the -- the -- yes, either one would be likely to be able to do that.

Q. And you read the records from the procedure where the rigid bronchoscopy and lasering was done? Have you read those records?

A. I have not in some time. I read those originally.

Q. Would it be an air bubble that would enter into the pulmonary vein or the pulmonary artery?

A. Yes, it'd be more likely the pulmonary vein to result in air that would go to the brain.

Q. And so there would have to be a perforation of the pulmonary vein in addition to the bronchial wall?

A. Yes, there would need to be a communication created between one of the pulmonary veins and the air space. The -- in this case it'd be the bronchus.

Q. And what would be the condition of the patients as

far as signs and symptoms if a pulmonary vein was invaded?

A. They might be restless; they might become unconscious. It would depend upon the amount of air that had entered. Here you have the difficulty that immediately, or shortly after the event, you -- the patient is intubated and sedated so the evaluation of that person is rendered more difficult.

Q. Would you not have bleeding?

A. Not necessarily.

Q. If you invaded a pulmonary vein you would not bleed? You would not have bleeding?

A. Again, the veins are lower pressure than the arteries are. And this does not have to be a large vein for there to be air to enter it.

Q. Aren't there four pulmonary veins?

A. Well, again, you're talking about the largest veins. But yes, there would be veins on both -- draining both lungs.

Q. And so there are four?

A. Right.

Q. And this is not the veins you're talking about?

A. Yes, again, but you could have smaller vessels that would be present. Again, you don't -- you asked if

you have to have a lot of bleeding for this to happen ---

Q. Would you not have ---

A. --- and I don't -- I don't think that you necessarily do.

Q. Have you treated anyone with an air embolism?

A. I have.

Q. Air embolism to the brain?

A. Yes.

Q. When?

A. Gosh, it's probably been 15 years ago.

Q. And what was the mechanism that caused that air embolism?

A. They were getting hyperbaric treatment and had developed some hemoptysis inside the chamber.

Q. What was the initial injury that this person suffered?

A. They were being treated for a foot problem.

Q. That was 15 years ago?

A. Probably so.

Q. What is the texture, tissue, or what -- help me with the word of the bronchial wall?

A. The texture?

Q. Tissue or what's it composed of? What's the bronchial wall made of?

A. Squamous cell in that -- in the larger bronchi. Ciliated bronchial cells. I'm not sure what I'm --

Q. Is it easily perforated? Is it easily punctured?

A. No, sir.

Q. Is it like cartilage?

A. Well, it's surrounded by cartilage through a lot of its cores.

Q. And do you intend on rendering an opinion as to whether or not Mr. Casey suffers from cognitive dysfunction as a result of an air embolism?

A. I'm not an expert in that area.

Q. So the answer is no?

A. No.

Q. Okay.

A. Is the possibility that there would be communication -- perforation of the bronchial wall with a pulmonary vein that could result in an air embolism to the brain, does this reach the level of a probability of medical certainty?

A. I don't think you can say that it was with probable certainty that this happened.

BY MR. KING:

Excuse me just a minute.

(OFF THE RECORD).

BY MR. KING:

No more questions. Mr. Gunn has some.

EXAMINATION BY MR. GUNN:

Q. Dr. Smith, I represent Dr. Shantha in the case.

A. Yes.

Q. And I believe that I can be somewhat brief with you.

A. Yes, sir.

Q. Let me ask you this, I think from some of what you've said earlier, that you have not reached any opinions or drawn any conclusions about the standard of care by Dr. Shantha?

A. No.

Q. And would not consider yourself in fairness qualified to do so?

A. Correct.

Q. Board certification. You are board certified in pulmonology; are you not, sir?

A. I am.

Q. And when were you first board certified?

A. '82.

Q. And that's the one that you're in the group that you don't have to get board recertified?

A. That's correct.

Q. Do you consider board certification in a specialty,

well, particularly in your primary line of work, pulmonology, to be an additional measure beyond just a medical license of competence in your field?

A. Yes, I think it has grown to that that if you are going to present yourself as an expert in that area that board certification would be a requirement.

Q. It's a demonstration. It's a good objective, fair demonstration of that professional competence?

A. And the hospitals are requiring it now for you to be able to put yourself forward as an expert in that area.

Q. Such as our hospital here, Spartanburg Regional Medical Center?

A. That's correct.

Q. And how long has that been the case that Spartanburg Regional requires that board certification, if you know? Just approximate it for me?

A. I would say we're talking within the last decade.

Q. I take it -- and Dr. Smith, for example, if you had a close friend or a loved one in some locality of the United States that needed the services of a pulmonologist and it just so happened that you didn't know anybody in that area, you'd get in a directory of some type. And the first thing that

you would look for, or one of the first things that you would look for is board certification, isn't it?

A. Well, you'd look where they trained, and their -- and that they are boarded.

Q. All right, sir, let me ask you this. This is along the lines of the last several question exchanges that you and Mr. King had. You indicated that -- I'm trying to sort of speed it along by trying to kind of summarize what you said, and if I misstate it you jump right in there and correct me.

A. Okay.

Q. I thought I understood you to say that a patient such as Mr. Casey, it is possible to suffer an air embolism that travels to the brain; is that a fair ---

A. Yes.

Q. --- summary of it?

A. Yes.

Q. And I think you further said that in order for that to happen there has to be a communication from the air source, in this instance, the bronchus to the pulmonary artery or vein, and then, in this instance, mostly likely the vein?

A. That's correct.

Q. When you use the term "communication," list for me, if you can, the modes of communication that you're talking about. I mean, would it ---

A. With all -- well, with the laser you have made a hole.

Q. Okay.

A. Now that hole could be into a large vein; it could be into the lung. We have a situation in which there was a pneumothorax on that side. We can't -- the other possibility is that the lung has been entered and that the lung then is distended as it would be after intubation and mechanical ventilation, it's possible for the air to be forced into the vein.

Q. All right, sir. In that instance, sir, would you not expect to see some manifestation of physical injury in some fashion?

A. Physical injury where?

Q. To the patient? Well, anywhere? I think I'm looking for answers.

A. Are you talking about the symptoms on the part of the patient?

Q. Yes, sir.

A. Yes.

Q. What would you expect to see?

A. You could. You would see again, confusion if they were awake. You might, if it was large, see some focal neurologic deficit. You could have ---

Q. By that --- by a focal neurologic ---

A. --- weak -- weakness of one extremity, loss of vision, something that would be more specific for a stroke in that area. But the symptoms also could be subtle, and just -- it just could be agitation, restlessness, or confusion.

Q. Indeed, would you not expect at some point to see some manifestation of the injury on imaging?

A. No.

Q. MRI most probably?

A. No.

Q. Might or might not?

A. Not necessarily. And it would have to be some kind of specific studies done to look for that possibility.

Q. And if it was -- and if such a study was done and was negative, would that -- I know it wouldn't be conclusive, but would that guide you away from that injury? There'd be some evidence of non-injury?

A. Again, it certainly is helpful if it's positive. It's not a conclusive negative.

Q. Right. Okay.

A. Okay. And the time course is important as well, since these, if they are small, may disappear.
Q. And if they're small and they would disappear, would you not expect any sequelae to disappear, or would you leave that up to a neurologist or ---
A. Well, again, this would depend on the amount and the location of where the -- they had produced occlusion of flow.
Q. Would you defer to a neurologist or, I guess, whatever Dr. Grace is?
A. Well, not a psychologist, but certainly you --- a neurologist would be the -- the one with the expertise in this area to assess the damage.

BY MR. GUNN:

I think I'm about through. Let me check, because this is kind of a speak now or forever hold your peace. Okay, that's all, sir. Thank you very much.

EXAMINATION RESUMED BY MR. GUNN:

Q. Let me ask you this. You still do procedures, do you not, sir, where patients are put to sleep?
A. And when you -- define "put to sleep" for me.
Q. Well, that require the services of an anesthesiologist?
A. That's pretty unusual for us to require an

anesthesia. More often we get called in to help them with a difficult intubation, something like that.

Q. Oh, okay. But I mean, what type of procedures do you do presently in your practice that require a patient in the surgical suite?

A. Probably the one where we might do that would be, again, the removal of a foreign body. But I have a partner who we usually defer those to.

Q. Do you do -- you indicated earlier that you do do flexible bronchoscopy?

A. Yes, sir. But there we use what's called moderate sedation where a nurse under our direction administers a cocktail of drugs to produce sedation.

Q. Sort of like a similar situation with a colonoscopy?

A. Yes, exactly.

BY MR. GUNN:

All right, sir. Thank you.

BY THE WITNESS:

And the other thing I'd add, just to extend on yours, because now I remember I did need the services of an anesthetist when we do procedures down at The Village, their bronchoscopies are

handled by the nurse anesthetist.

BY MR. GUNN:

Gotcha. Thank you, sir.

CROSS EXAMINATION BY MR. THOMPSON:

Q. Dr. Smith, I'm going to have just a few questions for you in follow-up. Have you seen this consult history and physical and summary. I believe it's dated 5/28/04 of Dr. Joseph A. Boscia?

A. Yes.

Q. And I've highlighted several places in yellow which can be copied after the deposition. But do you see in the history of present illness, if you can read where it starts, "Initial chest x-ray."

A. "An initial chest x-ray on admission showed what appeared to be a foreign body in the left main stem bronchus. I am being asked to comment on this."

Q. And under physical examination where it starts, "Chest x-rays have been reviewed."

A. "Chest x-ray has been reviewed and it does show what appears to be an irregular metallic foreign body in the left main stem bronchus."

Q. And in the summary just below that, if you could read the first sentence?

A. "46-year-old gentleman with what appears to be a foreign body in the left main stem bronchus. Will

perform fiberoptic bronchoscopy to see if this foreign body is removable."

Q. And the portable AP chest x-ray that Dr. Boscia is referring to that was taken upon Ms. Casey's arrival at Spartanburg Regional on 5/28/04, have you had a chance to study that x-ray?

A. Yes, I have.

Q. And where it's stated there in the consult history and physical and summary that the foreign metallic body appeared to be in the left main stem bronchus, is that consistent with your review and interpretation of that x-ray?

A. Well, I have to say that the foreign body, which looks like a small screw, looks to be actually above the bronchus rather than inside the bronchus.

Q. And so when you compare your interpretation of the x-ray to what Dr. Boscia has here, if the metallic foreign object projecting on the portable AP x-ray is not within the left bronchus, would it be accessible either by flexible or a rigid bronchoscopy procedure?

A. No.

Q. So if the x-ray was initially misinterpreted by Dr. Boschia in that the metallic foreign body was actually outside the bronchus, then the flexible

bronchoscopy procedure for removal of the foreign body, would that be a necessary or an unnecessary medical procedure?

A. It would be unnecessary.

Q. And whether or not the metallic foreign body projecting on the single portable AP chest scan, even if it shows it's outside the bronchus, would the standard of care still require Dr. Boscia to obtain a PA and lateral x-ray in order to determine whether or not the object is actually within the body and the approximate location within the body?

A. Yes, I think that would be prudent to do to establish the exact location of the object.

Q. And in the summary there of that two-page document ---

BY MR. THOMPSON:

I'd like to go ahead and get this marked, ma'am, if I could, as Plaintiff's Number 1.

(COURT REPORTER MARKS TWO-PAGE DOCUMENT AS PLAINTIFF'S EXHIBIT NO. 1; ATTACHED TO DEPOSITION).

CROSS EXAMINATION RESUMED BY MR. THOMPSON:

Q. In the summary, does Dr. Boscia indicate that he plans to do the fiberoptic bronchoscopy on 5/28 in an attempt to remove this foreign body which ---

A. He does.

Q. And then characterizes as metallic?
A. Yes.
Q. I'm going to show you the consent form of the flexible bronch procedure 5/28. And it appears to have the signature of William M. Casey and it looks like possibly Christy Lockhart witnessed it?
A. Lockhart, uh-huh (affirmative response).
Q. It's hard for me to make out, but would you know that to be possibly the signature of Dr. Boscia?
A. I believe that's ---
Q. And where you have number 1 on the consent form, and it has -- I'll just read the first part of it, "I authorize and direct Drs. Feldman, Boscia and such assistants as may be selected by him/her to perform the following procedures upon me: tube in lungs to obtain specimen as needed." If the procedure is to attempt to remove what is believed to be a foreign metallic body from the left main stem bronchus, is that an adequate description of the procedure to inform the patient, in your opinion, as a physician?
A. Well, I'll have to say, that's our standard consent form that we use. So I don't have any problem with the consent.
Q. And Dr. Feldman -- let me find his consent form.

There is a consent form that I've handed you dated 6/3/04 and it has the name of the patient, William Casey. And number 1, where it has "to perform the following operations upon me." It's blank after that; correct?

A. Well, actually he gives a description down below, still under number 1, of the procedure he was going to do.

Q. Okay. And it doesn't identify the doctor who is going to do the procedure, does it?

A. Well, it says that "Dr. Feldman has explained to me my conditions."

Q. But as far as number 1 where it has a slot to identify ---

BY MR. KING:

Object to the -- objection to the form of the question.

WITNESS ANSWERS:

A. Again, I'd have to say, this is our standard consent form that we use. And I think the assumption would be that if Dr. Feldman had explained the procedure and signed the consent that he would be the physician doing the procedure. I have to say, I don't see any problem with this.

Q. Okay. And the "time" there is left blank. In this

situation where there's been testimony that this was completed by Dr. Feldman in his handwriting and executed in the holding room next to the main OR just prior to the procedure, do you attach any significance that it doesn't have time as to when this was obtained?

A. I mean, I don't -- I don't find that a problem.

Q. Okay.

A. I mean, certainly they're on us all the time to time and date. And I guess we see to some extent why that's helpful. But again, I'd have to say the majority of the time, on my own consents, we just get the date and so I don't see that that's a problem. They require us to have this within 48 hours of the procedure. So if the date was appreciably different from the date of the procedure, that might be a problem. But the fact he didn't put the time there, I don't -- I don't have a problem with.

Q. And where it has "Description of Operation in Language of Laymen," could you read that for me?

A. Yes, it shows "rigid bronchoscopy and laser and removal of foreign body."

Q. And language of laymen, would your typical layman understand what a rigid bronchoscopy with a YAG

laser and -- plus removal of foreign body, would a typical layman understand what that is, from that language?

A. Well, I'd have to say, with that patient having had a previous flexible bronchoscopy and having the impression that there was a foreign body there, yes, I think that would be enough for him to understand what was about to take place.

Q. Is it clear to you that the purpose is for the removal of the foreign body?

A. Yes, sir.

Q. And in that, Dr. Feldman has testified in his deposition, and also responded to interrogatory requests that he never read the radiology report of his CT scan which was negative for metallic foreign body or any other radiopaque chest foreign body, and in fact was not even aware that such a CT scan had been scheduled at the request of Dr. Boscia. And also he never communicated the negative results of the CT scan to Mr. Casey. Do you think that Mr. Casey was given adequate information to be able to grant an informed consent for this particular procedure to remove what has been characterized as a metallic foreign body from his left main stream bronchus, not knowing that?

BY MR. KING:

Objection.

CROSS EXAMINATION RESUMED BY MR. THOMPSON:

Q. Not having been told that?

BY MR. KING:

Objection to the form of the question.

WITNESS ANSWERS:

A. Well, I would surmise, had he been told that no foreign body had been identified, that that would have changed his willingness to consent to that procedure, yeah.

Q. And I'm going to ask you to assume that Dr. Feldman has testified, and I could bring out the Interrogatory Responses, but it's clearly indicated that he did not communicate that to Mr. Casey and Dr. Boscia did not communicate that to Mr. Casey. And assuming that Mr. Casey did not have that knowledge, then the lack of his being told of those results would you consider this a informed consent or a defective consent?

BY MR. KING:

Objection to the form of the question.

WITNESS ANSWERS:

A. Well, I guess I'm ---

Q. And I'm not asking just about the form, because --

I'm asking about the information provided to the execution of the form, which I've asked you to assume that it -- the negative CT results were not ever communicated to Mr. Casey by Dr. Feldman or Dr. Boscia and it appears by no one else.

BY MR. KING:

Are you finished? Mr. Thompson, are you finished with the question?

BY MR. THOMPSON:

Yes.

BY MR. KING:

Objection to the form of the question.

BY MR. THOMPSON:

You can go ahead and answer.

WITNESS ANSWERS:

A. Well, I -- again, this is asking me to make a lot of assumptions here. But again, I just say, if he had known there wasn't a foreign body, he probably would have made a different approach to the consent.

Q. And having said that, is that something that should have been communicated to him by Dr. Feldman?

A. Again, had he known that, yes, he should have communicated that. But I don't have any information that says that Dr. Feldman knew that

prior to beginning the procedure.

Q. Is it a responsibility of a surgeon, such as Dr. Feldman, to review the patient's chart prior to the procedure?

A. Well, it is his responsibility to review the pertinent medical record.

Q. And I want you to assume that Dr. Peter Ryan's radiology report on the 5/28 CT scan was in the chart as testified by Mr. Gunn's client, Dr. Shantha at ---

BY MR. GUNN:

Dr. Shantha.

BY MR. THOMPSON:

Excuse me, Dr. Shantha.

CROSS EXAMINATION RESUMED BY MR. THOMPSON:

Q. At 11:00 p.m., less than an hour before the procedure?

A. Well, I -- again, as I said earlier, I think it would have been imperative of him to have obtained that or some other study to confirm that this object was where it was thought to be. But I don't know that I can say that he's required to know about an x-ray that he didn't know was taken.

Q. Dr. Smith, you had mentioned an x-ray, I think when I believe I was referring to the CT scan?

A. Yes, sir.
Q. And I've got his deposition and I can pull out and go to the specific entries if anyone would care for me to, but he testified in his deposition that he had not read the radiology report, Dr. Peter Ryan, as to the portable AP x-ray. He also testified that he had not read Dr. Ryan's radiology report as to the CT scan which was negative. He further testified that he had not read the history and physical of the ER physician, Dr. Leshman. He further testified that he had not read the monitoring notes from the ER from approximately 9:37 to 2:15 on 5/28/04 and he did not see Mr. Casey after his discharge on the 29th until the morning of the surgery in the holding room. If he had not previously read those things and there was a chart -- would the standard of care not require him to read those before he goes in and does his procedure?

BY MR. KING:

Objection to the form of the question.

WITNESS ANSWERS:

A. Well, here's what I would say, is that in the absence of an emergency situation, it is prudent to separate your assessment of the patient from the

procedure so that you do have an opportunity not under time pressure to review those things that are pertinent to going ahead with the procedure. And I think that was one of the things that did end up resulting in what happened, was that a visit to his office before hand where he could have seen the patient and established what had been done and hadn't been done in assessment, might have prevented this from happening.

Q. For that relevant medical information to be immediately accessible to him and his having failed to review it, would you consider that a breach of the standard of care in going forward with the procedure?

BY MR. KING:

Objection to the form of the question.

WITNESS ANSWERS:

A. I don't think it's a breach of the standard of care so much as it allows for mistakes to occur to have yourself under time pressure, which we always are if you do a case in the OR, you're dependent on the case in front of you finishing. The guy behind you is waiting for you to get done on time. You can't make the same level of assessment that you can prior to going ahead with what is a fairly invasive

procedure. Again, under certain circumstances you end up doing this, but this is not what you would consider ideal way to handle this procedure.

Q. Just a couple more questions. As noted on the consent form dated 6/3/04, rigid bronchoscopy with laser, plus removal of foreign body. And the foreign body having been consistently referred to as a "metallic foreign body." This being done in the main OR under general anesthesia, what is your consideration of using that laser as indicated in his operative note?

BY MR. KING:

Objection to the form of the question.

WITNESS ANSWERS:

A. Well, the problem as I see it is there is clearly no foreign body identified on the CT scan. So that throws the whole need to do this in question. Like I say, I don't have a problem with saying, I need to repeat the bronchoscopy because Dr. Boscia has found something abnormal, but I don't see where a rigid bronchoscopy or a laser comes into play in doing that. And certainly in using the laser, one wants to be very sure about what you're doing because this is many steps above in terms of risk from a routine bronchoscopy. And I think unless

you clearly have seen what you're going to do, that you're taking a lot of risk, unless you're very sure that there is an object there that you're going to find and remove.

BY MR. THOMPSON:

If you'll mark that. I've referred to it. And if you can mark this for me. I believe this is Dr. Feldman's operative note.

(COURT REPORTER MARKS DOCUMENTS AS PLAINTIFF'S EXHIBIT NO. 2 and 3; ATTACHED TO DEPOSITION).

CROSS EXAMINATION RESUMED BY MR. THOMPSON:

Q. And Dr. Smith, are you familiar with Dr. Feldman's operative note?

A. Yes, I've read it.

Q. Do you see in there where he makes mention to centering the laser on what appeared to him to be a crown and applying pulses and believing that it had been vaporized?

A. Yes.

Q. And with the history of the object having consistently been identified as metallic in nature, do you consider that acceptable treatment or is that a deviation from the standard of care?

BY MR. KING:

Objection to the form of the question.

WITNESS ANSWERS:

A. Well, it just -- again, I'm concerned that we have proceeded with the laser without clearly identifying that we've got what we thought we had. And that the object that was -- that appeared on the chest x-ray, which all this came about, was clearly a metallic object that resembled a screw. It did not resemble a crown or anything that would have come from somebody's tooth. So now we've found something for which we don't know for sure what we're dealing with and yet instead of establishing that diagnosis, we proceeded with the laser. And I think that's where we've gotten into trouble is having not found what we expected, we proceeded with the laser.

Q. So having not been aware of the negative chest CT scan and proceeding with a laser for removal of what has been consistently referred to as a metallic foreign body, would it be a deviation from the standard of care, not -- for Dr. Feldman not to have taken additional diagnostic procedures to get a definite confirmation of the presence of that foreign body in the bronchus of Mr. Casey?

BY MR. KING:

Objection to the form of the question, if that's a

question.

WITNESS ANSWERS:

A. Well, I certainly think it would have been a more -- a more acceptable and prudent course to have tried to establish what I was dealing with when it was not what I thought I was going to go and find. And it doesn't -- I think it somewhat sounds like this area was different than the area that Dr. Boscia had identified. So again, I would be concerned about what I was -- what I was dealing with and therefore it would have been prudent to have been -- to establish the diagnosis before proceeding with the removal.

Q. And when you say "prudent," in responding to my question, I think it was going forward without having taken additional diagnostic tests -- ordering additional diagnostic tests to get a clear, definite confirmation of the presence of this metallic foreign body in Mr. Casey's bronchus. Do you or do you not agree ---

A. Well, see what I go back to is not having established that object was not there, you approach it with a different mindset than if you are going in and you know that -- not for sure there's anything there. Now, I assume that what they

thought they saw here was something related to this original presumed object and that he was going to therefore remove it. So the error is made earlier in the line that leads to proceeding with something that wasn't necessary.

Q. So is it your testimony that this second procedure carried out by Dr. Feldman on 6/3/04 was medically unnecessary?

BY MR. KING:

Object to the form of the question.

WITNESS ANSWERS:

A. This particular procedure, no, was not indicated, had he known what was to be known prior to this procedure.

Q. And is that the same as saying medically unnecessary?

A. It was medically unnecessary. As I said, though, a repeat flexible bronchoscopy would have been reasonable based on Dr. Boscia's finding.

BY MR. THOMPSON:

Thank you, Dr. Smith, I have nothing further.

BY MR. KING:

Thank you, Doctor.

(There being no further questions, this deposition was concluded at approximately 5:24 p.m.)

STATE OF SOUTH CAROLINA COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG C. A. NO. 2006-CP-42-1728

William Mark Casey,
Plaintiff,
vs.
Gregory J. Feldman, MD,
Joseph A. Boscia III, MD,
Upstate Lung and Critical
Care Specialists, PC, and
Devendra Shantha, MD,
Defendants.

Certificate

This is to certify that the foregoing deposition of ***WILSON P. SMITH, M.D.*** was taken by the within court reporter, a notary public for the state of South Carolina, duly commissioned and qualified as such, on September 2, 2009, at The Ward Law Firm, 233 South Pine Street, Spartanburg, South Carolina.

That said court reporter is not a relative or employee of any of the parties or the attorneys, and further, is not of counsel or attorney for any of the parties to said action, and, is not in any manner

interested in the cause, financial or otherwise.

That the deponent was duly placed under oath and admonished to speak the whole truth; that the oral deposition was duly taken and transcribed as to the questions propounded and the answers given; that the foregoing 82 pages is a true, accurate, and correct record of the testimony given by the deponent; together with such changes as said deponent may have made, if any, during the reading over and signing procedure.

That the court reporter has retained the original deposition in its possession for the purpose of sealing and filing same with the proper official.

That all offered exhibits, stipulations and objections, if any, involved in this cause are duly attached or included herein.

In witness whereof, I have set my hand and official seal.

Date: 9-8-09

Joanne S. Quebe, Court Reporter
Notary Public for South Carolina
My Commission Expires 10-12-11

EXHIBITS

GUNN 004128

Lung & Chest Medical Associates

Chart No:_____

VACCINE		REFERRING MD	ALLERGIES
PNEUMOVAC	___/___/___	Honda	NKDA
	___/___/___		
FLU VAC	___/___/___	OTHER PHYSICIANS/SURGEONS	
	___/___/___		
	___/___/___		
	___/___/___		
	___/___/___		

PROCEDURES

PPD	___/___/___	LIVING WILL	YES NO	DICTATION_____
α_1AT	___/___/___	CODE STATUS	DNR FULL	L&C ✓ SRMC_____
IGE	___/___/___			MBMH_____
BRONCH	___/___/___			
C T LUNGS	___/___/___			
UPPER GI	___/___/___	HOME HEALTH AGENCY		
DXA	___/___/___			
GXT	___/___/___			
ECHO	___/___/___			
OTHER:	___/___/___	EQUIPMENT AGENCY		
_____	___/___/___			
_____	___/___/___			

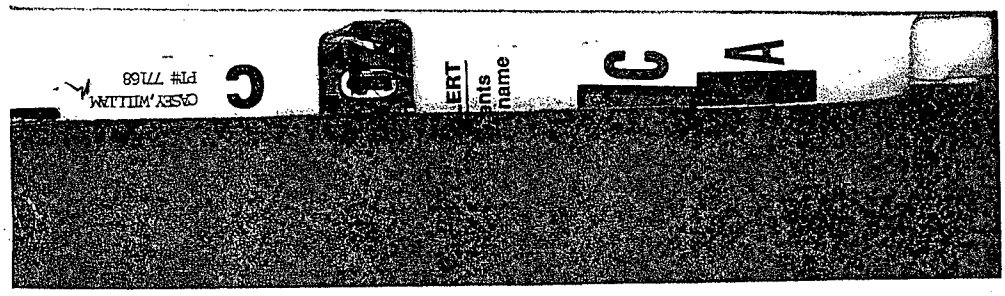
PHARMACY

ALERT

CMF WPS

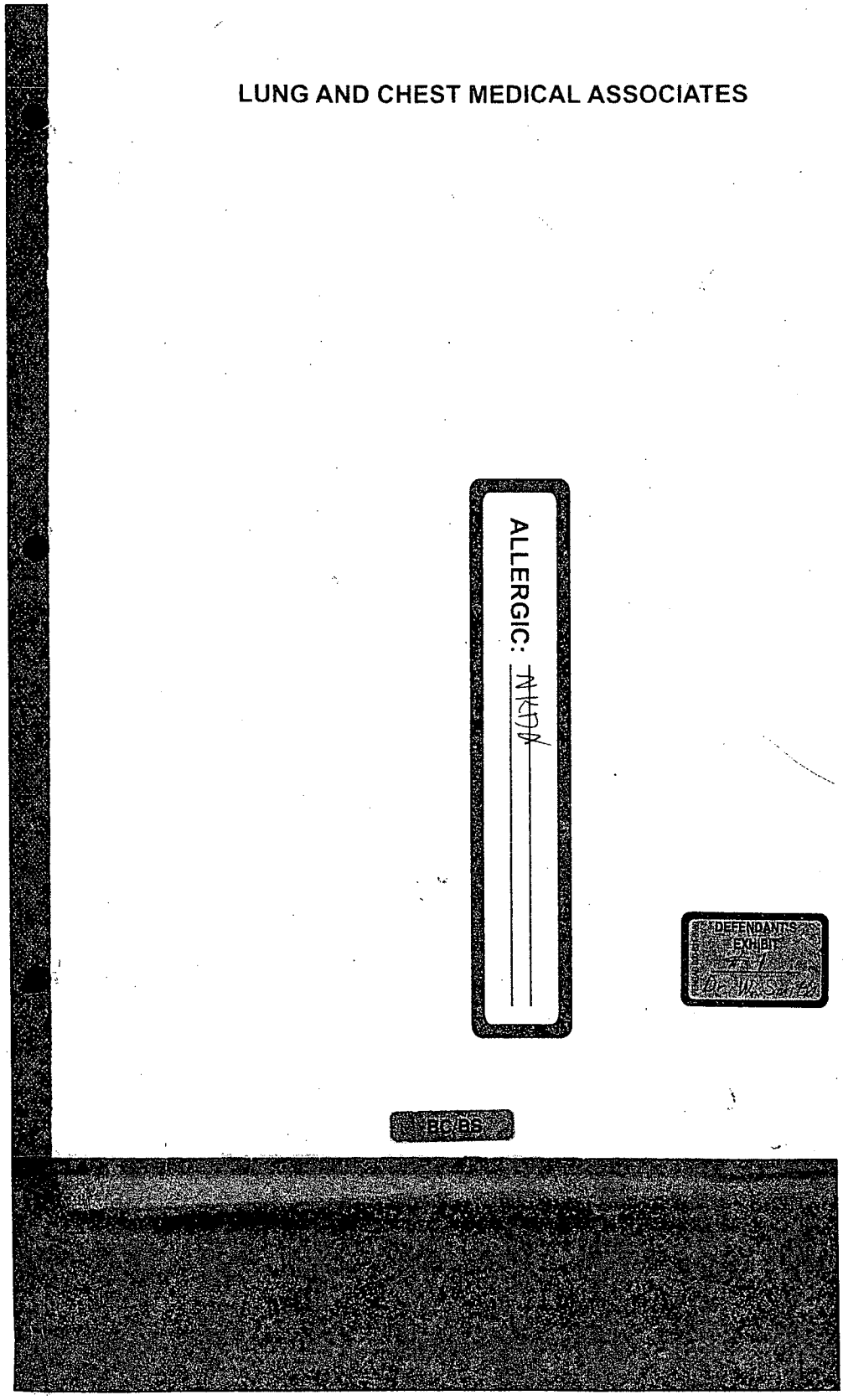
EBK RVM

MLA JDC



GUNN 004129

LUNG AND CHEST MEDICAL ASSOCIATES



GUNN 004130

****** ALLOW 2 LINES FOR PREDNISONE

LUNG & CHEST MEDICAL ASSOCIATES
2030 North Church Place, Spartanburg South Carolina

NAME William Casey CHART # 77168

ALLERGIES NKDA

ROUTINE MEDICATION LIST:

MEDICATION	Dose & Freqency Ordered by MD	Dosee & Freqency Taken by Patient	Start Date	Stop Date
Lipitor	20mg qd			
Bextra	20mg qd			
Tramadol	50mg (2) qid			
Advair 250/50	1 p bid	not using		8/12/04
Combivent	1 p 3-4 x day	not using		8/12/04

Date Reviewed and Updated/ By Whom

8/12/04 JF	/	/	/	/
/	/	/	/	/
/	/	/	/	/
/	/	/	/	/

GUNN 004131

4437

PROCEDURES-ADMISSIONS-REFERRAL FLOW SHEET/ PRECERTIFICATIONS

File

PATIENT NAME William Casey CHART # 77168

INSURANCE CO: BC BS PPO /TEL #800327-3238 PRIMARY CARE MD

DATE AND INITIAL	O NAME OF PROCEDURE O ADMISSION O IN-PATIENT O REFERRAL O OUT-PATIENT	**** PRECERT AUTH # *****	AUTHORIZED BY	WHERE (BE SPECIFIC)	WHEN DATE/ TIME	D/C SUMMARY/ RESULTS TO CHART DATE/INT
	records			Sylvia@ 560-1512		
7/19/04	Referral (FAXed 560-1510)			Dr. Joseph Grace	8-3-04	10:00am
aB 7.19.05	upper GI series r/o vomiting	only INPT precert per Back of card	regs per OF & Tasha	SRMC th.	7.28.05	8:30am
order faxed & sent w/ pt.				NPO afternight		
~~aB 7.21.05~~	~~carotid US~~ ~~coronary calcium~~					
aB 7.21.05	Cardiac scoring	not covered by insurance		Piedmont costs $99.00	7.25.05	8:30am
(a3) 7.21.05	US Gallbladder 787.03	NOT per	REQ Tasha	SRMC	8am	7.28

PARFLOW INC.

GUNN 004132

LUNG & CHEST MEDICAL ASSOCIATES

MEDICAL PROBLEM LIST

PATIENT NAME William Casey CHART # 77168

DATE DOCUMENTED	DESCRIPTION OF PROBLEM	DOCUMENTED BY	DATE RESOLVED

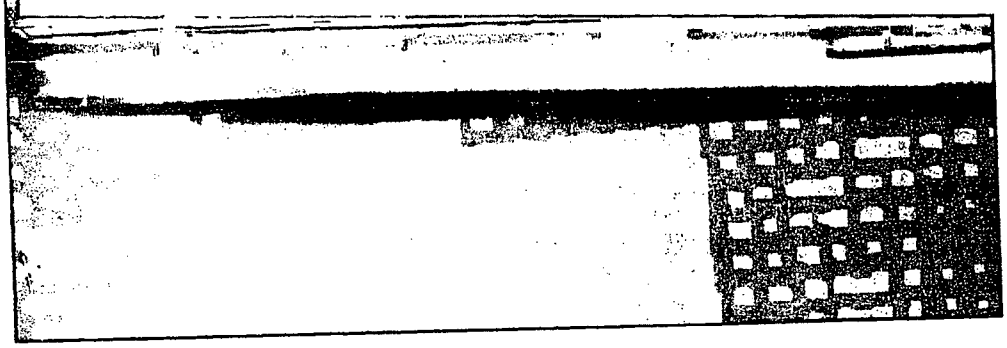
PROBLEM LST
10/10/96 LC-101

GUNN 004133

LAB/XRAY/WEIGHT - FLOW SHEET (DONE IN OUR OFFICE)

PATIENT NAME William Casey CHART # 7716 b

DATE	HT / WT	F_iO_2 / SAO_2		PH / PCO_2	PO_2 / O_2SAT	FVC / FEV1	LV DLCO	CXR / SINUS	THEO / Hgb	BUN / CREAT	K+ / GLU	HgbA,C	MAMMO-GRAM / PSA	EKG
7/14/04	171.6	.21/95				4.94/3.78		PAL						
7/15/05	174	.21/95				5.12/3.50				29/0.7	4.2/121			
7/12/05	176.6	.21/98				4.65/3.76								
8/4/05	178	.21/98												



GUNN 004134

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

M.D. Signed on-Line

Waste

CONSULT

PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 414900306
DATE OF SERVICE:
ATTENDING PHYSICIAN: KOSER, ANDRAS
ROOM:

HISTORY OF PRESENT ILLNESS: This 46-year-old smoking male presented to the hospital for chest pain. An initial chest x-ray on admission showed what appears to be a foreign body in the left mainstem bronchus. I am being asked to comment on this. This patient complains of pain in his chest that is sharp that goes directly straight to his back. There is a history of cough. No history of hemoptysis.

PAST MEDICAL HISTORY: includes hypercholesterolemia. No history of hypertension or diabetes.

SOCIAL HISTORY: He has a 25 pack year smoking history. He works at Michelin.

FAMILY HISTORY: Is noncontributory.

REVIEW OF SYSTEMS: Includes all mentioned in history of present illness. Also, he has chronic back pain, occasional headaches, occasional constipation. All other review of systems are negative.

PHYSICAL EXAMINATION: He appears well in no acute respiratory distress. Blood pressure is 150/90, pulse is 84. Pupils react to light. The oral mucosa is moist without thrush. Neck is supple. Heart is regular. Lungs are clear bilaterally. Abdominal exam reveal no hepatosplenomegaly. Extremities are without clubbing, cyanosis or edema. Skin is intact with no rashes. Joints are not inflamed. Neurologically, cranial nerves II through XII are intact without focality.

Chest x-rays been reviewed in it does show what appears to be an irregular metallic foreign body in the left mainstem bronchus.

IN SUMMARY: 46-year-old gentleman with what appears to be a foreign body in the left mainstem bronchus. He has consented to fiber-optic bronchoscopy which would be the most reasonable next step. Will perform fiber-optic bronchoscopy to see if this foreign body is

Note: Document is draft unless signed

PLAINTIFF'S EXHIBIT # 1 Dr. W Smith 9/2/08
PENGAD 800-631-6989

OK

000065

GUNN 004135

removable. If it is not removable or granulated in, than rigid bronchoscopy in the operating room will be performed. Risks, benefits, and alternatives were discussed with Mr. Casey and he agrees to proceed with bronchoscopy.

DICTATED BY: JOSEPH A BOSCIA III, M.D.
D:05/28/2004 14:26:33
T:06/03/2004 11:25:39/lb
65506/64110

cc: ANDRAS KOSER, M.D., Admitting Physician

SPARTANBURG
Regional Healthcare System

☐SRMC ☐SHRC ☐BJW

CONSENT FOR
OPERATIONS AND ANESTHETICS / DIAGNOSTIC AND TREATMENT PROCEDURES

Date: 6-3-04 Time: _____ M

Name of Patient: William Casey

1. I authorize and direct Doctor(s) _____
and/or such assistants as may be selected by him/her to perform the following operation(s) upon me: _____

☐ MODERATE SEDATION ADMINISTRATION: I have been informed of the risks, benefits, potential complications and options for moderate sedation and I agree to proceed.

Description of operation in language of laymen: RIGID BRONCH FOR REMOVAL OF FOREIGN BODY

2. Dr. Pierpont has explained to me my condition and the procedures which will be used in the operation(s). No guarantee or assurance has been made as to the results that may be obtained; and he/she has advised me of the risks and consequences, including possible complications of doing this procedure as well as not doing this procedure. He/she has advised me of the other methods and procedures of treating my condition and has answered all my questions concerning those methods.

3. I recognize that during the course of the operation(s) unforeseen conditions may necessitate additional or different operations and procedures than described above. I authorize and request that the above named physician and/or his assistants perform such operations and procedures as are, in his/her professional judgment, necessary and desirable.

4. I consent to the administration of such anesthetics as may be considered advisable by the physician responsible for this service with the exception of:
State exception if desired: _____
The physician responsible will discuss all risks, benefits, complications and alternatives prior to the above procedure.

5. I consent to the disposition by hospital authorities of any tissues which may be removed during the course of the operations and procedures.

6. I DO, DO NOT consent to the taking of photographs of myself by hospital authorities for the purpose of medical study or research only, before, during or after the operations and procedures. (Please circle one)

7. I DO, DO NOT consent to the presence of medical observers before, during or after the operations and procedures. (Please circle one)

8. I, THE UNDERSIGNED, HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM AND IT HAS BEEN EXPLAINED TO ME, TO MY SATISFACTION.

Witness: Peggy S. Poole, RN Patient: William M Casey

Physician Obtaining Consent — Person Authorized to Sign for Patient

Second Physician Obtaining Consent When Patient Incompetent — Relationship

PLAINTIFF'S EXHIBIT # 2 Dr. W. Smith 9/21/09

PENGAD 800-631-6989

FOR OPERATIONS INVOLVING STERILIZATION COMPLETE BELOW

I understand that as a result of the procedures described above, I may become permanently sterile. I know that the word "sterile" means that I may never be able to conceive or bear children, but no guarantee has been made as to the result.

Physician Obtaining Consent — Patient

Witness: _____ Spouse: _____

Transfusion Consent on Reverse Side of Page

PRINTED BY: FM2291 Patient Label

DATE 11/22/2004

041540004B 000-146220 06
CASEY,WILLIAM [redacted]68 M 45Y
ADM FELDMAN,GREGORY
REF FELDMAN,GREGORY

000132

1056 (REV. 02-03) Page

GUNN 004137

M.D. signed on line 5/11/06

OP REPORTS
PATIENT NAME: CASEY, WILLIAM
DOB [redacted]/1955
MEDICAL RECORD #: 146220
PROCEDURE DATE: 6/3/04
ACCOUNT NUMBER: 415400048
ROOM: ICU

PROCEDURE PERFORMED: Rigid bronchoscopy with laser bronch.

ENDOSCOPIST: Dr. Feldman.

INDICATIONS FOR PROCEDURE: 45 year old had been worked up by Dr. Paladugu and my partner, Dr. Boscia, with the finding of abnormal granulation tissue and abnormal subsegment in the left upper lobe corresponding to what appeared to be a crown foreign body on chest x-ray. The patient is now undergoing procedure in attempt to removal of chest x-ray abnormality suggestive of a crown; the patient does have a history of a missing crown.

After general anesthesia was induced, the patient was intubated with a rigid bronchoscope, size 16, without any difficulty. Careful inspection of the tracheobronchial tree was undertaken. The entire tracheobronchial tree was examined, there was no finding of a foreign body, however, a quite abnormal subsegment in the left upper lobe which appeared to be a pouch/granulation tissue has been identified. Laser of the area has been done with 45 watts over a 2-second period. Granulation tissue has been vaporized with the appearance of what appeared to be crown lying on the surface. With using 35 watts energy of the laser, there was no possibility of removal of the crown because it was deeply imbedded, and laser energy was applied to the center of the crown and it has been vaporized. However, below the surface there has been no further foreign body seen. The assumption was made that the entire crown other than on the surface had been vaporized, and attempt to pull it with a biopsy forceps and passage of the basket was unsuccessful. The washings were done of the area, and the procedure was terminated. The patient was extubated in recovery.

Although the patient did quite well during the procedure, he suddenly developed considerable pneumomediastinum and having immediately arrived to the bedside, Dr. Nguyenduy's consultation has been obtained. The decision was done by Dr. Nguyenduy and myself to place a chest tube, because of the impossibility to rule out pneumothorax, however, chest x-ray does not show pneumothorax, there is no foreign body seen, and also endotracheal tube is in good position. The patient was intubated by Anesthesia prior to that.

IMPRESSION: It is unclear to me at this point whether the laser went through the cartilage, and since I have not identified or pulled the crown itself, if in fact there was a crown it has been vaporized and is no longer seen on x-ray. At this point the patient will transfer to the ICU,

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Chart

GUNN 004138

antibiotics will be administered for disruption of the bronchus and pneumomediastinum. This will be followed by CT surgery and certainly if air leak into the pneumomediastinum would not stop, surgical intervention will be required. Hopefully this can be avoided by conservative management, but it is uncertain to me at this time whether the crown was vaporized or essentially the laser went through the highly abnormal area of the lung suggestive of closed congenital pouch rather than a foreign body, and significant irritation from previous bronchoscopy.

DICTATED BY: GREGORY FELDMAN, M.D.

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L. Randolph Waid, Ph.D.
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REPORT OF NEUROPSYCHOLOGICAL EVALUATION
Confidential-For Professional Use Only

Name: William Mark Casey

Age: 46 (DOB: [redacted]/58)

Sex: Male

Handedness: Right

Dates of Evaluation: August 30th and September 10th, 2005

Reason for Referral: William Mark Casey is a 46-year-old Caucasian male referred for neuropsychological evaluation through the offices of Ken Anthony, Esquire, and Ray E. Thompson, Jr., Esquire. The evaluation was conducted to assess Mr. Casey's brain behavior functions and emotional status. Mr. Casey's difficulties stem from medical procedures that were conducted due to recurrent chest pain in May of 2004. An emergent bronchoscopy was conducted following x-rays reportedly revealing a metallic fragment in the chest area. Reportedly, the bronchoscopy did not show a foreign body, but an area of erythema. The following week, Mr. Casey underwent a laser bronchoscopy that resulted in a perforation of the bronchial wall by the laser with resulting pneumomedistinum and respiratory distress necessitating intubation and heavy sedation. Subsequent to this, Mr. Casey has experienced disruptive symptomatology that has rendered him unable to return to employment capacities at the Michelin Company.

Relevant History: Mr. Casey was on time for his scheduled appointments. I reviewed with him the occurrence of chest pain for several weeks in May of 2004 while he was employed at resulting in him reporting it to the company nurse. Subsequently, he was transported to Spartanburg Regional Medical Center and underwent emergent evaluation. Medical records reveal that during the evaluation, Mr. Casey was found to have a left main bronchus containing some foreign body that was metallic in nature. Mr. Casey was seen in consultation by Dr. Feldman who asked Dr. Boscia to do a fiberoptic bronchoscopy. Reportedly, this procedure was undertaken but no piece of metal was found. Mr. Casey was discharged on 5/29/04.

Medical records reveal that Mr. Casey was re-admitted on June 3rd, 2004 and underwent an additional procedure conducted by Gregory Feldman, M.D. This involved bronchoscopy with laser. Acutely following the procedure, he developed considerable pneumomedistinum with reported pneumothorax on the left side. His condition necessitated placement of chest tubes, intubation and mechanical ventilation.

My understanding of Mr. Casey's case was assisted by review of the following medical records:

1. Extended medical records for treatment provided upon admission on 5/28/04 and 6/03/04.
2. Records from Spartanburg Regional Medical Center for procedures conducted in July of 2000.
3. Treatment records from Upstate Lung and Critical Care Specialists.
4. Treatment records from Lung and Chest Medical Associates.
5. Treatment records from Jeffrey Smith, M.D., Piedmont Psychiatric Services.
6. Treatment records from Joseph Grace, III, Ph.D.
7. Treatment records from Y. Eugene Mironer, M.D.
8. Mr. William Mark Casey's educational records from Spartanburg County School District #6.

Review of records revealed that Mr. Casey experienced disruptive symptoms following the procedure conducted on June 3rd of 2004. Initial follow-up treatment was provided at Upstate Lung and Critical Care Specialists with Mr. Casey complaining of fatigue, sleep disturbance, chest tightness, as well as being agitated and "unable to sit down." There was also report of longstanding chronic back pain. There was conservative intervention including use of Ambien. Difficulties persisted, and there was referral to Carolina Center for Advanced Management of Pain. Mr. Casey underwent evaluation by Eugene Mironer, M.D. He was assessed with mechanical low back pain, depression, and chest wall pain of no muscular origin. There was discussion regarding his treatment options.

Medical records reveal that Mr. Casey sought further evaluation for his difficulties at the Lung and Chest Medical Associates. Evaluation by Wilson P. Smith, Jr., M.D. reviewed the recent surgical procedures, noting that Mr. Casey remained with dyspnea and chest pain with exertion. Dr. Smith assessed Mr. Casey as being very anxious with report from family members noting a change in his ability to tolerate stress. It was noted that Mr. Casey was unable to participate in golf and other recreational activities. Dr. Smith's impression was that pulmonary functioning was normal and chest x-rays failed to show any evidence of sequelae of his bronchial perforation. Dr. Smith expressed concern that Mr. Casey may be experiencing a Posttraumatic Stress Disorder related to his injury and intensive care unit experience. There was recommendation of referral for a psychologist for further evaluation.

Records reveal that Mr. Casey subsequently came under the care of Joseph G. Grace, III, Ph.D. Care appeared to commence on August 4th, 2004. Initial medication intervention was coordinated with Frank Gonda, M.D., Mr. Casey's family physician. Subsequently, there was referral for psychiatric care with Jeffrey Smith, M.D. Treatment has been directed toward Mr. Casey's depression, sleep disturbance, anxiety, restlessness, irritability with low frustration tolerance, and poor stress tolerance. There has been use of antidepressants and other medications. Psychiatric evaluation with Jeffrey Smith, M.D., was conducted in early November. Dr. Smith modified the medication regimen including stopping use of Zoloft and adding Cymbalta 60 mg. Dr. Smith's assessment was one of major depression, single episode, moderate.

In interview, Mr. Casey reported that he has continued under the care of Joseph Grace, III, Ph.D. as well as Jeffrey Smith, M.D. Medical records reveal that Mr. Casey underwent further evaluation at the Lung and Chest Medical Associates in July of 2005. On initial evaluation, he was experiencing dry heaves and nausea as well as chest pain and a squeezing sensation present without exertion. A cardiogram was normal and Dr. Fogarty's impression was chest pain, probably chest wall; nausea and vomiting improved; persistent difficulty concentrating and staying focused; status post laser bronchoscopy complicated by pneumomedistmum and pneumothorax. Dr. Fogarty further stated that Mr. Casey's nausea/vomiting symptoms have appeared to improve since discontinuing Strattera. Dr. Fogerty stated that with regard to Mr. Casey's difficulty concentrating, "air emboli have been reported as a complication of laser bronchoscopy, even without perforation of the endotracheal tree with resulting leakage of air into extrapleural, vascular, and medistinal spaces. Although, he is fortunate not to have any gross motor deficit, he (Mr. Casey) may well have a permanent neurological deficit in which case the indication for taking medication such as Strattera may be mute."

Mr. Casey also underwent intellectual assessment by Joseph G. Grace, III, Ph.D., in June of 2005. Dr. Grace reviewed Mr. Casey's academic records, stating that Mr. Casey had undergone intelligence testing in the 2nd, 4th, and 6th grades with intellectual quotients in the high average range. Reportedly, academic achievement test scores were generally above the 65th percentile. Dr. Grace conducted intellectual testing with Mr. Casey earning a Full Scale I.Q. of 97, a Verbal I.Q. of 100, and a Performance I.Q. of 91. The test administered was the Wechsler Adult Intelligence Scale-III (WAIS-III). Dr. Grace opinioned that there was a significant discrepancy between Mr. Casey's early intellectual ability measures and the current I.Q. test results. Dr. Grace stated that the "only reasonable conclusion is that Mr. Casey has experienced a neurological event which has diminished his ability to process information and perform in a number of areas as effectively as he once did."

In interview, Mr. Casey reported that he continues with fatigue and "lack of motivation." He reported that he lost his job at Michelin approximately one year ago. This has resulted in financial stressors. He reported that he was an active employee at Michelin, performing 12-hour shifts. Mr. Casey also complained of a decreased capacity for attention and memory. As Mr. Casey stated, "I can't remember things." He provided examples of absentmindedness as well as making misjudgments that have resulted in accidents. There was also report of being socially withdrawn and isolated. Mr. Casey reported being avoidant of crowds, offering that he'd rather "stay at home and not be bothered." He acknowledged continuing back pain that pre-existed the medical incidents of May/June, 2004.

A structured symptom review failed to reveal any complaint by Mr. Casey with regard to sensory perceptual functions. Vision is corrected. There was no report of auditory acuity difficulties or tinnitus.

With regard to motor functioning, there was no report of paralysis or lateralized weakness. Mr. Casey reported continuing muscle spasms affecting the lower back. He denied coordination/balance problems. He reported occasional numbness affecting the hands and feet. There was report of paresthesias in the back region.

Mr. Casey reported that back pain is aggravated by physically exerting activities. He continues with episodic chest pain that is aggravated by exertional activities. Mr. Casey was not complaining of headache difficulties. There was report of occasional dizziness, but no report of vertigo, blackout spells, or seizures.

With regard to cognitive processes, Mr. Casey reported a decreased capacity for attention/concentration with an easy distractibility. He reported an inability to think as quickly as before (bradyphrenia). He also stated, "I know I am more forgetful."

With regard to psychological functioning, Mr. Casey acknowledged problems with sadness/depression, stating, "I don't have that much that is making me happy these days." There are episodic difficulties with sleep, though he did state that use of Ambien "definitely helps." He reported experiencing weird dreams, but denied disruptive nightmare activity. There is longstanding anxiety and fearfulness about heights. He reported being impatient and irritable with a lower ability to tolerate stress. Energy level was characterized as diminished. Clinical evaluation failed to reveal paranoid ideation or delusional thinking. Mr. Casey acknowledged considerable worry, particularly with regard to the future. There was no report of hallucinatory processes or evidence of psychotic symptomatology. Appetite was characterized as "variable." Libido was characterized as reduced with a lack of desire.

Mr. Casey reported a significant decline in his pursuit of social and recreational activities. This was particularly relevant to golf which he used to avidly pursue prior to his medical difficulties.

Mr. Casey reported current medications consist of Lipitor, Tricor, Mobic, Hydrocodone 10/500, Tramador 50 mg 2 tabs q.i.d., Cymbalta, and Ambien 10 mg as needed for sleep. There has also been use of Adderall XR 20 mg b.i.d. to assist with attention/focus. As of 9/10/05, Adderall had been discontinued.

Medical History: Mr. Casey denied previous head or neck injury. There is a history of back pain associated with two bulging discs and arthritis. He has undergone previous hemorrhoidectomy as well as hospitalization for evaluation of chest pain in 2000, undergoing cardiac catheterization.

Mr. Casey denied history of serious infections, allergies, diabetes, or hypertension.

Mr. Casey denied history of psychiatric illness or need for formal treatment. He denied having lifelong problems with his nerves, depression, or mood swings. He is a rare, occasional consumer of alcohol. He denied history of excessive alcohol usage. He does not utilize illicit drugs. There has been no history of formal substance abuse treatment.

Family History: Noncontributory for psychiatric illness and/or substance abuse problems. Family history is significant for diabetes in a mother and a heart attack in a father.

Psychosocial Review: Mr. Casey is a high school graduate. Reportedly, he was an active athlete while attending Dorman Senior High School in Spartanburg. He denied any repetition of grades or history of learning disabilities or Attention Deficit Disorder. Review of educational records confirmed him to be a high school graduate with a reported intellectual quotient of 113 attained in the 6th grade.

Mr. Casey reported that he was employed at the Michelin Company for over 20 years. His job title was manufacturing professional. He denied ever being in the military service. Mr. Casey attained a formal divorce from his wife after being married for 23 years. The couple were separated for several years before the divorce decree was attained in March of 2005. There are two biological children, a son, age 22, and a daughter, age 19.

Procedures: Wechsler Adult Intelligence Scale-III, Wechsler Memory Scale-III, California Verbal Learning Test-II, Stroop Test, Conner's Continuous Performance Test-II, Judgment of Line Orientation Test, Wisconsin Card Sorting Test, Trail Making Test, Controlled Oral Word Association Test, Paced Auditory Serial Addition Test, Seashore Rhythm Test, Speech Sounds Perception Test, Aphasia Screening Exam, Tactual Performance Test, Sensory Perceptual Examination, Finger Tapping Test, Grip Strength Test, Grooved Pegboard Test, Behavioral Dyscontrol Scale, Test of Memory Malingering, Word Memory Test, Personality Assessment Inventory, Ruff Neurobehavioral Inventory.

Examination Results

Neurobehavioral Status: Mr. Casey was on time for his scheduled appointments. He was appropriately attired with good personal hygiene. There was maintenance of appropriate eye contact. There was no evidence of psychomotor retardation or excitement. Mr. Casey was friendly and cooperative in his interactions with the examiner. There was no difficulty understanding instructional sets. He participated well in the evaluative process. He was observed to be somewhat fatigued following a lunch break. A second session was utilized to complete the evaluative process. Affect was mildly depressed, though psychological difficulties did not appear to interfere with his test performance. Specific assessment of effort was undertaken via administration of two symptom validity tests, the Test of Memory Malingering (TOMM) and Word Memory Test. Mr. Casey's performance on both of these tests was within stringent criteria consistent with our observation of providing good effort.

Language Functions: There was no aphasic or agnostic symptomatology. Mr. Casey's conversational speech was prosodic, fluent, of normal rate and tone with occasional slurring. There were no word finding difficulties in conversational speech. Mr. Casey's performance on a letter fluency test (T=45) was in the average range for an individual of his age and educational level. There was no evidence of receptive language dysfunction.

Sensory Perceptual/Motor Functions: Evaluation failed to reveal any evidence of imperceptions or suppressions affecting tactile or visual modalities during unilateral or bilateral stimulation paradigms. Mr. Casey demonstrated imperceptions and suppressions to left sided auditory stimulation. He performed efficiently on a tactile finger recognition test and made a few unsystematic errors on a Test of Graphesthesia. Mr. Casey had no difficulty recognizing gross tactile forms in each of his extremities.

Mr. Casey reports being right hand dominant. He ambulated without difficulty or need for assistance. He reported some residual low back pain that is aggravated by physically exerting activities. On a test demanding fine motor speed (Finger Tapping Test), he demonstrated bilateral slowness suggestive of moderate impairment. Assessment of grip strength revealed mild deviation from expected performance bilaterally. Mr. Casey's performance on a test demanding fine motor speed and dexterity (Grooved Pegboard Test) revealed deviation from expected performance bilaterally suggestive of mild impairment.

Attention/Memory Functioning: Mr. Casey was errorless in his performance on an extended test of information and orientation. On the Stroop Test, he demonstrated slowed and impaired processing speed for word (T=29) and color (T=35) stimuli. He remained mildly slow, but without added decrement in his performance on a divided attentional task (T=40). Mr. Casey's performance on an attentional task demanding discrimination of rhythmic sounds was below average (T=41) for an individual of his age and educational level. On an attentional task demanding discrimination of speech sounds and matching them to their phonemes (T=36), his performance was suggestive of mild impairment. Mr. Casey's performance on WAIS-III tasks assessing working memory placed him at the 25th percentile. Mr. Casey was also administered the Paced Auditory Serial Addition Test (PASAT), a measure of information processing speed and attentional regulation. Mr. Casey was able to meet the demands of this test. Observation of test performance revealed an average initial trial performance with mild decrements in his performance as the trials became more rapid and demanding. Mr. Casey's total recall score on the PASAT was within the average range (T=57) for an individual of his age and educational level.

Mr. Casey was also administered the Conner's Continuous Performance Test-II to further assess his attentional capacities. Observation of test performance revealed slow responding coupled with lots of errors which is a distinctively problematic pattern that cannot easily be explained by response style. Generally, this pattern is a strong indicator of an attention related deficit. Mr. Casey was generally erratic in his responding, indicative of poor attention capacity. He was also substantially affected by the interstimulus interval. Specifically, responses became slower and a lot more erratic when the interstimulus interval was slowed from one second to two and four seconds. The finding may reflect limitations in his ability to adjust to change in task demands.

Mr. Casey was administered the Wechsler Memory Scale-III (WMS-III) to assess different components of anterograde memory. Mr. Casey was variable in his performance across WMS-III tasks. Mr. Casey's performance on tasks assessing immediate auditory memory placed him at the 34th percentile. Mr. Casey was less efficient in his performance on WMS-III tasks assessing immediate visual memory (10th percentile). He demonstrated an adequate ability to retain auditory (30th percentile) and visual (50th percentile) information after a period of delay. Mr. Casey's performance on WMS-III tasks assessing working memory was in the low average range (21st percentile).

Analysis of separate WMS-III scale performance revealed Mr. Casey to have an average ability to immediately learn and recall orally presented narrative passages. Mr. Casey was below average in his performance on a visual memory task demanding free recall of family pictorial stimuli. He demonstrated a low average ability to retain and recall previously learned narrative passages after a period of delay (percent retention =81). Mr. Casey was deficient in his performance on a visual memory task involving the immediate learning and reproduction of visual designs (2nd percentile). He demonstrated an adequate ability to retain and reconstruct previously learned visual designs after a period of delay (percent retention =77).

Mr. Casey was also administered the California Verbal Learning Test-II (CVLT-II), a repetitive word list learning task. Mr. Casey's total recall score after five administrations of the word list placed him at the 50th percentile compared to age related peers. Observation of test performance revealed significant deficit in his initial trial performance consistent with difficulties with attentional capacities and immediate learning. Yet, Mr. Casey showed a good ability to profit from repetitive administrations, demonstrating a good learning curve. He demonstrated difficulties in his ability to retain and recall word list information in a short and long delay, free and cued recall process. Assessment of learning characteristics revealed heavy reliance on recall from the recency region of the word list. There were no excessive intrusive errors. Mr. Casey was generally efficient in his performance on a recognition task demanding that he discriminate target from non-target words, though he made six false positive errors. Mr. Casey performed efficiently on a long delay, forced choice recognition test consistent with our observation of providing good effort.

Visual Spatial/Visual Constructional Functions: There was no evidence of visual inattention or neglect processes. Nor was there evidence of constructional difficulties. Mr. Casey's performance on WAIS-III tasks assessing perceptual organizational skills placed him at the 63rd percentile. His performance was improved from that obtained in previous I.Q. testing conducted by Dr. Grace (47th percentile). On a test demanding fine discriminations of lines in space, Mr. Casey's performance was in the low average range (22nd percentile). On a visuographic sequencing test involving the serial processing of numbers, he was slow in the completion of the task (T=42) but without confusional error. When the task became more demanding, involving alternation between numbers and letters in sequential fashion, Mr. Casey's performance was within average limits (T=53).

Higher Reasoning/Problem Solving Abilities: Mr. Casey was able to inhibit and sequence fine motor movements on go-no go types of tasks. Mr. Casey performed efficiently on an executive functioning task involving letter fluency as well as being able to meet the set shifting skills associated with Trail Making Test-Part B.

Mr. Casey was re-administered the Wechsler Adult Intelligence Scale-III (WAIS-III) classifying his intellectual functioning to be in the average range with a Full Scale I.Q. of 96, a Verbal I.Q. of 91, and a Performance I.Q. of 104. Mr. Casey's Full Scale I.Q. places him at the 39th percentile. His performance was generally consistent with that obtained in previous evaluation conducted by Dr. Grace (FS I.Q.=97, V I.Q. =100, P I.Q. =104).

WAIS-III analysis revealed Mr. Casey to perform in the average range on tasks assessing perceptual organizational skills (63rd percentile). Mr. Casey was less efficient in his performance on WAIS-III tasks assessing verbal comprehension skills (32nd percentile). Mr. Casey's performance on tasks assessing working memory (25th percentile) was less efficient than that obtained in previous evaluation by Dr. Grace. Yet, Mr. Casey was more efficient with regard to his performance on processing speed tests (21st percentile) compared to that obtained by Dr. Grace (4th percentile).

Analysis of separate WAIS-III scale performance revealed significant strength on a task demanding attention to visual detail in the tangible environment (91st percentile).

Mr. Casey was administered the Wisconsin Card Sorting Test, which demands the ability to generate and discover the correct solution set as well as to shift the basis of one's responding when the externally imposed demands of the task necessitated this. Observation of test performance revealed Mr. Casey to readily identify the 1st correct hypothesis. Observation of test performance revealed that concentration difficulties interfered considerably with his effective problem solving abilities. Mr. Casey attained only four of the expected six categories but with an acceptable rate of perseverative errors (10%) and six failures to maintain set. The latter finding is consistent with disruption due to attention/concentration difficulties.

Mr. Casey was also administered the Tactual Performance Test (TPT) which demands keen kinesthetic/proprioceptive abilities as well as organizational/planning skills. Mr. Casey's initial dominant hand performance was above average (T=56). Yet, he demonstrated considerable difficulty profiting from this initial learning trial during his 2nd trial, non-dominant hand performance (T=36). Mr. Casey was improved in his 3rd trial, both hands performance (T=43). His incidental memory score (T=33) was suggestive of mild to moderate impairment. Yet, his location score (T=50) was in the average range.

Emotional/Mood State Functioning: Review of medical records revealed considerable concerns regarding Mr. Casey experiencing disruptive psychological difficulties as the result of his involvement in the medical incidents. There has been persistence of fatigue, agitation, and somatic symptomatology as well as concern regarding depression, anxiety, and posttraumatic stress.

In the current evaluation, Mr. Casey reported continuing difficulties with sadness/depression, sleep disturbance which is assisted by use of Ambien, irritability/impatience, and low energy level. He appears to be quite withdrawn and not engaging in social and recreational pursuits. There are additional environmental stressors including financial stress.

Mr. Casey was administered the Personality Assessment Inventory (PAI) to further assess his psychological functioning. Mr. Case's response set (validity scales) to the PAI indicated that he presented himself in an honest, straight forward fashion.

The obtained PAI clinical profile reveals an individual who is reporting significant unhappiness, moodiness, and tension. Mr. Casey's self esteem is quite low at this time, and he views himself as inafectional and powerless to change the direction of his life. The disruptions in his life have left him uncertain about his goals and priorities, and tense and pessimistic about what the future may hold. Mr. Casey reports difficulties in concentrating and making decisions.

Separate scale elevations reveal report of highly disruptive depression. Mr. Casey reports being severely depressed, discouraged, and withdrawn. He appears to be plagued by fears of worthlessness, hopelessness, and personal failure. There is also report of experiencing a discomforting level of anxiety and tension. He is socially isolated at this time and identifies few interpersonal relationships that he describes as being close and warm.

Consistent with ongoing disruptive somatic symptomatology, Mr. Casey reports concern about physical functioning and health matters. He sees his life as being highly compromised by his ongoing numerous and varied physical/health problems.

Mr. Casey reports experiencing recurrent episodes of anxiety associated with a traumatic experience in his life. He identifies the traumatic experience as being the medical incident.

Self concept appears to be quite harsh and negative at this time. Mr. Casey's interpersonal style is best characterized as being withdrawn and isolated at this time. He appears to be very uncomfortable in social situations at this time.

Mr. Casey also reported experiencing periodic and transient thoughts of self harm. He denied any specific suicidal plan. He does endorse being pessimistic and unhappy about his prospects for the future.

Overall, the PAI profile is consistent with an individual who is experiencing disruptive depression and anxiety in the context of ongoing somatic difficulties. There is report of associated neurocognitive difficulties as well as being quite socially withdrawn and isolated.

Mr. Casey also responded to the Ruff Neurobehavioral Inventory. The Ruff allows for an assessment of individuals in the domains of cognitive emotional and physical functioning as well as quality of life pre and post their involvement in a traumatic incident.

Mr. Casey's responses indicated that he did not believe he had any ongoing disruptions in the realms of cognitive, emotional, or physical functioning prior to his involvement in the medical incident.

Mr. Casey reported that post accident, he has experienced significant disruption in cognitive emotional, and physical realms of functioning as well as quality of life. In the cognitive domain, he identified significant disruption with regard to attention/concentration, executive functioning, and learning and memory.

In the emotional domain, Mr. Casey reported significant disruption with regard to anxiety, depression, posttraumatic stress, as well as anger and irritability.

In the physical realm, he reported significant disruption with regard to somatic symptomatology and pain. Mr. Casey also reported significant disruption of his ability to pursue vocational activities.

Summary/Integration: Mr. Casey is a 46-year-old Caucasian male referred for neuropsychological evaluation. Intellectual evaluation revealed Mr. Casey to be functioning in the average range of abilities. Neurocognitive evaluation revealed slowed mental/information processing speed with variability in Mr. Casey's attentional capacities. Assessment of memory functioning revealed difficulties with immediate learning/memory capacities but no compelling evidence of rapid forgetting (amnestic syndrome). Neuropsychological evaluation revealed Mr. Casey's primary impairments to be deficits in his speed of processing with difficulties sustaining attention/concentration, and reduced immediate learning capacities. There was no compelling evidence for impairment specifically affecting visual spatial skills, receptive or expressive language functions, or higher reasoning capacities. Assessment of sensory perceptual functioning revealed imperceptions and suppressions affecting left sided auditory processes. Motor functioning was characterized by slowness and weakness.

Assessment of emotional functioning revealed continuing difficulties with depression, fatigue/low energy level, anxiety/stress, social withdrawal/isolation, and disruptive pain and somatic symptomatology. Mr. Casey has not efficaciously responded to psychological/psychiatric treatment. This suggests the potential that difficulties/impairments are at least partially attributable to organic injury.

Overall, Mr. Casey's presentation is one of neurocognitive deficits that would be consistent with a subcortical injury. Dr. Fogerty provided rationale for the potential that Mr. Casey may well have a permanent neurological deficit. Pain symptomatology, depression, sleep disturbance, and fatigue could also be contributing to his experience of neurocognitive impairments. Mr. Casey's current neurocognitive and emotional/behavioral deficits are likely due to a multifactorial etiology. What is evident is that Mr. Casey has remained highly compromised with regard to cognitive, emotional, and physical functioning, rendering him unable to return to employment pursuits.

Based on The Diagnostic and Statistical Manual of Mental Disorders-4th Edition-TR (DSM-IV-TR), the following multiaxial assessment is provided:

Axis I	Mood Disorder with depressed mood (293.83) secondary to persistent somatic symptomatology and potential permanent neurological deficit due to complication of laser bronchoscopy. Cognitive Disorder, NOS (294.90) due to the interfering effects of somatic symptomatology, mood disturbance, sleep disturbance/fatigue, and potential permanent neurological deficit due to complications of laser bronchoscopy.
Axis II	No diagnosis (V71.09).
Axis III	Pain/somatic symptomatology; motor weakness; residual back pain; episodic chest pain; status post laser bronchoscopy complicated by pneumomedistnum and pneumothorax.
Axis IV	Marital separation/divorce; disability/unemployment; Workers' Compensation litigation.
Axis V	GAF=50 (Current).

Thank you for allowing me to participate in the evaluative care of Mr. William Mark Casey. If you have any questions regarding the evaluation or report, please do not hesitate to call me.

L. R. Waid Ph.D

L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist
Clinical Associate Professor in Psychiatry/Neurology, MUSC

LRW/emf

1/10/06
WM

Joseph G. Grace III, Ph.D.
Licensed Counseling Psychologist
853 N. Church Street, Suite 510
Spartanburg, South Carolina 29303
(864) 560-1512

INTELLECTUAL ASSESSMENT

NAME:	William Mark Casey
AGE:	45
DATE OF BIRTH:	[redacted]/58
SS #:	[redacted]
EDUCATION:	Completed a year of college
OCCUPATION:	Disabled (Formerly a production worker with Michelin Tire Co.)
MARITAL STATUS:	Separated

COMPONENTS OF THE ASSESSMENT:

Spartanburg County School District #6 cumulative academic records of Mark Casey (10/17/66 – 06/08/77)
Wechsler Adult Intelligence Scale – 3rd Edition (WAIS-III) (06/02/05)

REVIEW OF MARK CASEY'S ACADEMIC RECORDS:

Mark Casey was administered three intelligence tests (readiness level ability testing) in the 2nd, 4th, and 6th grades. In the 2nd grade Mr. Casey earned an IQ score of 107 (67th percentile), in the 4th grade he earned an IQ score 115 (84th percentile), and in the 6th grade he earned an IQ score of 113 (81st percentile). Further, his achievement test scores from 2nd grade (1966) through 10th grade (1975) range from highs of 99th percentile to a low of 17th percentile with the vast majority of scores being above the 65th percentile. Also, Mr. Casey's Dorman Senior High School transcript reflects a well-rounded student who was a versatile athlete.

BEHAVIORAL OBSERVATIONS OF MARK CASEY FROM RECENT IQ TESTING:

Mr. Casey was administered the WAIS-III on 06/02/05. He appeared to make a conscientious effort throughout the thirteen test sections, but became frustrated and even dejected on Subtests in which he performed below his own expectations. Also, Mr. Casey exhibited lapses in concentration and memory, particularly on Subtests requiring abstract reasoning.

ANALYSIS OF TEST DATA:

Mark Casey earned a Full Scale IQ score of 97 (42nd percentile) on the Wechsler Adult Intelligence Scale – 3rd Edition. He earned a Verbal IQ score of 100 (50th percentile) and a Performance IQ score of 91 (27th percentile). These scores fall within the lower half of the "average" range of intellectual functioning (90 – 109). His Working Memory Index score of 106 (66th percentile) is his highest, while his Processing Speed Index score of 73 (4th percentile) is his lowest. Mr. Casey earned a Verbal Comprehension Index score of 100 (50th percentile) and a Perceptual Organization Index score of 99 (47th percentile). His Subtest scaled scores are as follows:

Verbal Subtests		Performance Subtests	
Vocabulary	11	Picture Completion	10
Similarities	10	Digital Symbol – Coding	4
Arithmetic	10	Block Design	9
Digit Span	11	Matrix Reasoning	11
Information	9	Picture Arrangement	10
Comprehension	10	Symbol Search	6
Letter–Number Sequencing	12		

The mean score for all Wechsler Subtests is 10 with a normal range of 8-12. Thus, Mr. Casey's scores on the two Processing Speed Index Subtests of Digit Symbol – Coding (4) and Symbol Search (6) are far below the normal range. These two Subtests are measures of visual perception analysis (ability to ascribe meaning to symbols, identify and discriminate between symbols); short-term visual memory; and visual-motor dexterity, speed and accuracy.

SUMMARY:

A review of Mr. Mark Casey's school records reveal that he was administered three IQ tests between the ages of about 7 and 12 years old. The average of these three ability measures is about 112 which placed him at the 79th percentile intellectually. Also, the vast majority of his achievement test scores between the 2nd and 11th grades are at or above the 65th percentile. However, Mr. Casey obtained a Full Scale IQ score of 97 (42nd percentile) on intellectual testing administered in June 2005. Further, he earned very deficient scores on Subtests involving processing speed (visual perception analysis; short-term visual memory; and visual-motor dexterity, speed and accuracy). IQ/intellectual

ability scores by test design remain unchanged over the course of one's lifetime except in the event of neurological disease or brain injury. Since there is a significant discrepancy between Mr. Casey's early intellectual ability measures and current IQ test results, the only reasonable conclusion is that he has experienced a neurological event which has diminished his ability to process information and perform in a number of areas as effectively as he once did.

Joseph G. Grace, III, Ph.D.
Licensed Counseling Psychologist
S. C. License # 278
June 17, 2005

1/10/06
WK

GUNN 004150

S: TANBURG REGIONAL MEDICAL C TER
Radiology Report

NAME: CASEY,WILLIAM
ORDERING PHYSICIAN: FOGARTY,CHARLES_M
OC: OPT
t. Type:OPT
DOB: [redacted]/58
UNIT #: 000146220
CI#: 1480551
AN#:S0520101451

Exam
50041 XR G I SERIES
74246
Date: 07/28/05 0836
Ord Diag: 787.03-VOMITING ALONE

Double-contrast upper GI, 7/28/2005

Indication: Several week history of nausea and vomiting

Findings: Under fluoroscopy the patient shows normal swallowing and esophageal motility. The esophagus distends normally. Note is made only of a single small distal esophageal mucosal cleft or diverticulum, this is only a few millimeters in size. With Valsalva no hiatal hernia is seen. During assessment of the stomach several episodes of mild reflux into the distal esophagus were seen.

The stomach distends normally with no abnormal mass or impression and no mucosal irregularity. The duodenal bulb is somewhat irregular, I do not see a discrete ulcer but this could be deformed from peptic ulcer disease. Contrast does freely progress through this into the duodenum. In the third portion of the duodenum there are 2 diverticula adjacent to one another. One is relatively prominent in size, equal to that of the duodenal bulb. No retained material is seen within these and contrast freely progresses through this to the proximal small bowel.

Impression: Small mucosal cleft or diverticulum noted in the distal esophagus. This is probably a normal variant although could represent focal change of mild esophagitis. A few episodes a very mild GE reflux were seen during this study.

2. Duodenal bulb somewhat deformed although no discrete ulcers seen. This could be change from peptic ulcer disease but there is no evidence of stricturing, contrast freely progresses into the proximal small bowel on this study.

2. 2 duodenal diverticula in the third portion of the duodenum, one of these is a giant diverticulum equal in size the duodenal bulb. They

FINAL

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: CASEY,WILLIAM
ORDERING PHYSICIAN: FOGARTY,CHARLES M
LOC: OPT
Pt. Type:OPT
DOB: [redacted]/58

UNIT #: 000146220
CI#: 1480551
AN#:S0520101451

Checkin-Exam Code Summary
1480551-50041

otherwise appear unremarkable on this exam and are not likely of clinical significance.

Read By: William T JoyceMD
Released By: William T JoyceMD

n

FINAL

Page 2

GUNN 004152

#77168
DOLV 7-21-05 no Appt.

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report
ACR Accredited Facility for Ultrasound

NAME: CASEY,WILLIAM
ORDERING PHYSICIAN: FOGARTY,CHARLES M
LOC: OPT
Pt. Type:OPT
DOB: [redacted]/58
UNIT #: 000146220
CI#: 1480525
AN#:S0520101451

Exam
80073 US GALLBLADDER
76705
Date: 07/28/05 0812
Ord Diag: 787.03-VOMITING ALONE

Sonogram of the gallbladder. 7/28/2005.

History: Epigastric pain with nausea.

Findings: Gallbladder is fluid filled. No stones are seen. Common duct is 5 mm which is normal. Pancreas and liver are unremarkable.

Conclusion: Negative sonogram of the gallbladder.

Read By: John HarrillMD
Released By: John HarrillMD

FINAL

GUNN 004153

DISCHARGE SUMMARY
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 414900306
ADMISSION DATE: 05/28/2004 DISCHARGE DATE: 05/29/2004
ATTENDING PHYSICIAN: KOSER, ANDRAS

PRESENTATION AND HOSPITAL COURSE: This 45-year-old Caucasian male with a history of elevated cholesterol, history of herniated disc, history of arthritis, who apparently has been having vague chest discomfort every time when he goes to work. The patient came in because of tightness that went straight to the back according to the emergency room physician; however, upon the workup the patient was found to have a left main bronchus containing some foreign body that was metallic in nature. It looks like a screw. It could have been dental filling. The patient was seen in consultation with Dr. Feldman who asked Dr. Boscia to do fiberoptic bronchoscopy and take a look inside and see if he can get it out. Apparently the area was quite difficult to get to. Some bleeding was visualized on the left main bronchus and then tried to dig it out but couldn't find any piece of metal and, hence, he did not do it. The patient was to undergo rigid bronchoscopy a week or two weeks later in Dr. Feldman's office. We feel at this time that the patient does not need any further inpatient stay.

DISCHARGE DIAGNOSES:
1. Noncardiac chest pain.
2. Metallic foreign body in the left main bronchus.
3. Elevated cholesterol.
4. White coat hypertension.

DISCHARGE MEDICATIONS:
1. Lipitor 10 mg p.o. q.d.

DISCHARGE DISPOSITION: The patient is going home.

FOLLOW UP: The patient will follow up with Dr. Gonda in one week.

DICTATED BY: RAJA PALADUGU, M.D.
D:05/29/2004 14:35:42
T:06/03/2004 08:31:40/bt
65743/64000

cc:
ANDRAS KOSER, M.D., Admitting Physician

%%END
Authenticated by Raja Paladugu, M.D. On 6/03/04 3:37:13 PM

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

CONSULT Page 1 of 2
CASEY, WILLIAM
146220

Note: Document is draft unless signed.
<END FOOTER>

CONSULT
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 414900306
DATE OF SERVICE:
ATTENDING PHYSICIAN: KOSER, ANDRAS
ROOM:

HISTORY OF PRESENT ILLNESS: This 46-year-old smoking male presented to the hospital for chest pain. An initial chest x-ray on admission showed what appears to be a foreign body in the left mainstem bronchus. I am being asked to comment on this. This patient complains of pain in his chest that is sharp that goes directly straight to his back. There is a history of cough. No history of hemoptysis.

PAST MEDICAL HISTORY: includes hypercholesterolemia. No history of hypertension or diabetes.

SOCIAL HISTORY: He has a 25 pack year smoking history. He works at Michelin.

FAMILY HISTORY: Is noncontributory.

REVIEW OF SYSTEMS: Includes all mentioned in history of present illness. Also, he has chronic back pain, occasional headaches, occasional constipation. All other review of systems are negative.

PHYSICAL EXAMINATION: He appears well in no acute respiratory distress. Blood pressure is 150/90, pulse is 84. Pupils react to light. The oral mucosa is moist without thrush. Neck is supple. Heart is regular. Lungs are clear bilaterally. Abdominal exam reveal no hepatosplenomegaly. Extremities are without clubbing, cyanosis or edema. Skin is intact with no rashes. Joints are not inflamed. Neurologically, cranial nerves II through XII are intact without focality.

Chest x-rays been reviewed in it does show what appears to be an irregular metallic foreign body in the left mainstem bronchus.

IN SUMMARY: 46-year-old gentleman with what appears to be a foreign body in the left mainstem bronchus. He has consented to fiber-optic bronchoscopy which would be the

most reasonable next step. Will perform fiber-optic bronchoscopy to see if this foreign body is removable. If it is not removable or granulated in, than rigid bronchoscopy in the operating room will be performed. Risks, benefits, and alternatives were discussed with Mr. Casey and he agrees to proceed with bronchoscopy.

DICTATED BY: JOSEPH A BOSCIA III, M.D.
D:05/28/2004 14:26:33
T:06/03/2004 11:25:39/lb
65506/64110

cc:
ANDRAS KOSER, M.D., Admitting Physician

%%END
Authenticated by Joseph A. Boscia, MD. On 6/07/04 5:08:48 PM

S RTANBURG REGIONAL MEDICAL ( )TER
Radiology Report

NAME: CASEY,WILLIAM
ORDERING PHYSICIAN: KOSER,ANDRAS
LOC: 4W-434-A
t. Type:IP

DOB: [redacted]/58

UNIT #: 000146220
CI#: 1216733
AN#:S0414900306

Exam
60220 CT LUNG WITHOUT CONTRAST Date: 05/28/04 1805
71250 Ord Diag: Chest Pain NOS 786.50

Chest CT scan 5/28/2004.

Indication: Evaluate for possible foreign body. Patient works in construction and apparently on a chest x-ray had a metallic foreign body.

The chest x-ray cannot be located for comparison. Spiral images were obtained through the chest without contrast. There are no metallic foreign bodies evident other than snaps and monitoring leads on the patient's skin. The lungs are free of nodules and infiltrates. There is left anterior descending coronary artery calcification. No other abnormalities are evident of the noncontrasted mediastinum.

Impression:

1. Negative for opaque foreign body.

2. Left anterior descending coronary artery calcification.

Read By: Peter Ryan, M.D.
Released By: Peter Ryan, M.D.

LMB

FINAL

GUNN 004157

ID#:146220
45 years Male Caucasian
Ord.Dr.HILL
Tech:KB
OPT. Priority:STAT
DX:V82.9
ACC#:0414900306

ER
Time:09.44.50 05/28/04
SPARTANBURG REG.MED.CENT.

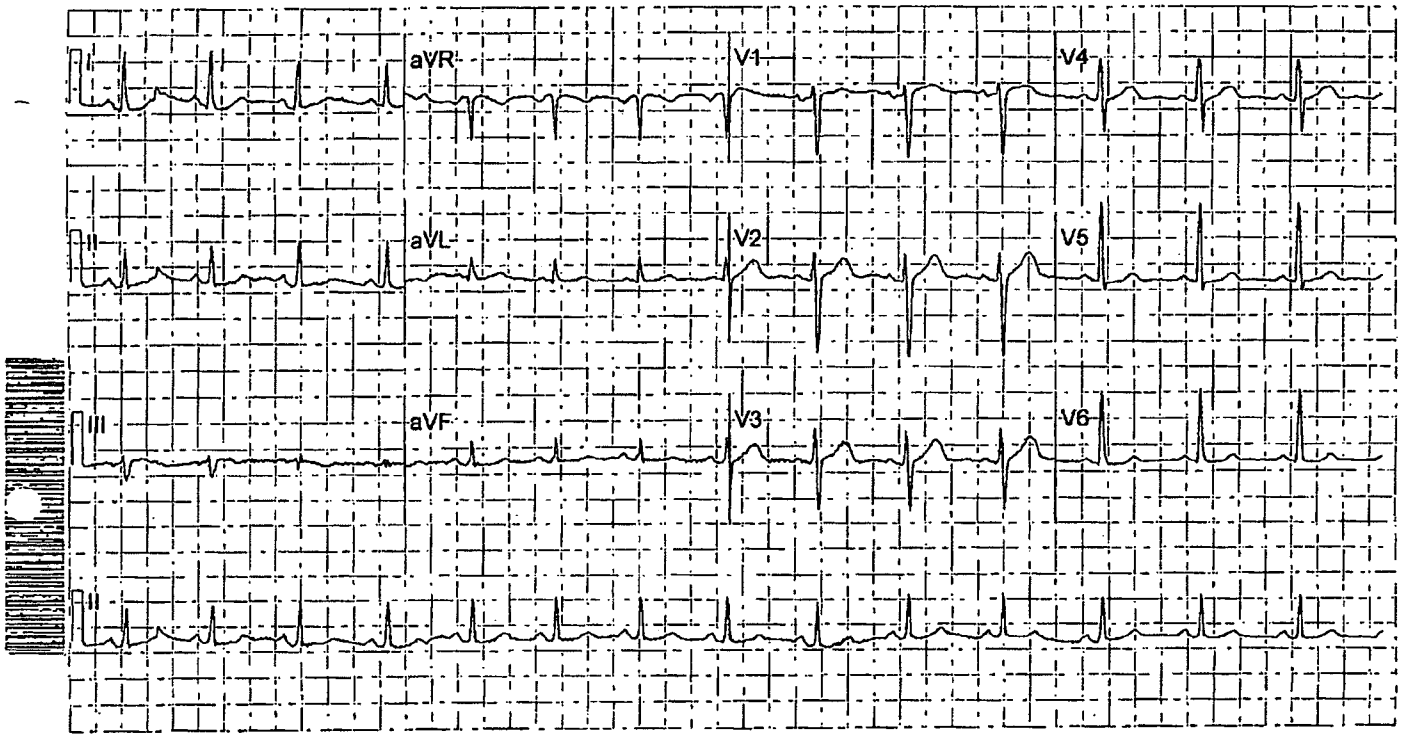
--Durations--
P : 100
QRS: 80
--Intervals--
PR : 134
QT . 356
QTc: 401
QTd: 24
--Axes--
P : 45
QRS: 29
T : 32

Lateral ST-T changes are nonspecific

Borderline ECG

Reviewed by: Dr. Tom Robinson

Speed: 25 mm/s Limb Lead Gain: 10.0 mm/mV Chest Lead Gain: 10.0 mm/mV Filter(s): 60Hz Notch, 40Hz Artifact



CONFIRM Current ECG Printed 05/29/04 11.52.41 Transcribed By: Dr. Tom Robinson 05/29/04 11.52.36
PLUS1 PLUS11.93/3.19/16.11/1.64

Page 1 of 1

4463

GUNN 004158

DISCHARGE SUMMARY
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 415400048
ADMISSION DATE: 06/03/2004 DISCHARGE DATE: 06/06/2004
ATTENDING PHYSICIAN: FELDMAN, GREGORY

FINAL DIAGNOSES:
1. Status post recent bronchoscopy with laser for abnormal appearing airway, on flexible bronchoscopy suspected foreign body.
2. Complication of the procedure was pneumomediastinum and pneumothorax requiring chest tube insertion by Dr. Nguyenduy.
3. Asthma and heavy smoking.
4. Disabling back pain with a bulging disk and arthritis, long.

PLAN: The patient is discharged home on prednisone 20 mg q.d., Percocet 1-2 pills t.i.d. p.r.n. The patient will be seen in my office within a week. Diet and activity as tolerated.

HOSPITAL COURSE: This is a patient who underwent initial bronchoscopy by Dr. Boscia with finding of a quite irritated, blistered airway. Corresponding chest x-ray appeared to be missing dental material. The patient underwent bronchoscopy for assumption of airway caused by retained foreign body. It appeared to be that there was granulation tissue; however, after laser was applied it became apparent that instead of a normal airway, it is a pouch and procedure terminated with no foreign body recovered. The patient tolerated the procedure well; however, in recovery the patient suddenly developed subacute emphysema and x-ray revealed pneumomediastinum with pneumothorax on the left side. A small chest tube was inserted. The patient was kept on the respiratory overnight. His subcu air has subsided remarkably. The patient felt much, much improved. He was extubated and transferred to the floor. Repeat chest x-ray showed pneumothoraces on both right and left but unchanged in size and small at the time of discharge. The patient felt good with no complaints and was discharged home. We will assess in my office within the next two days. The patient has been instructed if he develops fever or increased subcu air or shortness of breath immediately to come back to see me.

DICTATED BY: GREGORY FELDMAN, M.D.
D:06/07/2004 09:28:57
T:06/11/2004 08:24:49/bt
68523/67665

cc:
TUAN NGUYENDUY, M.D., Consulting Physician

%%END
Authenticated by Gregory Feldman, M. D. On 6/19/04 10:26:38 AM

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

CONSULT

PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 414900306
DATE OF SERVICE:
ATTENDING PHYSICIAN: KOSER, ANDRAS
ROOM:

HISTORY OF PRESENT ILLNESS: This 46-year-old smoking male presented to the hospital for chest pain. An initial chest x-ray on admission showed what appears to be a foreign body in the left mainstem bronchus. I am being asked to comment on this. This patient complains of pain in his chest that is sharp that goes directly straight to his back. There is a history of cough. No history of hemoptysis.

PAST MEDICAL HISTORY: includes hypercholesterolemia. No history of hypertension or diabetes.

SOCIAL HISTORY: He has a 25 pack year smoking history. He works at Michelin.

FAMILY HISTORY: Is noncontributory.

REVIEW OF SYSTEMS: Includes all mentioned in history of present illness. Also, he has chronic back pain, occasional headaches, occasional constipation. All other review of systems are negative.

PHYSICAL EXAMINATION: He appears well in no acute respiratory distress. Blood pressure is 150/90, pulse is 84. Pupils react to light. The oral mucosa is moist without thrush. Neck is supple. Heart is regular. Lungs are clear bilaterally. Abdominal exam reveal no hepatosplenomegaly. Extremities are without clubbing, cyanosis or edema. Skin is intact with no rashes. Joints are not inflamed. Neurologically, cranial nerves II through XII are intact without focality.

Chest x-rays been reviewed in it does show what appears to be an irregular metallic foreign body in the left mainstem bronchus.

IN SUMMARY: 46-year-old gentleman with what appears to be a foreign body in the left mainstem bronchus. He has consented to fiber-optic bronchoscopy which would be the most reasonable next step. Will perform fiber-optic bronchoscopy to see if this foreign body is removable. If it is not removable or granulated in, than rigid bronchoscopy in the operating room

Note: Document is draft unless signed.

will be performed. Risks, benefits, and alternatives were discussed with Mr. Casey and he agrees to proceed with bronchoscopy.

DICTATED BY: JOSEPH A BOSCIA III, M.D.
D:05/28/2004 14:26:33
T:06/03/2004 11:25:39/lb
65506/64110

cc: ANDRAS KOSER, M.D., Admitting Physician

2 cc
CSIL

D
Rigid
Bronchoscopy

procedure/
risks explained
(See Throat
Bleeding
precautions/

Note: Document is draft unless signed.

OP REPORTS
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
PROCEDURE DATE: 6/3/04
ACCOUNT NUMBER: 415400048
ROOM: ICU

PROCEDURE PERFORMED: Rigid bronchoscopy with laser bronch.

ENDOSCOPIST: Dr. Feldman.

INDICATIONS FOR PROCEDURE: 45 year old had been worked up by Dr. Paladugu and my partner, Dr. Boscia, with the finding of abnormal granulation tissue and abnormal subsegment in the left upper lobe corresponding to what appeared to be a crown foreign body on chest x-ray. The patient is now undergoing procedure in attempt to removal of chest x-ray abnormality suggestive of a crown; the patient does have a history of a missing crown.

After general anesthesia was induced, the patient was intubated with a rigid bronchoscope, size 16, without any difficulty. Careful inspection of the tracheobronchial tree was undertaken. The entire tracheobronchial tree was examined, there was no finding of a foreign body, however, a quite abnormal subsegment in the left upper lobe which appeared to be a pouch/granulation tissue has been identified. Laser of the area has been done with 45 watts over a 2-second period. Granulation tissue has been vaporized with the appearance of what appeared to be crown lying on the surface. With using 35 watts energy of the laser, there was no possibility of removal of the crown because it was deeply imbedded, and laser energy was applied to the center of the crown and it has been vaporized. However, below the surface there has been no further foreign body seen. The assumption was made that the entire crown other than on the surface had been vaporized, and attempt to pull it with a biopsy forceps and passage of the basket was unsuccessful. The washings were done of the area, and the procedure was terminated. The patient was extubated in recovery.

Although the patient did quite well during the procedure, he suddenly developed considerable pneumomediastinum and having immediately arrived to the bedside, Dr. Nguyenduy's consultation has been obtained. The decision was done by Dr. Nguyenduy and myself to place a chest tube, because of the impossibility to rule out pneumothorax, however, chest x-ray does not show pneumothorax, there is no foreign body seen, and also endotracheal tube is in good position. The patient was intubated by Anesthesia prior to that.

IMPRESSION: It is unclear to me at this point whether the laser went through the cartilage, and since I have not identified or pulled the crown itself, if in fact there was a crown it has been vaporized and is no longer seen on x-ray. At this point the patient will transfer to the ICU,

antibiotics will be administered for disruption of the bronchus and pneumomediastinum. This will be followed by CT surgery and certainly if air leak into the pneumomediastinum would not stop, surgical intervention will be required. Hopefully this can be avoided by conservative management, but it is uncertain to me at this time whether the crown was vaporized or essentially the laser went through the highly abnormal area of the lung suggestive of closed congenital pouch rather than a foreign body, and significant irritation from previous bronchoscopy.

DICTATED BY: GREGORY FELDMAN, M.D.

D:06/03/2004 16:02:26
T:06/03/2004 16:44:07/lb
67504/64298

cc:

Note: Document is draft unless signed.<END FOOTER>

%%END
Authenticated by Gregory Feldman, M. D. On 6/04/04 2:35:35 PM

S RTANBURG REGIONAL MEDICAL NTER
Radiology Report

NAME: CASEY,WILLIAM
ORDERING PHYSICIAN: FELDMAN,GREGORY
OC: DIS
t. Type:IP

UNIT #: 000146220
CI#: 1221417
DOB: [redacted]/58
AN#:S0415400048

Exam
50342 XR CHEST PA AND LATERAL Date: 06/06/04 1248
71020 Ord Diag: Foreign Body In Larynx 933.1

PA and lateral chest

June 6, 2004

Comparison: Previous day

Findings: Bilateral pneumothoraces again seen and appear unchanged from yesterday. Subsegmental atelectasis is noted in the lung bases. Subcutaneous air is noted in the neck.

Impression: Bilateral pneumothoraces appear similar in size compared to the previous day.

Read By: Joseph Kavanagh, M.D.
Released By: Joseph Kavanagh, M.D.

EH

FINAL

GUNN 004165

SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
DRS. DAVIS, LOWRY, WREN, NELSON, RAINER, LAPHAM, MIMS, CALDWELL \T\ BURKS

CASEY WILLIAM MR#: (0002)00014-62-20 Fin.No.:0421101061 Admitted: 29JUL04
45 YRS MALE DOB: [redacted]/1958 Office Id: Page: 1
Dr. SMITH WILSON P CUMULATIVE Printed: 03AUG04
Location: - PRIVATE OUT PT VISIT ANEMIA NOS 2027

C H E M I S T R Y

----------REFERENCE LAB TESTS----------

Procedure:	TIBC @	IRON @	% SATURATION @	
Units:	ug/dL	ug/dL	%	
^^JUL04 1340	434 Hf	87 f	20 f	
.....				Reference Range: 250-400
IRON.....				Reference Range: 40-190

TIBC should be ordered with iron for optimal utility.

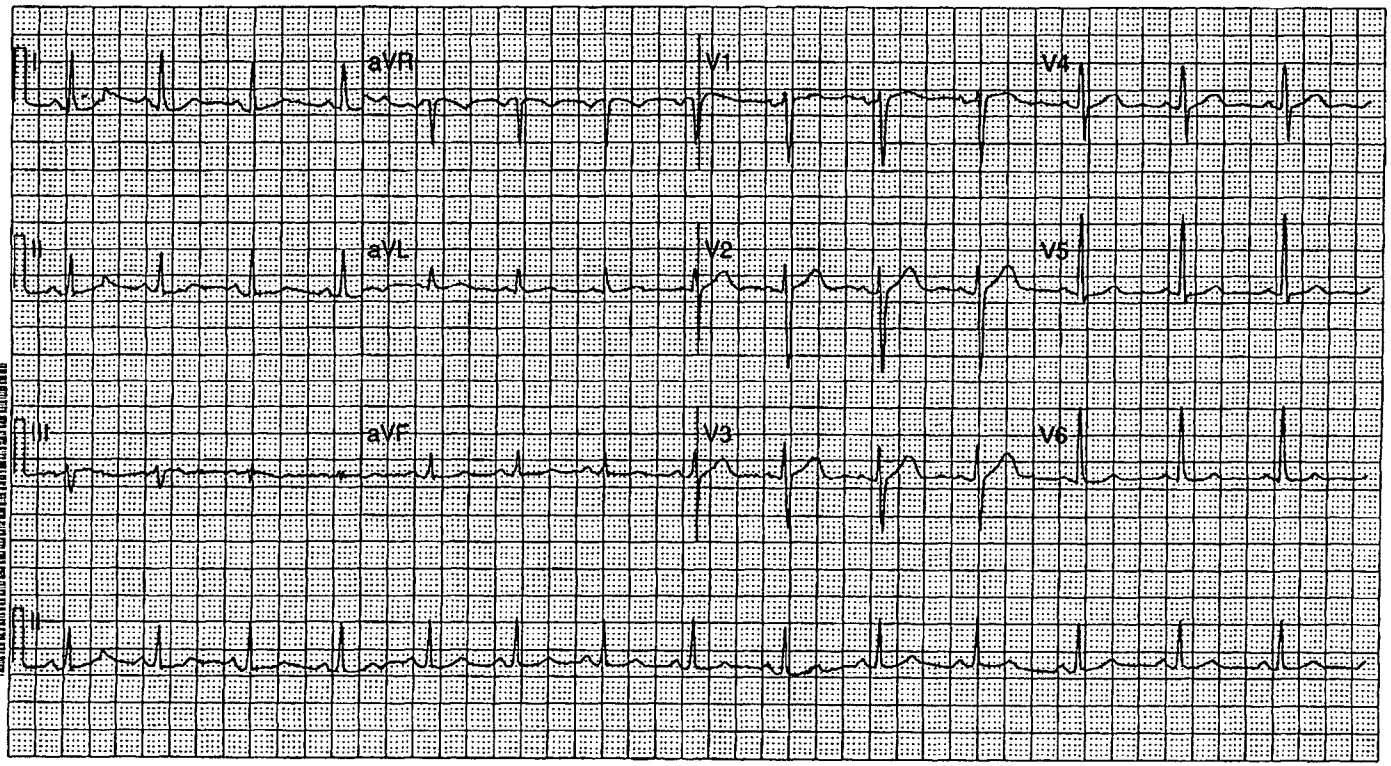
% SATURATION.. Reference Range: 15-50

GUNN 004166

4472

CADE: ,WILLIAM	Vent rate: 87	Sinus rhythm
ID#:146220		Lateral ST-T changes are nonspecific
45 years Male Caucasian	--Durations--	
Ord.Dr.HILL	P : 100	Borderline ECG
Tech:KB	QRS: 80	
OPT: Priority:STAT	--Intervals--	
DX:V82.9	PR : 134	
ACC#:0414900306	QT : 356	
	QTc: 401	
	QTd: 24	
ER	--Axes--	
Time:09.44.50 05/28/04	P : 45	
SPARTANBURG REG.MED.CENT.	QRS: 29	Reviewed by: Dr. Tom Robinson
	T : 32	

Speed: 25 mm/s Limb Lead Gain: 10.0 mm/mV Chest Lead Gain: 10.0 mm/mV Filter(s): 60Hz Notch, 40Hz Artifact



RETRIEVE Current ECG Printed 06/03/04 10.08.02 Transcribed By: Dr. Tom Robinson 05/29/04 11.52.36
PLUS1 PLUS11.93/ 1/16.11/1.64

GUNN 004167

Casey, William M. [redacted]/1958
Office/Outpatient Visit
Visit Date: Tue, Jul 12, 2005 10:31 am
Provider: Jeffrey Smith, MD, M.D. (Supervisor: Jeffrey Smith, MD, M.D.)
Location: Piedmont Psychiatric Services

This note has not been signed and may be incomplete. Printed on 08/16/2005 at 10:31 am.

SUBJECTIVE:

HPI:

"Maybe slight improvement" in memory and concentration. No s.e. to Adderall XR. Mood is pretty good. No s.i. Interest and motivation seem to be lagging more than he has previously indicated.

OBJECTIVE:

Exams:

Affect is euthymic. No s.i.

ASSESSMENT:

296.22 Major depression, single episode, moderate

PLAN:

Cont. Cymbalta 60 mg two qam.

Stop Adderall.

Add Strattera 40 mg one qam for seven days, then increase two qam. # 63 samples.

Cont. Ambien 10 mg one or two qhs. prn insomnia.

Ret. in 4 wks.

cc: Joseph Grace, PhD

Major depression, single episode, moderate

Orders:
90862 Pharmacologic management with no more than minimal medical psychotherapy

Casey, William M. [redacted]/1958
Office/Outpatient Visit
Visit Date: Mon, Jun 13, 2005 10:47 am
Provider: Jeffrey Smith, MD, M.D. (Supervisor: Jeffrey Smith, MD, M.D.)
Location: Piedmont Psychiatric Services

This note has not been signed and may be incomplete. Printed on 08/16/2005 at 10:31 am.

SUBJECTIVE:

HPI:

The depression is still pretty well controlled.

The Concerta has not helped with memory, concentration, or ability to focus. He tried taking 72 mg for two days and it did not help.

No s.i.

OBJECTIVE:

Exams:

Affect is euthymic.

ASSESSMENT:

296.22 Major depression, single episode, moderate

PLAN:

Cont. Cymbalta 60 mg two qam.

Stop Concerta.

Add Adderall XR 20 mg two qam.

Cont. Ambien 10 mg one or two qhs prn insomnia.

Ret. in 4 wks.

Major depression, single episode, moderate

Orders:
90862 Pharmacologic management with no more than minimal medical psychotherapy

Casey, William M. [redacted]/1958
Office/Outpatient Visit
Visit Date: Mon, May 16, 2005 10:26 am
Provider: Jeffrey Smith, MD, M.D. (Supervisor: Jeffrey Smith, MD, M.D.)
Location: Piedmont Psychiatric Services

This note has not been signed and may be incomplete. Printed on 08/16/2005 at 10:31 am.

SUBJECTIVE:

HPI:

He feels that depression and anxiety are well controlled. No medication s.e.

Memory is not good and concentration is poor. Has difficulty focusing on tasks.

OBJECTIVE:

Exams:

Affect is euthymic. No s.i.

ASSESSMENT:

296.22 Major depression, single episode, moderate

PLAN:

Cont. Cymbalta 60 mg two qam.

Cont. Ambien 10 mg one or two qhs prn insomnia.

Add Concerta 36 mg one qam.

Ret. in 4 wks.

Major depression, single episode, moderate

Orders:
90862 Pharmacologic management with no more than minimal medical psychotherapy

Casey, William M. [redacted] 1958
Office/Outpatient Visit
Visit Date: Mon, Mar 14, 2005 10:56 am
Provider: Jeffrey Smith, MD, M.D. (Supervisor: Jeffrey Smith, MD, M.D.)
Location: Piedmont Psychiatric Services

This note has not been signed and may be incomplete. Printed on 08/16/2005 at 10:32 am.

SUBJECTIVE:

HPI:

"I believe it is definitely doing me good." "Less tense and less agitated." He thinks additional Cymbalta has really improved anxiety and depression. Stressors are about the same.

Some memory problems--he wonders if this is stress related or related to the Cymbalta.

OBJECTIVE:

Exams:
Affect is bright and relaxed.

ASSESSMENT:

296.22 Major depression, single episode, moderate

PLAN:

Cont. Cymbalta 60 mg two qam.

Cont. Ambien 10 mg one or two qhs prn insomnia.

Ret. in 8 wks.

Monitor memory--if does not improve, consider changing Cymbalta or adding a stimulant or Aricept.

Major depression, single episode, moderate

Orders:
90862 Pharmacologic management with no more than minimal medical psychotherapy

Casey, William M. [redacted]/1958
Office/Outpatient Visit
Visit Date: Mon, Jan 17, 2005 10:17 am
Provider: Jeffrey Smith, MD, M.D. (Supervisor: Jeffrey Smith, MD, M.D.)
Location: Piedmont Psychiatric Services

This note has not been signed and may be incomplete. Printed on 08/16/2005 at 10:32 am.

SUBJECTIVE:

HPI:

"Some really good days." But, room for improvement in mood. No medicaiton s.e. No s.i.

OBJECTIVE:

Exams:

Affect is still down.

ASSESSMENT:

296.22 Major depression, single episode, moderate

PLAN:

Increase Cymbalta 60 mg two qam.

Cont. Ambien 10 mg one or two qhs pm insomnia.

Ret. in 4 wks.

Major depression, single episode, moderate

Orders:
90862 Pharmacologic management with no more than minimal medical psychotherapy

Casey, William M. [redacted]/1958
Office/Outpatient Visit
Visit Date: Wed, Dec 15, 2004 10:14 am
Provider: Jeffrey Smith, MD, M.D. (Supervisor: Jeffrey Smith, MD, M.D.)
Location: Piedmont Psychiatric Services

This note has not been signed and may be incomplete. Printed on 08/16/2005 at 10:32 am.

SUBJECTIVE:

HPI:

Over the past 10 days, he is feeling better with more motivation and interest. No medication s.e. now–had some early nausea. Sleep is good on 20 mg Ambien.

OBJECTIVE:

Exams:

Affect is less constricted.

ASSESSMENT:

296.22 Major depression, single episode, moderate

PLAN:

Cont. Cymbalta 60 mg one qam and give it more time to work.

Cont. Ambien 10 mg two qhs prn insomnia. He does not take this every night.

Ret. in 4 wks.

Major depression, single episode, moderate

Orders:
90862 Pharmacologic management with no more than minimal medical psychotherapy

Casey, William M. [redacted]/1958
Office/Outpatient Visit
Visit Date: Wed, Nov 10, 2004 05:16 pm
Provider: Jeffrey Smith, MD, M.D. (Supervisor: Jeffrey Smith, MD, M.D.)
Location: Piedmont Psychiatric Services

This note has not been signed and may be incomplete. Printed on 08/16/2005 at 10:32 am.

SUBJECTIVE:

HPI:

46 yom referred by Dr. Joseph Grace.

See full history by Al Bennett on this same day.

He is Zoloft 150 mg qd and Ambien 10 mg one qhs prn insomnia.

He is reluctant to acknowledge depression despite symptoms that suggest this diagnosis. He does have a lot of ruminations.

He thinks Zoloft has helped take the edge of anxiety and has decreased ruminations. More withdrawn than he would like. Poor energy. Poor motivation. Interest and enthusiasm. Some insomnia, unless he takes Ambien. Some overeating. Easily agitated. No s.i. Some hopeless feelings.

No mania or psychosis.

No alcohol or drug abuse.

OBJECTIVE:

Exams:

Affect is irritable. No s.i. or h.i. Judgement and insight fair. No psychosis. Gait, dress, speech, and hygiene normal. Sensorium clear. No gross cognitive deficits.

ASSESSMENT:

296.22 Major depression, single episode, moderate

PLAN:

Stop Zoloft.

Add Cymbalta 60 mg one qam with food. # 42 samples.

Cont. Ambien 10 mg one qhs prn insomnia.

Ret. in 3-4 wks.

CC: Joseph Grace, PhD

Major depression, single episode, moderate

Orders:
90862 Pharmacologic management with no more than minimal medical psychotherapy

Health Summary

Piedmont Psychiatric Services
2094 Woodruff Road
Greenville, SC 29607
Phone: (864)676-9211 Fax: (864)676-9432

Patient: Casey, William M.

Date: 8/16/2005

Current Problems

Major depression, single episode, moderate

Current Medications

Adderall XR 20mg Capsules, Extended Release two qam
Ambien 10mg Tablet 1-2 qhs prn
Cymbalta" 60 mg two qam
Lipitor
Lortab prn
Bextra

⚠ Allergies / Adverse Reactions

NKDA

Past Medical History

Past Medical History:
Bulging disk, back pain
Chest pain with exertion

Family History:
Denies.

Social History:
Divorce is pending. Sepateated 2 years. Two children, ages 18, 21. Has worked production job with Michelin for over 20 years Reports financial problems.

Tobacco/Alcohol/Supplements:
12 pack beer/month.

Substance Abuse History:
Denies.

Mental Health History:
Current counseling with Jay Grace, PhD.

Past meds: Zoloft, Ambien Concerta Adderall XR

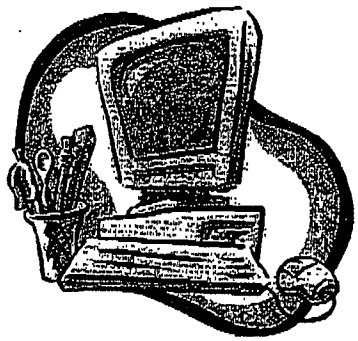
GUNN 004175

JOSEPH G. GRACE III, PH.D.
Center for Family Medicine
853 N. Church Street, Suite 510
Spartanburg, SC 29303
864-560-1512

FAX TRANSMITTAL

No. of Pages incl. Cover Sheet: 5 ~~2~~ copys!

* Per Sylvia - 10/27/04
Being referred to
Dr Jeff Smith for psych
consult.



To:	From:
Dr. Wilson Smith Attn: Maria Fax: ~~542-9043~~ 585-0999 RE: Mark Casey	Sylvia for J. Grace Date: 10-27-04 Phone: (864) 560-1512 Fax: (864) 560-1510

REMARKS: ☐ Urgent ☐ For Your Review ☐ Reply ASAP ☐ Please Comment

September 16, 2004

Frank E. Gonda, MD
2212 Old Furnace Rd.
Spartanburg, SC 29316
Fax #: 578-7098

Re: William Mark Casey
D.O.B. [redacted]/58
SS# [redacted]

Dear Frank,

I have been following Mark Casey on a weekly basis and saw him most recently on September 16, 2004. He reportedly has been taking Zoloft, 100 mg per day for about eight weeks now as you prescribed. He estimated that he has gained about 50% benefit from Zoloft, but for about the past four weeks he seems to have plateaued and there appears to be no subjective or objective improvements. Thus, the following depressive symptoms persist: initial and terminal sleep disturbances, depressive affect most days with atypical cynicism, irritability with low frustration tolerance, anxiety and restlessness, atypical somatic symptoms, excessive worry, easily fatigued, and an inability to deal with normal life stresses.

On August 9, 2004, I administered to Mark the MMPI-II. The validity scales indicate that his test results are valid and the clinical picture is probably unchanged since that test administration. The clinical scales of his MMPI-II indicate that he is moderately depressed, moderately anxiety, but in good reality contact. He is prone to develop ulcers and other GI disturbances under stress. Also, he is prone to sudden anxiety and panic episodes. Test results confirm that he is overwhelmed with problems, is guilt-ridden, and has feeling of inadequacy and unworthiness. He tends to be quite despondent and is slowed in thought and action. Mark is also inclined to experience obsessional thoughts which trigger compulsive behaviors. His personality profile also indicates that he is angry and resentful, rigid and stubborn. He tends to be suspicious and inclined to question the motives of others. However, when not overwhelmed and depressed, he is likely to be much more adaptable, dependable and responsible. In addition, when not in an emotional crisis, he is probably realistic and practical, and is viewed by others as sociable, friendly and enthusiastic.

FILE COPY

Mark has a twenty-plus year history with Michelin and reportedly has been a very productive employee. He indicated, however, that he has been out of work since May 28th and several very recent phone calls from Michelin supervisors indicate that his job may be in jeopardy. Thus, it seems only reasonable that we accelerate his treatment in an effort to expedite his return to work. The simplest solution seems to be to increase his Zoloft to 150 mg per day. Another possibility would be to augment the therapeutic benefit of Zoloft with a second anti-depressant such as Cymbalta. Cymbalta would probably be a good choice since it would be combining the serotonergic benefits of Zoloft with the nordarenergic benefits of Cymbalta. Also, the addition of BuSpar could be helpful in the treatment of Mark's numerous anxiety symptoms.

If you are not comfortable, Frank, with a more complex psychotropic regimen, then either you or I can refer him to one of the Greenville psychiatrists with the recommendation that he be seen at their earliest opening. Michelin is not really satisfied with Mark being out on a three and one-half month leave under the care of a family physician and psychologist for a psychiatric disorder. However, since it could take two to three weeks for Mark to be seen by a psychiatrist, please consider a medication increase/change in the meantime.

Please advise (560-1512).

Sincerely yours,

Jay Grace, Ph.D.
Licensed Counseling Psychologist

Aetna

Attending Physician Behavioral Health Statement

Complete and sign the form using BLUE or BLACK ink.

1. Patient Instructions – The Physician will complete Sections 2 through 9.
The Patient will complete Section 1. The Patient should also fill in their name at the top of Page 2.

The *Patient* is responsible for completing this section, and for ensuring that their Attending Physician completes the remainder of this statement. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call (877) 465-0424.**

(a) Control Number 607472

(b) CASEY, WILLIAM MARK | [redacted] | [redacted]-58 | 15'8" | 170
Patient Name *(Last, First, Middle Initial)* | Social Security Number | Birth Date *(MM/DD/YYYY)* | Height | Weight(lb)

(c) Patient Gender ☑ Male ☐ Female

(d) 240 LIGHTWOOD FARM ROAD, WOODRUFF, S.C. 29388
Patient Home Address – Required *(Current No., St., Town, State, Zip – no PO boxes)* ☐ Check if New

(e) Mailing Address, if different from Home address (SAME)

(f) Patient Employer Name/City/State MICHELIN TIRE, SPARTANBURG, S.C.

(g) Patient Telephone Number (864) 486-9131 ☐ Check if New

(h) Job Title/Occupation PRODUCTION (ASSEMBLY LINE WORKER)

(i) Type of Claim: ☑ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium ☐ Long Term / Permanent Total Disability

2. Physician Instructions

The *Attending Physician* should **complete the items below,** based upon a **recent examination.** Attach additional documentation as needed. If you have any questions, please call (877) 465-0424.

Please complete form in its entirety and fax to (866) 888-2308. Page 2 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

DSM IV-TR MULTIAXIAL DIAGNOSIS: (please indicate the primary impairing diagnosis at this time with an*)

AXIS I Primary Diagnosis 296.23 Secondary Diagnosis: 309.81 ICD-9 codes 300.02
AXIS II Primary Diagnosis (NONE) Secondary Diagnosis: — ICD-9 codes —
AXIS III Primary Diagnosis (DEFERRED) Secondary Diagnosis: — ICD-9 codes —
Axis IV Primary Diagnosis OCCUPATIONAL PROBS, Secondary Diagnosis: HEALTH PROBS, SUPPORT GROUP PROBS.
Axis V (GAF) CURRENT 55 High last year 90 Goal for return to work 80
(Please support GAF with objective findings in the symptom assessment section below)

SYMPTOM ASSESSMENT

(a) Subjective symptoms and complaints: INITIAL AND TERMINAL SLEEP DISTURBANCES, DEPRESSIVE AFFECT ATYPICAL CYNICISM, IRRITABILITY & LOW FRUSTRATION TOLERANCE, ANXIETY AND RESTLESSNESS, ATYPICAL SOMATIC COMPLAINTS, EXCESSIVE WORRY, EASILY FATIGUED, AND INABILITY TO COPE W/ NORMAL LIFE STRESSES.

(b) Objective findings(include mental-status findings, testing results, rating scales, etc) BORDERLINE MENTAL STATUS EXAM, AND MMPI-II INDICATING MODERATE BAN. AND DEPRESSIVE TENDENCIES TO DEVELOP G.I. DISTURBANCES, PANIC EPISODES, SLOWED IN THOUGHT & ACTION,

(c) Describe interpersonal stressors that impact ability to function OBSESSIONAL THOUGHTS AND COMPULSIVE BEHAVIORS.

(d) Describe work stressors that impact ability to function STRESS OF MEETING PRODUCTION, PHYSICALLY DEMANDING FOR NUMBER OF HOURS AND LIFTING HEAVY TIRES CONTINUALLY/

TREATMENT

(a) Medication(s) / Dose / Frequency: ZOLOFT 150MG QD, AND SOMA 1.5.

(b) Impairment from medication effects SEDATION
Compliant with meds? YES

(c) Recent hospitalization? (where, when) RESPIRATORY ARREST AND COMA PRIOR TO PSYCH SYMPTOMS.

(d) Office visit dates: First 8-4-04 Last ____ Next ____ Frequency of appointments WEEKLY

(e) Compliant with tx? YES Tx Goals VERY

4. History

(a) Has patient ever had same or similar condition? ☑ No ☐ Yes, state when and describe

(b) Is condition due to injury or illness arising out of patient's employment? ☑ No ☐ Yes ☐ Unknown

(c) Name / Specialty / City / State of other Treating Physicians or Therapists (NOT DIRECTLY)
Name WILSON SMITH, M.D. Specialty PULMONOLOGY City SPARTANBURG State S.C.
Name FRANK GONDA, M.D. Specialty FAM. PRACT. City " State "
Name JEFFREY SMITH, M.D. Specialty PSYCHIATRY City GREENVILLE State S.C.

AP DT 01-002 ME
GC-1493-1 (6-03)

GUNN 004179

Patient Name *(Last, First Middle Initial)* **Required**
~~William~~ CASEY, WILLIAM MARK

5. Abilities/Limitations

(a) **Is this person capable of signing checks and directing the proceeds?** _____

(b) **Please check the appropriate response of the employee's ability to perform these job functions now.**

	Unlimited Limitations	Limited	Marked	Unable To Perform
Follow work rules	☑	☐	☐	☐
Able to work with others	☑	☐	☐	☐
Able to give supervision to others	☐	☑	☐	☐
Able to work cooperatively with others in group settings	☐	☑	☐	☐
Able to maintain persistence to task	☐	☐	☑	☐
Able to maintain attention and concentration	☐	☐	☑	☐
Able to work alone or in physical isolation from others	☐	☑	☐	☐
Able to interact with supervisors	☑	☐	☐	☐
Able to interact with public/customers	☑	☐	☐	☐
Able to use judgement and make decisions	☐	☐	☑	☐
Able to attain set standards and limits	☐	☐	☐	☑
Able to direct, control or plan activities of others	☐	☐	☑	☐

(c) **Objective findings that substantiate impairment** *(current laboratory, physical and/or mental status examination, and other testing)*:
SEE "SYMPTOM ASSESSMENT" SECTION

(d) **What psychological/medical restrictions/limitations are you placing on this patient?** *(Activities of Daily Living, Driving, etc)*
LIMITED RECREATION ACTIVITIES AND VERY LIMITED VOCATIONAL ACTIVITIES

- Number of Hours patient is capable of working in a day: ☐12 ☐10 ☐8 ☐6 ☐4 ☐2 ☐1 Hour/Day NONE
- Number of Days per week patient is able to work: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 Days/Week NONE
- Date you prescribed restriction on work activities ..... Month 8 Day 4 Year 04
- How long are these restrictions/limitations in effect? UNTIL ANXIETY AND DEPRESSIVE SYMPTOMS ARE ADEQUATELY TREATED ☐ No Longer
  ROUGH ESTIMATE Days Weeks Months
- Estimated return to work date? Nov 30, 04 modified duty 1/2 TIME full duty INITIALLY
  (MM/DD/YYYY) (MM/DD/YYYY)

(e) **Other/ Comments** _____

6. Current Status

(a) Patient is/has ..... ☑ Improved ☐ Unchanged ☐ Regressed

(b) Is there a medical contra-indication for patient to participate in Vocational Rehabilitation (job retraining) programs?
☐ No ☑ Yes, please explain WOULD BE OF NO BENEFIT TO THIS PATIENT

(c) In your opinion, is your patient motivated to return to work? YES BUT RESTRICTED BY PSYCHIATRIC DISORDERS.

7. Regulation Notice

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.
California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.
Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.
Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

8. Physician Certification

Attending Physician's Name *(Print)*	Degree	Specialty
JOSEPH G GRACE, III	PH. D.	CLINICAL/COUNSELING PSYCHOLOGY
Address *(No. Street, City, State, Zip Code)*	**Telephone Number**	**Fax Number**
853 N. CHURCH ST, SUITE 510 SPARTANBURG, S.C. 29303	(864) 560-1512	(864) 560-1565

9. Physician Signature

Signature	Date *(MM/DD/YYYY)*
Joseph G. Grace, III, PhD	10-19-04

AP DT 01-002 ME
GC-1493-1 (6-03)

GUNN 004180

DISCHARGE SUMMARY
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 414900306
ADMISSION DATE: 05/28/2004 DISCHARGE DATE: 05/29/2004
ATTENDING PHYSICIAN: KOSER, ANDRAS

PRESENTATION AND HOSPITAL COURSE: This 45-year-old Caucasian male with a history of elevated cholesterol, history of herniated disc, history of arthritis, who apparently has been having vague chest discomfort every time when he goes to work. The patient came in because of tightness that went straight to the back according to the emergency room physician; however, upon the workup the patient was found to have a left main bronchus containing some foreign body that was metallic in nature. It looks like a screw. It could have been dental filling. The patient was seen in consultation with Dr. Feldman who asked Dr. Boscia to do fiberoptic bronchoscopy and take a look inside and see if he can get it out. Apparently the area was quite difficult to get to. Some bleeding was visualized on the left main bronchus and then tried to dig it out but couldn't find any piece of metal and, hence, he did not do it. The patient was to undergo rigid bronchoscopy a week or two weeks later in Dr. Feldman's office. We feel at this time that the patient does not need any further inpatient stay.

DISCHARGE DIAGNOSES:
1. Noncardiac chest pain.
2. Metallic foreign body in the left main bronchus.
3. Elevated cholesterol.
4. White coat hypertension.

DISCHARGE MEDICATIONS:
1. Lipitor 10 mg p.o. q.d.

DISCHARGE DISPOSITION: The patient is going home.

FOLLOW UP: The patient will follow up with Dr. Gonda in one week.

DICTATED BY: RAJA PALADUGU, M.D.
D:05/29/2004 14:35:42
T:06/03/2004 08:31:40/bt
65743/64000

cc:
ANDRAS KOSER, M.D., Admitting Physician

PRINTED BY: JC26378
%%END DATE 10/29/2004
Authenticated by Raja Paladugu, M.D. On 6/03/04 3:37:13 PM

GUNN 004181

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

MD ORDER TIME #1 #2 #3 ICD 9 DX CODE

BLOOD
- CBC auto man
- BMP
- CMP
- CKMB / Troponin
- Lipase / Amylase
- PT/PTT
- BHCG ql qnt
- Group RH
- T & S
- T & C: 1 2 3 4
- Culture 1 2

URINE
- UA cc cath c&s
- UCG
- UDS

LEVELS
- ETOH
- ASA
- Tylenol
- Digoxin
- Lithium
- Theoph
- Dilantin
- Depakote
- Tegretol
- Phenob

GYN
- GC/Chlamydia
- Wet Prep

PULM
- EKG
- ABG RA 2L 100%
- HHN 1 2 cont

IMAGING
- CXR: pa/lat port
- Abd 2view KUB
- Spine C T L
- Shoulder L R
- Elbow L R
- Wrist L R
- Hand L R
- Pelvis
- Hip L R
- Knee L R
- Ankle L R
- Foot L R
- US GB Abd Pelvis
- CT Head Face Abd Pelvis
- DOP vn art L R UE LE

ORDERS	CONSULTANT	1st	2nd	3rd
1	1			
2	2			
3	3			
4				
5				
6				

☒ Template ASSESSMENT ☐ Dictated | MEDS & INTERVENTION | NURSE/TECH | TIME

CP Pathway
D FOREIGN BODY (1) MAIN BRANCHES
D ITN
D Tech
STAFF ALERT
RADIOLOGY: Ambulance Bed

Dx chest pain. Admit MD Bed

ED Physician Deshman 12382 Resident / NP / PA Consultant / PMD.

PATIENT

ACCOUNT NO	ADMISSION DATE / TIME	FC	DATE OF BIRTH	AGE	SEX	RACE	M/S	SERVICE	ARRIVAL	PAT TYPE	BY	UNIT NUMBER
S 0414900306	05/28/04 0950	SP	[redacted]	45Y	M	1	M	EME	1	ER	JM	000-146220

ADMITTING DOCTOR	ATTENDING DOCTOR	ACCIDENT/WORK RELATED	ACCIDENT DATE/TIME	ADM TYPE / SOURCE
PHYSICIANS,ED	PHYSICIANS,ED	NO		1 7

PATIENT INFORMATION
CASEY,WILLIAM
240 LIGHTWOOD FARM ROAD
WOODRUFF SC 29388-

SOC SEC NO [redacted]
PRIMARY PHYSICIAN [redacted]
TELEPHONE NO 864476-9100
DATE [redacted]

PATIENT EMPLOYER
MICHELIN TIRE
PO BOX 5049
SPARTANBURG SC 29304
TELEPHONE NO (864)599-3151

ED8

GUNN 004182

33 **Chest Pain**

DATE: 5/28 TIME: 952A ROOM _____ EMS Arrival

HISTORIAN: patient paramedic translator other_____

AGE_____ M / F_____

History limited by _____

HPI

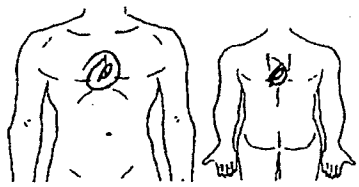
chief complaint: chest pain discomfort

duration / started: several days

timing:
still present better
gone now
lasted_____
resolved on arrival in E D
constant waxing & waning"
intermittent episodes lasting
months
worse/persistent since

quality:
pressure
tightness
indigestion
burning
dull
like prior MI
sharp
stabbing
"pain"
"numbness"
_____

Location of pain:



R / L lateral / precordial / substernal

radiation: none diagrammed above _____

associated symptoms:
nausea
vomiting
shortness of breath
sweating

modifying factors:

worsened by:
change in position
deep breaths / turning
exertion
nothing

relieved by:
sitting up
rest
antacids
nothing

CNTG 1 2 3
patient's own supply
given by paramedics
relief: none / partial / complete / transient
ASA by paramedics/EMS
Oxygen NRB L

context:
onset during:
sleep rest light activity
mod / heavy exertion
emotional upset
cannot recall

severity:
maximum (1-10)_____
mild moderate severe
when seen in ED (1-10)_____
gone almost gone mild moderate severe
residual discomfort in arm (L / R)_____

Similar symptoms previously_____

Recently seen/treated by doctor_____
AMO Bryant Bailey Laney

PRINTED [illegible]

Spartanburg Regional Healthcare System
EMERGENCY PHYSICIAN RECORD

☐ Agree w/ nurse's note for PFSH / ROS

ROS
☐ ROS below otherwise negative

CHEST-CONST
fever
chills
cough
sputum
ankle swelling
calf / leg pain

FEMALE REPRODUCTIVE
LNMP_____
vaginal discharge
abnormal bleeding
denies pregnancy

NEURO
headache
blackouts

EYES-ENT
blurred vision
sore throat

GI and GU
abdominal pain
black / bloody stools
problems urinating

SKIN & LYMPH & MS
skin rash
joint pain
swollen glands

PAST HISTORY Prior records ordered / reviewed ☐ Tetanus UTD
* = MI risk factors

*high blood pressure
*diabetes insulin / oral / diet
*high cholesterol lipitor
*heart disease
heart attack (MI)
angina / heart failure
DVT / PE / risk factors
other problems

emphysema
collapsed lung
stroke
peptic ulcer
documented? yes no
gall stones

Surgeries/Procedures none

cardiac bypass
cardiac cath 2yrs
angioplasty
thrombolytics
pacemaker

tonsillectomy
cholecystectomy
appendectomy
hysterectomy

Medications none see list
acetaminophen BCP's

Allergies NKDA
see list

SOCIAL HX smoker *drugs_____
alcohol (recent / heavy / occasional)_____
lives alone lives in nursing home lives at home_____
occupation_____

FAMILY HX CAD (<55yo / >55yo)_____

S 0414900306 000-146220 [redacted] /58
CASEY,WILLIAM DOB
ADM PHYSICIANS,ED
ADM DATE/TIME 05/28/04 0950

CONSTITUTIONAL
☐ agree w/ vital signs Other_____
Pulse Ox _____ % _____ O_2 L/min
Interpretation: normal abnormal Dx_____
Exam limited by _____
Distress: NAD mild moderate severe

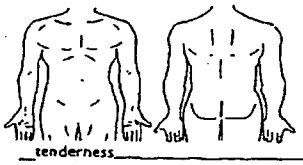
HEENT
normocephalic, atraumatic
PERRL
ENT nml inspection
post-surgical pupillary defect (R/L)_____
scleral icterus / pale conjunctivae
TM obscured by cerumen (R/L)_____
abnml TM / hearing deficit
pharyngeal erythema

NECK
nml inspection
thyromegaly
lymphadenopathy (R / L)

RESPIRATORY
no resp distress
chest non-tender
nml breath sounds
see diagram
respiratory distress
manifests distinct pain on movement of R / L arm of trunk
splinting / decrsd air mvmnt
rales/rhonchi/wheezing

CVS
regular rate, rhythm
no murmur
no gallop
no friction rub
irregularly irregular rhythm
extrasystoles (occasional / frequent)
tachycardia / bradycardia
PMI displaced laterally
JVD present
murmur grade__/6 sys / dias
cresc / cresc-decresc / decresc
gallop (S3 / S4)
friction rub
decreased pulse(s)
R carotd___ fem___ dors ped_____
L carotd___ fem___ dors ped_____

T = tenderness
G = guarding
R = rebound
m = mild
mod = moderate
sv = severe
(e.g., Tsv = severe tenderness)



GI / ABDOMEN
non-tender
no organomegaly
tenderness
guarding
rebound
abnml bowel sounds
hepatomegaly /splenomegaly / mass

SKIN
color nml, no rash
warm, dry
cyanosis / diaphoresis / pallor
skin rash

MUSCULOSKELETAL / EXTREMITIES
non-tender
normal ROM
no pedal edema
no calf tenderness
pedal edema
calf tenderness
clubbing

NEURO
awake and alert
oriented x3
CN's nml as tested
no motor/sensory deficit
lethargic
disoriented to person/place/time
facial droop/EOM palsy/anisocoria
weakness/sensory loss

Chest Pain-33

PRINTED BY: JC26378
DATE 10/29/2004

PSYCH-
mood/affect nor
depressed affect
anxious

LABS, EKG, and XRAYS

CBC *normal*	Chemistries		Gluc	Myo
nml except	*normal*		BUN	PT
WBC	*nml except*		Creat	PTT
Hgb	Na			UA *nml*
Hct	K		CK	*nml except*
Platelets	Cl		CKMB	
	CO2		Troponin	

Rhythm ECG (1 - 3 Lead) NSR abnml Time
12 Lead ECG- Time
Rate
NSR tachycardia / bradycardia / atrial fibrillation
nml QRS wide QRS LBBB RBBB IVCD
nml intervals heart block 1° 2° 3°
nml ST / T non-specific ST - T abnormalities
ST elevation / ST depression / T-wave inversion
PRIOR ECG- unchngd unavail changed
☐ interp contemporaneously by me ☐ I agree w/ confirm computer reading

CXR *chest- PA/LAT AP port. # of views*
nml heart size
nml lung markings
nml great vessels and mediastinum
nml
NAD
obtained to R/O pneumonia
under-penetrated / over-penetrated / rotated
decr lung markings c/w COPD
density c/w pleural effusion
cardiomegaly
incr lung markings / infiltrate
PRIOR XRAY- unchngd unavail changed
☐ interp contemporaneously by me ☐ discussed w/ Radiologist
☐ interp by Radiologist ☐ personally reviewed by me

ED COURSE. Time 1100 re-examined unchanged improved

Crit Care- ____ min (excluding seperately billable procedures)
Discussed with Dr Time
patient will be seen in office / ED / hospital
Counseled patient / family regarding Rx given
lab results / diagnosis need for follow-up
☑ EMTALA EMC present ☐ EMTALA EMC absent
☐ Stable for discharge / out patient follow up

CLINICAL IMPRESSION:

Chest Pain acute precordial	Acute MI
Chest Wall Pain- acute	Unstable Angina
Pulmonary Embolism	Dissecting Aneurysm

Follow up with Dr
DISPOSITION- ☐ discharge ☐ admit ☐ transfer
Time ☐ placed in obs. (See obs template) ☐ Left AMA
CONDITION- ☐ unchanged ☐ improved ☐ stable unless otherwise markd

ARNP / PA
PHYSICIAN- Time
PHYSICIAN Time
☐ T Complete ☐ T Sheet Add-On ☐ Copy PMD ☐ Dictated

S 0414900306 000-146220
CASEY,WILLIAM DOB [redacted]/58
ADM PHYSICIANS,ED
ADM DATE/TIME 05/28/04 0950

SPARTANBURG
Regional Healthcare System

☒SRMC ☐SHRC ☐BJW

GENERAL CONSENT TO TREAT/
PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by the Spartanburg Regional Health Services District, Inc. (District) for the patient whose name appears at the bottom of this page

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Spartanburg Regional Health Services District, Inc and its associated hospitals, physicians, clinicians and other personnel I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations I/we understand that certain healthcare professionals furnishing services including but not limited to, radiologist, pathologist, anesthesiologist and emergency room physicians are independent contractors with the patient and are not employees or agents of the District

AUTHORIZATION FOR RELEASE OF INFORMATION

The hospital and attending physician are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this admission I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the District I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits I/we understand the District can obtain my/our credit report for review in collection of this debt In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collection fees and costs, including reasonable attorney's fees. For Medicare beneficiaries I/we have provided all necessary information for proper assignment of Medicare benefits

VALUABLES RELEASE FORM

I/we have been requested to check valuables with the hospital and release the District of any liability and assume responsibility for any items not deposited to the hospital's care Any valuables not claimed within thirty (30) days of discharge will become the property of the hospital

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we have received a copy of the Notice of Privacy Practices The notice describes how my health information may be used or disclosed I understand that I should read it carefully I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www srhs com

5/28/04
DATE AND TIME

William M Casey
SIGNATURE OF PATIENT OR PARENT, GUARDIAN OR LEGALLY AUTHORIZED REPRESENTATIVE
(Relationship to Patient)

HOSPITAL WITNESS

SIGNATURE OF GUARANTOR (RELATIONSHIP TO PATIENT)

Patien
S 0414900306 000-146220
CASEY,WILLIAM DOB [redacted]58
ADM PHYSICIANS,ED
ADM DATE/TIME 05/28/04 0950

PRINTED BY: JC26378
DATE 10/29/2004
1336 (REV. 02-03)

GUNN 004185

SPARTANBURG
Regional Healthcare System

☐ SRMC ● SHRC ☐ BJW

MD ORDER TIME #1 #2 #3 ICD 9 DX CODE

BLOOD
- CBC
- BMP
- CMP
- CKMB / Troponin
- Lipase / Amylase
- PT/PTT
- BHCG ql qnt
- Group RH
- T & S
- T & C 1 2 3 4
- Culture 1 2

URINE
- UA cc cath c&s
- UCG
- UDS

LEVELS
- ETOH
- ASA
- Tylenol
- Digoxin
- Lithium
- Theoph
- Dilantin
- Depakote
- Tegretol
- Phenob

GYN
- GC/Chlamydia
- Wet Prep

PULM
- EKG
- ABG: RA 2L 100%
- HHN 1 2 cont

IMAGING
- CXR: pa/lat port
- Abd 2view KUB
- Spine: C T L
- Shoulder L R
- Elbow: L R
- Wrist: L R
- Hand: L R
- Pelvis:
- Hip L R
- Knee L R
- Ankle: L R
- Foot L R
- US GB Abd Pelvis
- CT. Head Face Abd Pelvis
- DOP. vn art L R UE LE

ORDERS		CONSULTANT	1st	2nd	3rd
1	4	1			
2	5	2			
3	6	3			

☒ Template ASSESSMENT ☐ Dictated	MEDS & INTERVENTION	NURSE/TECH	TIME
CP Pathway D Foreign Body (L) Main Branches D HTN D TCad.	STAFF ALERT. Pain Med Fluids		

Dx chest pain. Admit MD Bed.

ED Physician: Lashman 12382 Resident / NP / PA Consultant / PMD

PATIENT

ACCOUNT NO	ADMISSION DATE / TIME	FC	DATE OF BIRTH	AGE	SEX	RACE	MS	SERVICE	ARRIVAL	PAT TYPE	BY	UNIT NUMBER
S 0414900306	05/28/04 0950	SP	[redacted]58	45Y	M	1	M	EME	1	ER	JM	000-146220

ADMITTING DOCTOR	ATTENDING DOCTOR	ACCIDENT/WORK RELATED	ACCIDENT DATE/TIME	ADM TYPE / SOURCE
PHYSICIANS,ED	PHYSICIANS,ED	NO		1 7

PATIENT INFORMATION SOC SEC NO [redacted]
CASEY,WILLIAM
240 LIGHTWOOD FARM ROAD
WOODRUFF SC 29388-
TELEPHONE NO (864)476-9100

PATIENT EMPLOYER
MICHELIN TIRE
PO BOX 5049
GREENVILLE SC 29304
TELEPHONE NO (864)599-3151

PRINTED BY [redacted]578
DATE [redacted]

ED8

33 **Chest Pain**

☐ Agree w/nurse's note for PFSH / ROS

DATE 5/28 TIME 9:28A ROOM: _____ EMS Arrival

HISTORIAN: patient _paramedic _translator _other _____

AGE _____ M / F

_History limited by _____

HPI

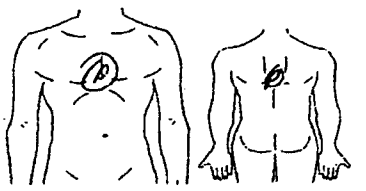
chief complaint: chest pain / discomfort

duration / started: several days

timing:
- still present _better
- _gone now
  - lasted _____
- _resolved on arrival in ED
- _constant _waxing & waning"
- _intermittent episodes lasting _____
- _worse/persistent since _____

quality:
pressure
tightness
indigestion
burning
dull
like prior MI
sharp
stabbing
"pain"
"numbness"

Location of pain:



R / L lateral / precordial / substernal

radiation: none diagrammed above _____

associated symptoms:
- nausea _____
- _vomiting _____
- _shortness of breath _____
- _sweating _____

modifying factors:

worsened by:
change in position
deep breaths / turning
exertion
nothing

relieved by:
sitting up
rest
antacids
nothing

CMTG 1 2 3
patient's own supply
given by paramedics
relief: none / partial / complete / transient
_ASA by paramedics/EMS
_Oxygen _NRB _L

context:
onset during
sleep rest light activity
mod / heavy exertion
emotional upset
cannot recall

severity:
maximum (1-10) _____
mild moderate severe _____
when seen in ED (1-10) _____
gone almost gone mild moderate severe
residual discomfort in arm (L / R) _____

_Similar symptoms previously _____

_Recently seen/treated by doctor _____ MD

ROS
☐ ROS below otherwise negative

CHEST-CONST
- fever
- chills
- cough
  - sputum
- ankle swelling
- calf / leg pain

FEMALE REPRODUCTIVE
- LNMP
- vaginal discharge
- abnormal bleeding
- denies pregnancy

NEURO
- headache
- blackouts

EYES-ENT
- blurred vision
- sore throat

GI and GU
- abdominal pain
- black / bloody stools
- problems urinating

SKIN & LYMPH & MS
- skin rash
- joint pain
- swollen glands

PAST HISTORY _Prior records ordered / reviewed ☐ Tetanus UTD

* = MI risk factors
- *_high blood pressure
- *_diabetes insulin / oral / diet
- *_high cholesterol unknown
- *_heart disease
  - heart attack (MI)
  - angina / heart failure
- _DVT / PE / risk factors
- _other problems
- _emphysema
- _collapsed lung
- _stroke
- _peptic ulcer
  - documented? yes no
- _gall stones

POOR ORIGINAL

Surgeries/Procedures _none
- _cardiac bypass
- *_cardiac cath 2yrs
- _angioplasty
- _thrombolytics
- _pacemaker
- _tonsillectomy
- _cholecystectomy
- _appendectomy
- _hysterectomy

Medications _none _see list
- _acetaminophen _BCP's

Allergies _NKDA
- _see list

SOCIAL HX _smoker _*drugs
- _alcohol (recent / heavy / occasional)
- _lives alone _lives in nursing home _lives at home
- _occupation

FAMILY HX CAD (<55yo / >55yo) _____

S:0414900306 000-146220 [redacted] /58
CASEY,WILLIAM DOB
ADM PHYSICIANS,ED
ADM DATE/TIME 05/28/04 0950

PRINTED BY UC26378

Spartanburg Regional Healthcare System 5/29/2004

EMERGENCY PHYSICIAN RECORD

Version October 2002

GUNN 004187

PATIENT NAME: CASEY, WILLIAM
MEDICAL RECORD #: 146220
DATE OF BIRTH: [redacted]/1958
ACCOUNT NUMBER: 414900306
DATE OF ADMISSION: 05/28/2004
ROOM: 434

CHIEF COMPLAINT: Chest pain.

HISTORY OF PRESENT ILLNESS: This is a 45-year-old Caucasian male with a history of elevated cholesterol, history of herniated disk, and a history of arthritis apparently been having vague chest discomfort every time he goes to work. The patient comes in because of substernal chest tightness that radiates to the back. The patient had extensive cardiac workup done on the last admission which was in the year 2000, July. At that time the patient underwent cardiac catheterization, which showed normal coronaries. The patient comes in, does not give this chest pain history, doesn't have any associated symptoms whatsoever. No diaphoresis, no shortness of breath. Radiating to the back is the only one. No nausea. Currently feels fine. He says the patient was given some aspirin, nitroglycerin.

PHYSICAL EXAMINATION:
CNS: The patient is alert and oriented times three.
HEENT: Normocephalic, atraumatic. Pupils are equal, round, and reactive to light and accommodation.
CHEST: Clear to auscultation bilaterally.
CARDIOVASCULAR: Regular rate and rhythm.
ABDOMEN: Soft, nontender.
EXTREMITIES: No cyanosis, clubbing, or edema.
NEUROLOGICAL: Cranial nerves II through XII grossly intact. Motor 5/5 bilaterally. Sensory intact bilaterally.

REVIEW OF SYSTEMS: no fever or chills. No headache or dizziness. No cough or phlegm. Chest pain as described above. The rest of the review of systems essentially negative.

PAST MEDICAL HISTORY: Reveals a herniated disk and arthritis.

MEDICATIONS: Lipitor, Bextra, Ultram, Lortab.

ALLERGIES: No known drug allergies.

PAST SURGICAL HISTORY: Negative.

SOCIAL HISTORY: Positive smoker. Occasional ETOH.

ALLERGIES: No known drug allergies.

LABORATORY DATA: : CPK 103, MB 1.4, index 1.1 troponin less than 0.07, myoglobin 28.9, PT 12.3, INR 1.1, PTT 29.8. Sodium 137, potassium 3.9, chloride _____ BUN 12, creatinine 0.8, glucose 106, WBC 9.1, hemoglobin 12, hematocrit 36, platelets 539.

PRINTED BY: JC2 6378
DATE 10/29/2004

GUNN 004188

IMPRESSION/PLAN:
1. Noncardiac chest pain most likely secondary to _____in the left main bronchus. We will get pulmonary to see this patient for possible bronchoscopy and removal if possible.
2. Hypertension. The patient's blood pressure is elevated. Never told that he has been hypertensive before, although the patient has been noncompliant with medications and follow up and, hence, we will keep an eye on the blood pressure. We will place the patient on Lopressor 50 mg q.d. for now. Has multiple blood pressure readings in the emergency room. Continues to stay high diastolic of 109.
3. Elevated cholesterol. We will check a lipid profile in the morning.

DICTATED BY: RAJA PALADUGU

D:05/28/2004 13:31:23
T:05/28/2004 15:55:39/bt
65475/62344

Cc:
ANDRAS KOSER, M.D., Attending Physician

Note: Document is draft unless signed.<END FOOTER>

Authenticated by Raja Paladugu, M.D. On 5/29/04 4:43:13 PM

PRINTED BY: JC26378
DATE 10/29/2004

OP REPORTS
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
PROCEDURE DATE: 5/28/2004
ACCOUNT NUMBER: 414900306
ROOM:

PROCEDURE(S) PERFORMED: Bronchoscopy.

REASON FOR PROCEDURE: 45 year-old male with what appears to be a foreign body.

MEDICATIONS: Versed 10 mg IV (intravenous), Fentanyl 100 mcg IV (intravenous), topical lidocaine.

DESCRIPTION OF PROCEDURE: After informed consent was obtained, the right nostril was anesthetized with topical lidocaine. The bronchoscope was advanced to the trachea without difficulty. Trachea as well as right segmental and subsegmental bronchi were normal, patent, without bronchial pathology. However, upon entering the left main stem bronchus, the distal end where the take off of the left upper lobe starts on the medial wall, there is a very erythematous area that was easily friable. No observable foreign body was noted. The airway post the erythematous take off of the left upper lobe was normal. The bronchoscope was withdrawn. The patient tolerated the procedure well.

DICTATED BY: JOSEPH A BOSCIA III, M.D.

D:05/28/2004 14:37:52
T:06/03/2004 21:43:08/lf
65517/64371

cc:
ANDRAS KOSER, M.D., Admitting Physician

Note: Document is draft unless signed.<END FOOTER>

%%END
Authenticated by Joseph A. Boscia, MD. On 6/07/04 5:08:47 PM

PRINTED BY: JC26378
DATE 10/29/2004

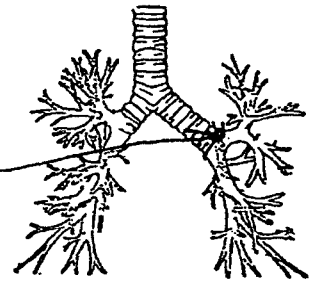
SPARTANBURG
Regional Healthcare System

☐SRMC ☐SHRC ☐BJW

ENDOSCOPY IMMEDIATE POST-OP NOTE
BRONCHOSCOPY RECORD

Job #
64993

Cytomatous granuloma
? foreign body



DATE: 5/28
MEDS: Versed 10mg fentanyl 100 mcg
PROCEDURE:
Bronch c aspiration of foreign

POST-OP DIAGNOSIS: foreign body
COMPLICATIONS (IF ANY)
SPECIMENS (IF ANY)

REFERRING PHYSICIAN:

ENDOSCOPIST'S SIGNATURE:

Patient Label
CASEY,WILLIAM DOB [redacted]58
ADM PHYSICIANS,ED
ADM DATE/TIME 05/28/04 0950

PRINTED BY: JC26378
DATE 10/29/2004

1198 (Rev 09-03)

GUNN 004191

SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
DRS. DAVIS, LOWRY, WREN, NELSON, RAINER, LAPHAM, MIMS, CALDWELL \T\ BURNS

CASEY WILLIAM MR#: (0001)00014-62-20 Fin.No.:0414900306 Admitted: 28MAY04
45 YRS MALE DOB: [redacted]/1958 Office Id: Page: 1
Dr. KOSER ANDRAS CUMULATIVE Printed: 29MAY04
Location: 4W 434 -A 4TH WEST CHEST PAIN NOS 0738

HEMATOLOGY

BLOOD CELL PROFILE

Procedure:	WBC	RBC	HEMOGLOBIN	HCT	MCV	MCH	MCHC	RDW
Ref Range:	(4.5-11.0)	(4.30-5.70)	(13.5-17.5)	(40.0-52.0)	(82.0-98.0)	(28.0-33.0)	(32.5-36.0)	(11.5-14.5)
Units:	K/CMM	M/CMM	G/DL	%	FL	PG	%	
28MAY04 0950	9.1	3.91 L	12.8 L	36.8 L	94.1	32.8	34.9	12.7

Procedure:	PLATELET
Ref Range:	(130-400)
Units:	K/CMM
28MAY04 0950	539 H

AUTOMATED DIFFERENTIAL

Procedure:	NEUTS %	LYMPHS %	MONOS %	EOS %	BASOS %
Ref Range:	(32.3-72.9)	(18.8-50.3)	(3.7-12.2)	(0.0-6.9)	(0.1-2.1)
Units:	%	%	%	%	%
28MAY04 0950	75.3 H	16.3 L	5.5	2.6	0.3

MANUAL DIFFERENTIAL

Procedure:	AGC
28MAY04 0950	7116

PRINTED BY: JC26378
DATE 10/29/2004

GUNN 004192

PRINTED BY: JC26378
DATE 10/29/2004

GUNN 004193

CASEY WILLIAM MR#: (0001)00014-62-20 Fin.No.:0414900306 Admitted: 28MAY04
45 YRS MALE DOB: [redacted]/1958 Office Id: Page: 2
Dr. KOSER ANDRAS CUMULATIVE Printed: 29MAY04
Location: 4W 434 -A 4TH WEST CHEST PAIN NOS 0738

COAGULATION

Procedure:	PROTIME	PROTIME INR	PTT
Ref Range:	(09.2-12.9)		(21.3-33.3)
Units:	SEC		SEC
28MAY04 0950	12.3	1.1	29.8

PROTIME (08APR04 -- Current)
SRMC NEW REFERENCE RANGES EFFECTIVE 04/05/04
PROTIME INR (08APR04 -- Current)
THERAPEUTIC RANGE: 2.0 3.0
PROSTHETIC HEART VALVE RANGE: 2.5-3.5
PTT (11MAY04 -- Current)
SRMC NEW REFERENCE RANGES EFFECTIVE 04/05/04
NOTE: EFFECTIVE 04/05/04 FOR SRMC PATIENTS ON HEPARIN THERAPY, THE THERAPEUTIC RANGE IS 42.7 - 71.6 SECONDS

NOTE: EFFECTIVE 03/18/03 FOR RESTORATIVE CARE HOSPITAL PATIENTS ON HEPARIN THERAPY THE THERAPEUTIC RANGE IS 40 - 60 SECONDS

BJW NOTE: EFFECTIVE 04/22/04 FOR BJW PATIENTS ON HEPARIN THERAPY, THE THERAPEUTIC RANGE IS 53-100 SECONDS.

CHEMISTRY

------ BASIC METABOLIC PROFILE -----

Procedure:	NA++	K+	CHLORIDE	CO2	GLUCOSE	BUN	CREAT	ANION GAP	BUN/CREAT	OSMO CALC
Ref Range:	(133-146)	(3.5-4.9)	(100-111)	(23.0-32.6)	(77-117)	(6-20)	(.6-1.2)	(6-13)	(0-23)	(271-310)
Units:	MMOL/L	MMOL/L	MMOL/L	MMOL/L	MG/DL	MG/DL	MG/DL	MMOL/L		MOSKG
Y04 0950	136	3.9	104	28.0	106	12	.8	8	15	272

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DATE 10/29/2004

GUNN 004194

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DATE 10/29/2004

GUNN 004195

SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
DRS. DAVIS, LOWRY, WREN, NELSON, RAINER, LAPHAM, MIMS, CALDWELL \T\ BURKS

CASEY WILLIAM
45 YRS MALE
Dr. KOSER ANDRAS
Location: 4W 434 -A

MR#: (0001)00014-62-20 Fin.No.:0414900306
DOB: [redacted]/1958 Office Id:
4TH WEST CUMULATIVE CHEST PAIN NOS

Admitted: 28MAY04
Page: 3
Printed: 29MAY04 0738

CHEMISTRY

SINGLE CHEMISTRIES

Procedure:	CALCIUM	TROPONIN I	MYOGLOBIN
Ref Range:	(8.9-10.3)	(< .07)	(< 110.0)
Units:	MG/DL	NG/ML	NG/ML
28MAY04 0950	8.8 L	<0.07	28.9

TROPONIN I (04MAR04 Current)
NEW REFERENCE RANGE FOR NORMAL IS <0.07 NG/ML
NEW CUTOFF FOR ACUTE MYOCARDIAL INFARCTION IS 0.50 NG/ML
NOTE : TROPONIN MAY REMAIN ELEVATED SEVERAL DAYS AFTER MI

BJW REFERNCE VALUES
NORMAL = <0.03
INTERMEDIATE = 0.04-0.49
ACUTE MI = >0.50

MYOGLOBIN (18AUG03 -- Current)
MYOGLOBIN RESULTS >110 NG/ML IS HIGHLY SUGGESTIVE OF MYOCARDIAL INFARCTION

LIPID STUDIES

Procedure:	CHOLESTEROL	TRIGLYCERIDES	HDL	LDL	VLDL	HDL/LDL RATIO
Ref Range:	(< 200)	(44-150)	(40-60)	(< 100)	(5-35)	(< 3)
Units:	MG/DL	MG/DL	MG/DL	MG/DL	MG/DL	
29MAY04 0555	149	555 H	22 L	76	111 H	3

MI/CARDIAC PROFILES

rocedure:	CPK	CK-MB	CK INDEX
ef Range:	(42-231)	(.0-6.0)	(0.0-1.8)
Units:	IU/L	NG/ML	
28MAY04 0950	103	1.4	1.4

CK INTERPRET: NO ENZYME EVIDENCE OF MYOCARDIAL INJURY.

Symbols:
L = Low, H = High

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DATE 10/29/2004

GUNN 004196

**END

PRINTED BY: JC26378
DATE 10/29/2004

S[illegible]TANBURG REGIONAL MEDICAL C[illegible]ER
Radiology Report

NAME: CASEY,WILLIAM
ORDERING PHYSICIAN: KOSER,ANDRAS
OC: 4W-434-A
t. Type:IP

DOB: [redacted]/58

UNIT #: 000146220
CI#: 1216733
AN#:S0414900306

Exam
60220 CT LUNG WITHOUT CONTRAST
71250

Date: 05/28/04 1805
Ord Diag: Chest Pain NOS 786.50

Chest CT scan 5/28/2004.

Indication: Evaluate for possible foreign body. Patient works in construction and apparently on a chest x-ray had a metallic foreign body.

The chest x-ray cannot be located for comparison. Spiral images were obtained through the chest without contrast. There are no metallic foreign bodies evident other than snaps and monitoring leads on the patient's skin. The lungs are free of nodules and infiltrates. There is left anterior descending coronary artery calcification. No other abnormalities are evident of the noncontrasted mediastinum.

Impression:

1. Negative for opaque foreign body.

2. Left anterior descending coronary artery calcification.

Read By: Peter Ryan, M.D.
Released By: Peter Ryan, M.D.

LMB

FINAL

PRINTED BY: JC26378
DATE 10/29/2004

GUNN 004198

CASEY ,WILLIAM
ID#:146220
45 years Male Caucasian
Ord.Dr.HILL
Tech:KB
OPT. Priority:STAT
DX:V82.9
ACC#:0414900306

ER
Time:09.44.50 05/28/04
SPARTANBURG REG.MED.CENT.

Vent rate: 87

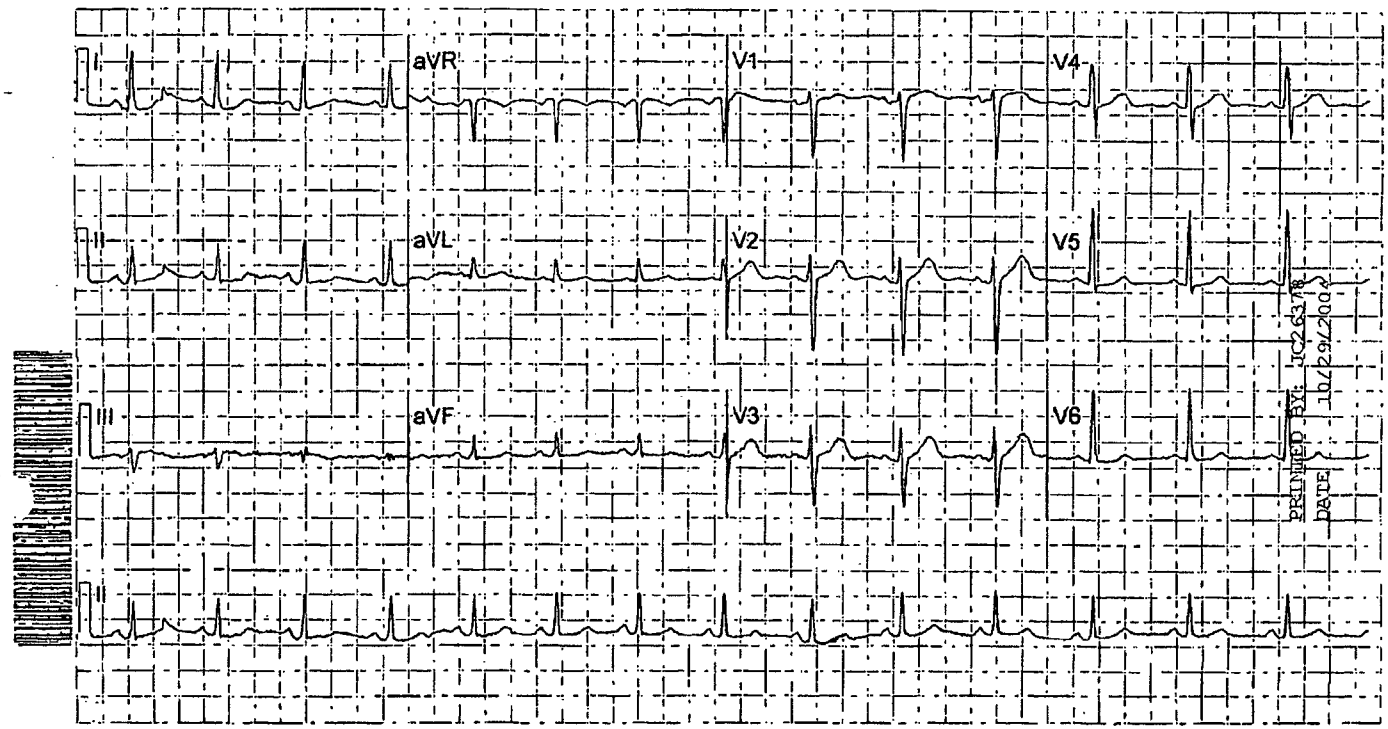
--Durations--
P : 100
QRS: 80
--Intervals--
PR : 134
QT . 356
QTc: 401
QTd: 24
--Axes--
P : 45
QRS: 29
T : 32

Sinus rhythm
Lateral ST-T changes are nonspecific

Borderline ECG

Reviewed by: Dr. Tom Robinson

Speed: 25 mm/s Limb Lead Gain: 10.0 mm/mV Chest Lead Gain: 10.0 mm/mV Filter(s): 60Hz Notch, 40Hz Artifact



CONFIRM Current ECG Printed 05/29/04 11.52.41 Transcribed By: Dr. Tom Robinson 05/29/04 11.52.36
PLUSI PLUSI1.93/3.19/16.11/1.64

4504

GUNN 004199

4505

CASEY ,WILLIAM
ID#:146220
45 years Male Caucasian
Ord.Dr.HILL
Tech:KB
OPT: Priority:STAT
DX:V82.9
ACC#:0414900306

ER
Time:09.44.50 05/28/04
SPARTANBURG REG.MED.CENT.

Vent rate: 87

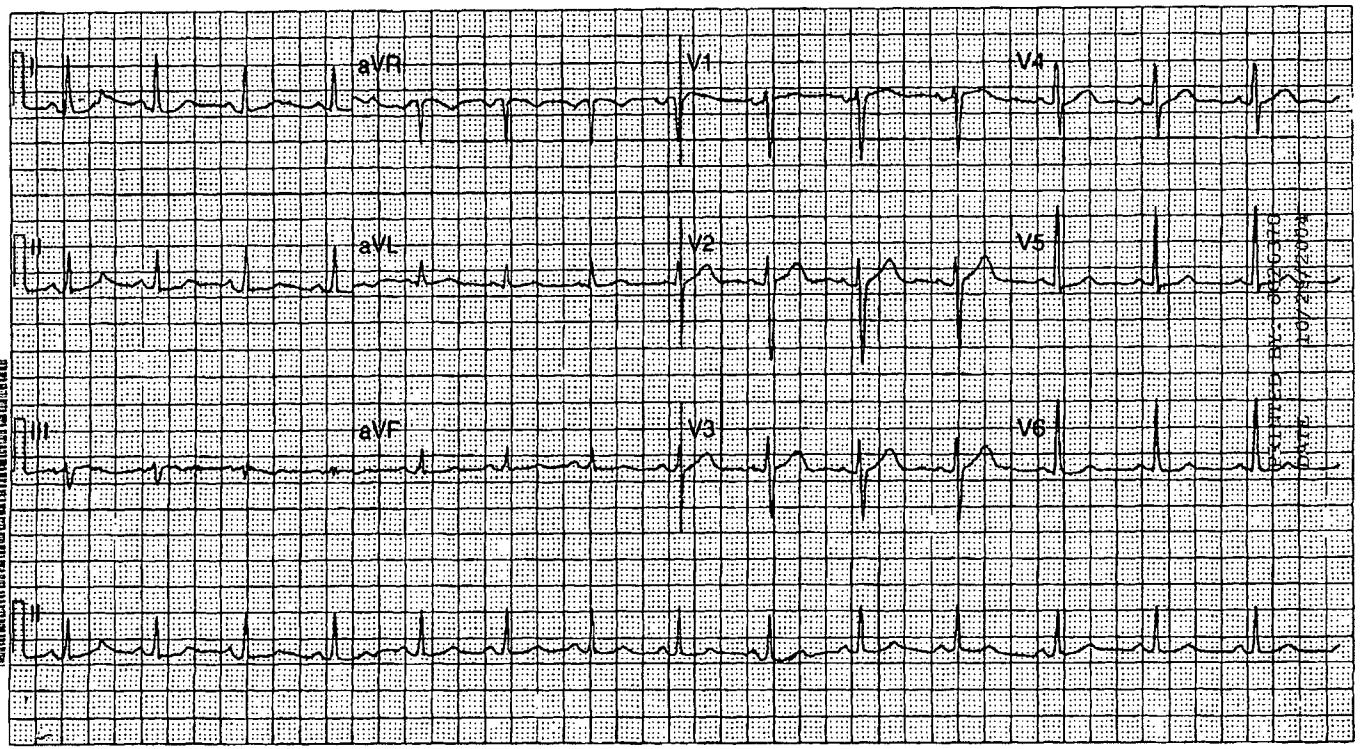
--Durations--
P : 100
QRS: 80
--Intervals--
PR : 134
QT : 356
QTc: 401
QTd: 24
--Axes--
P : 45
QRS: 29
T : 32

Sinus rhythm
Lateral ST-T changes are nonspecific

Borderline ECG

Reviewed by: Dr. Tom Robinson

Speed: 25 mm/s Limb Lead Gain: 10.0 mm/mV Chest Lead Gain: 10.0 mm/mV Filter(s): 60Hz Notch, 40Hz Artifact



RETRIEVE Current ECG Printed 05/03/04 10.08.02 Transcribed By: Dr. Tom Robinson 05/29/04 11.52.36
PLUS1 PLUS11.93/3 6.11/1.64

GUNN 004200

Upstate Lung & Critical Care Specialists, P.C
1091 Boiling Springs Road
Spartanburg, SC 29303
Phone: 864-573-6320
Fax: 864-573-6323

Gregory J. Feldman, M.D.
Joseph A. Boscia III, M.D.
David R. Erb, M.D

Resending Final Sheets from Friday

Fax

To: 11-1-04 Fax:

From: USCC Date:

Re: Wm. Cases Pages: which didn't get thur

CC:

☒ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Attention

Ladies

If you don't get 13 pages

D. Furtick

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

11686

OP REPORTS
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted] 1958
MEDICAL RECORD #: 146220
PROCEDURE DATE: 06/03/2004
ACCOUNT NUMBER: 415400048
ROOM:

M.D. Signature
JUN 22 2004

PREOPERATIVE DIAGNOSES:
1. Possible left tension _____.
2. Bronchial trauma status post rigid bronchoscopy and laser therapy.
3. Cigarette smoking.
4. Dyslipidemia.

POSTOPERATIVE DIAGNOSES:
1. Possible left tension _____.
2. Bronchial trauma status post rigid bronchoscopy and laser therapy.
3. Cigarette smoking.
4. Dyslipidemia.

PROCEDURE: Emergency placement of a left thoracostomy tube.

SURGEON: Dr. Nguyenduy.

ANESTHESIA: IV narcotics.

INDICATIONS: The patient is a 45-year-old white male who is status post a rigid bronchoscopy for possible foreign body aspiration and postoperatively in the recovery room he developed subcutaneous emphysema and respiratory distress requiring insertion of endotracheal tube. He then became stable and concern of a left pneumothorax because of his subacute emphysema. Was asked to put in an emergency left thoracostomy tube.

PROCEDURE IN DETAIL: This is happening in the recovery room.

The patient was in the supine position, intubated and ventilated on the respirator. The left chest was scrubbed and painted with Betadine solution. A 3 cm incision was made at the x-ray line that is just above the 2nd intercostal space. A quick dissection was carried through with subcutaneous tissue to the muscle using the Metzenbaum scissors down to the intercostal space. Then using a Kelly clamp, the left pleural space was entered without any problems. Digital examination was

OK

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GUNN 004202

performed and the lung was mobile and free from any adhesions at the site of entry. A 32 French trocar was inserted in the left pleural space without any problems with good air return which fogged the chest tube. The chest tube was anchored and stayed with 2-0 Prolene mattress sutures. The chest tube was then connected to collecting unit and placed on –20 cm water continuous wall suction.

Postprocedure chest x-ray was obtained and showed that the tube is in good vision in left pleural space with extensive subacute and some continuous emphysema.

DICTATED BY: TUAN NGUYENDUY, M.D.

D:06/03/2004 18:40:28
T:06/09/2004 06:07:50/abi
67596/66415

cc: GREGORY FELDMAN, M.D., Admitting Physician

Note: Document is draft unless signed.

OR REPORTS
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
PROCEDURE DATE: 6/3/04
ACCOUNT NUMBER: 415400048
ROOM: ICU

M.D. Signed on-Line 6/11/04

PROCEDURE PERFORMED: Rigid bronchoscopy with laser bronch.

ENDOSCOPIST: Dr. Feldman.

INDICATIONS FOR PROCEDURE: 45 year old had been worked up by Dr. Paladugu and my partner, Dr. Boscia, with the finding of abnormal granulation tissue and abnormal subsegment in the left upper lobe corresponding to what appeared to be a crown foreign body on chest x-ray. The patient is now undergoing procedure in attempt to removal of chest x-ray abnormality suggestive of a crown; the patient does have a history of a missing crown.

After general anesthesia was induced, the patient was intubated with a rigid bronchoscope, size 16, without any difficulty. Careful inspection of the tracheobronchial tree was undertaken. The entire tracheobronchial tree was examined, there was no finding of a foreign body, however, a quite abnormal subsegment in the left upper lobe which appeared to be a pouch/granulation tissue has been identified. Laser of the area has been done with 45 watts over a 2-second period. Granulation tissue has been vaporized with the appearance of what appeared to be crown lying on the surface. With using 35 watts energy of the laser, there was no possibility of removal of the crown because it was deeply imbedded, and laser energy was applied to the center of the crown and it has been vaporized. However, below the surface there has been no further foreign body seen. The assumption was made that the entire crown other than on the surface had been vaporized, and attempt to pull it with a biopsy forceps and passage of the basket was unsuccessful. The washings were done of the area, and the procedure was terminated. The patient was extubated in recovery.

Although the patient did quite well during the procedure, he suddenly developed considerable pneumomediastinum and having immediately arrived to the bedside, Dr. Nguyenduy's consultation has been obtained. The decision was done by Dr. Nguyenduy and myself to place a chest tube, because of the impossibility to rule out pneumothorax, however, chest x-ray does not show pneumothorax, there is no foreign body seen, and also endotracheal tube is in good position. The patient was intubated by Anesthesia prior to that.

IMPRESSION: It is unclear to me at this point whether the laser went through the cartilage, and since I have not identified or pulled the crown itself, if in fact there was a crown it has been vaporized and is no longer seen on x-ray. At this point the patient will transfer to the ICU,

antibiotics will be administered for disruption of the bronchus and pneumomediastinum. This will be followed by CT surgery and certainly if air leak into the pneumomediastinum would not stop, surgical intervention will be required. Hopefully this can be avoided by conservative management, but it is uncertain to me at this time whether the crown was vaporized or essentially the laser went through the highly abnormal area of the lung suggestive of closed congenital pouch rather than a foreign body, and significant irritation from previous bronchoscopy.

DICTATED BY: GREGORY FELDMAN, M.D.

D:06/03/2004 16:02:26
T:06/03/2004 16:44:07/lb
67504/64298

cc:

Note: Document is draft unless signed.<END FOOTER>

%%END
Authenticated by Gregory Feldman, M. D. On 6/04/04 2:35:35 PM

11486

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

DISCHARGE SUMMARY

PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 415400048
ADMISSION DATE: 06/03/2004 DISCHARGE DATE: 06/06/2004
ATTENDING PHYSICIAN: FELDMAN, GREGORY

M.D. Signed On-Line

FINAL DIAGNOSES:

1. Status post recent bronchoscopy with laser for abnormal appearing airway, on flexible bronchoscopy suspected foreign body.
2. Complication of the procedure was pneumomediastinum and pneumothorax requiring chest tube insertion by Dr. Nguyenduy.
3. Asthma and heavy smoking.
4. Disabling back pain with a bulging disk and arthritis, long.

PLAN: The patient is discharged home on prednisone 20 mg q.d., Percocet 1-2 pills t.i.d. p.r.n. The patient will be seen in my office within a week. Diet and activity as tolerated.

HOSPITAL COURSE: This is a patient who underwent initial bronchoscopy by Dr. Boscia with finding of a quite irritated, blistered airway. Corresponding chest x-ray appeared to be missing dental material. The patient underwent bronchoscopy for assumption of airway caused by retained foreign body. It appeared to be that there was granulation tissue; however, after laser was applied it became apparent that instead of a normal airway, it is a pouch and procedure terminated with no foreign body recovered. The patient tolerated the procedure well; however, in recovery the patient suddenly developed subacute emphysema and x-ray revealed pneumomediastinum with pneumothorax on the left side. A small chest tube was inserted. The patient was kept on the respiratory overnight. His subcu air has subsided remarkably. The patient felt much, much improved. He was extubated and transferred to the floor. Repeat chest x-ray showed pneumothoraces on both right and left but unchanged in size and small at the time of discharge. The patient felt good with no complaints and was discharged home. We will assess in my office within the next two days. The patient has been instructed if he develops fever or increased subcu air or shortness of breath immediately to come back to see me.

DICTATED BY: GREGORY FELDMAN, M.D.
D:06/07/2004 09:28:57
T:06/11/2004 08:24:49/bt
68523/67665

PHYSICIAN COPY
Note: Document is draft unless signed.

DICTATING

cc: TUAN NGUYENDUY, M.D., Consulting Physician

Note: Document is draft unless signed

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

NC

M.D. Signed on-Line

OP REPORTS
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
PROCEDURE DATE: 5/28/2004
ACCOUNT NUMBER: 414900306
ROOM:

PROCEDURE(S) PERFORMED: Bronchoscopy.

REASON FOR PROCEDURE: 45 year-old male with what appears to be a foreign body.

MEDICATIONS: Versed 10 mg IV (intravenous), Fentanyl 100 mcg IV (intravenous), topical lidocaine.

DESCRIPTION OF PROCEDURE: After informed consent was obtained, the right nostril was anesthetized with topical lidocaine. The bronchoscope was advanced to the trachea without difficulty. Trachea as well as right segmental and subsegmental bronchi were normal, patent, without bronchial pathology. However, upon entering the left main stem bronchus, the distal end where the take off of the left upper lobe starts on the medial wall, there is a very erythematous area that was easily friable. No observable foreign body was noted. The airway post the erythematous take off of the left upper lobe was normal. The bronchoscope was withdrawn. The patient tolerated the procedure well.

DICTATED BY: JOSEPH A BOSCIA III, M.D.

D:05/28/2004 14:37:52
T:06/03/2004 21:43:08/lf
65517/64371

cc: ANDRAS KOSER, M.D., Admitting Physician

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SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

OP REPORTS

PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
PROCEDURE DATE: 6/3/04
ACCOUNT NUMBER: 415400048
ROOM: ICU

M.D. Signed on-Line

PROCEDURE PERFORMED: Rigid bronchoscopy with laser bronch.

ENDOSCOPIST: Dr. Feldman.

INDICATIONS FOR PROCEDURE: 45 year old had been worked up by Dr. Paladugu and my partner, Dr. Boscia, with the finding of abnormal granulation tissue and abnormal subsegment in the left upper lobe corresponding to what appeared to be a crown foreign body on chest x-ray. The patient is now undergoing procedure in attempt to removal of chest x-ray abnormality suggestive of a crown; the patient does have a history of a missing crown.

After general anesthesia was induced, the patient was intubated with a rigid bronchoscope, size 16, without any difficulty. Careful inspection of the tracheobronchial tree was undertaken. The entire tracheobronchial tree was examined, there was no finding of a foreign body, however, a quite abnormal subsegment in the left upper lobe which appeared to be a pouch/granulation tissue has been identified. Laser of the area has been done with 45 watts over a 2-second period. Granulation tissue has been vaporized with the appearance of what appeared to be crown lying on the surface. With using 35 watts energy of the laser, there was no possibility of removal of the crown because it was deeply imbedded, and laser energy was applied to the center of the crown and it has been vaporized. However, below the surface there has been no further foreign body seen. The assumption was made that the entire crown other than on the surface had been vaporized, and attempt to pull it with a biopsy forceps and passage of the basket was unsuccessful. The washings were done of the area, and the procedure was terminated. The patient was extubated in recovery.

Although the patient did quite well during the procedure, he suddenly developed considerable pneumomediastinum and having immediately arrived to the bedside, Dr. Nguyenduy's consultation has been obtained. The decision was done by Dr. Nguyenduy and myself to place a chest tube, because of the impossibility to rule out pneumothorax, however, chest x-ray does not show pneumothorax, there is no foreign body seen, and also endotracheal tube is in good position. The patient was intubated by Anesthesia prior to that.

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SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

M.D. Signed on-Line

Waste

CONSULT

PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 414900306
DATE OF SERVICE:
ATTENDING PHYSICIAN: KOSER, ANDRAS
ROOM:

HISTORY OF PRESENT ILLNESS: This 46-year-old smoking male presented to the hospital for chest pain. An initial chest x-ray on admission showed what appears to be a foreign body in the left mainstem bronchus. I am being asked to comment on this. This patient complains of pain in his chest that is sharp that goes directly straight to his back. There is a history of cough. No history of hemoptysis.

PAST MEDICAL HISTORY: includes hypercholesterolemia. No history of hypertension or diabetes.

SOCIAL HISTORY: He has a 25 pack year smoking history. He works at Michelin.

FAMILY HISTORY: Is noncontributory.

REVIEW OF SYSTEMS: Includes all mentioned in history of present illness. Also, he has chronic back pain, occasional headaches, occasional constipation. All other review of systems are negative.

PHYSICAL EXAMINATION: He appears well in no acute respiratory distress. Blood pressure is 150/90, pulse is 84. Pupils react to light. The oral mucosa is moist without thrush. Neck is supple. Heart is regular. Lungs are clear bilaterally. Abdominal exam reveal no hepatosplenomegaly. Extremities are without clubbing, cyanosis or edema. Skin is intact with no rashes. Joints are not inflamed. Neurologically, cranial nerves II through XII are intact without focality.

Chest x-rays been reviewed in it does show what appears to be an irregular metallic foreign body in the left mainstem bronchus.

IN SUMMARY: 46-year-old gentleman with what appears to be a foreign body in the left mainstem bronchus. He has consented to fiber-optic bronchoscopy which would be the most reasonable next step. Will perform fiber-optic bronchoscopy to see if this foreign body is

OK

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GUNN 004210

removable. If it is not removable or granulated in, than rigid bronchoscopy in the operating room will be performed. Risks, benefits, and alternatives were discussed with Mr. Casey and he agrees to proceed with bronchoscopy.

DICTATED BY: JOSEPH A BOSCIA III, M.D.
D:05/28/2004 14:26:33
T:06/03/2004 11:25:39/lb
65506/64110

cc: ANDRAS KOSER, M.D., Admitting Physician

Note: Document is draft unless signed.

DISCHARGE SUMMARY
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 414900306
ADMISSION DATE: 05/28/2004 DISCHARGE DATE: 05/29/2004
ATTENDING PHYSICIAN: KOSER, ANDRAS

PRESENTATION AND HOSPITAL COURSE: This 45-year-old Caucasian male with a history of elevated cholesterol, history of herniated disc, history of arthritis, who apparently has been having vague chest discomfort every time when he goes to work. The patient came in because of tightness that went straight to the back according to the emergency room physician; however, upon the workup the patient was found to have a left main bronchus containing some foreign body that was metallic in nature. It looks like a screw. It could have been dental filling. The patient was seen in consultation with Dr. Feldman who asked Dr. Boscia to do fiberoptic bronchoscopy and take a look inside and see if he can get it out. Apparently the area was quite difficult to get to. Some bleeding was visualized on the left main bronchus and then tried to dig it out but couldn't find any piece of metal and, hence, he did not do it. The patient was to undergo rigid bronchoscopy a week or two weeks later in Dr. Feldman's office. We feel at this time that the patient does not need any further inpatient stay.

DISCHARGE DIAGNOSES:
1. Noncardiac chest pain.
2. Metallic foreign body in the left main bronchus.
3. Elevated cholesterol.
4. White coat hypertension.

DISCHARGE MEDICATIONS:
1. Lipitor 10 mg p.o. q.d.

DISCHARGE DISPOSITION: The patient is going home.

FOLLOW UP: The patient will follow up with Dr. Gonda in one week.

DICTATED BY: RAJA PALADUGU, M.D.
D:05/29/2004 14:35:42
T:06/03/2004 08:31:40/bt
65743/64000

M.D. Signature

JUN 08 2004

cc:
ANDRAS KOSER, M.D., Admitting Physician

%%END
Authenticated by Raja Paladugu, M.D. On 6/08/04 3:37:13 PM

GUNN 004212

PATIENT NAME: CASEY, WILLIAM
MEDICAL RECORD #: 146220
DATE OF BIRTH: [redacted]/1958
ACCOUNT NUMBER: 414900306
DATE OF ADMISSION: 05/28/2004
ROOM: 434

CHIEF COMPLAINT: Chest pain.

HISTORY OF PRESENT ILLNESS: This is a 45-year-old Caucasian male with a history of elevated cholesterol, history of herniated disk, and a history of arthritis apparently been having vague chest discomfort every time he goes to work. The patient comes in because of substernal chest tightness that radiates to the back. The patient had extensive cardiac workup done on the last admission which was in the year 2000, July. At that time the patient underwent cardiac catheterization, which showed normal coronaries. The patient comes in, does not give this chest pain history, doesn't have any associated symptoms whatsoever. No diaphoresis, no shortness of breath. Radiating to the back is the only one. No nausea. Currently feels fine. He says the patient was given some aspirin, nitroglycerin.

PHYSICAL EXAMINATION:
CNS: The patient is alert and oriented times three.
HEENT: Normocephalic, atraumatic. Pupils are equal, round, and reactive to light and accommodation.
CHEST: Clear to auscultation bilaterally.
CARDIOVASCULAR: Regular rate and rhythm.
ABDOMEN: Soft, nontender.
EXTREMITIES: No cyanosis, clubbing, or edema.
NEUROLOGICAL: Cranial nerves II through XII grossly intact. Motor 5/5 bilaterally. Sensory intact bilaterally.

REVIEW OF SYSTEMS: no fever or chills. No headache or dizziness. No cough or phlegm. Chest pain as described above. The rest of the review of systems essentially negative.

PAST MEDICAL HISTORY: Reveals a herniated disk and arthritis.

MEDICATIONS: Lipitor, Bextra, Ultram, Lortab.

ALLERGIES: No known drug allergies.

PAST SURGICAL HISTORY: Negative.

SOCIAL HISTORY: Positive smoker. Occasional ETOH.

ALLERGIES: No known drug allergies.

LABORATORY DATA: : CPK 103, MB 1.4, index 1.1 troponin less than 0.07, myoglobin 28.9, PT 12.3, INR 1.1, PTT 29.8. Sodium 137, potassium 3.9, chloride _____ BUN 12, creatinine 0.8, glucose 106, WBC 9.1, hemoglobin 12, hematocrit 36, platelets 539.

GUNN 004213

IMPRESSION/PLAN:
1. Noncardiac chest pain most likely secondary to _____ in the left main bronchus. We will get pulmonary to see this patient for possible bronchoscopy and removal if possible.
2. Hypertension. The patient's blood pressure is elevated. Never told that he has been hypertensive before, although the patient has been noncompliant with medications and follow up and, hence, we will keep an eye on the blood pressure. We will place the patient on Lopressor 50 mg q.d. for now. Has multiple blood pressure readings in the emergency room. Continues to stay high diastolic of 109.
3. Elevated cholesterol. We will check a lipid profile in the morning.

DICTATED BY: RAJA PALADUGU

D:05/28/2004 13:31:23
T:05/28/2004 15:55:39/bt
65475/62344

Cc:
ANDRAS KOSER, M.D., Attending Physician

Note: Document is draft unless signed.<END FOOTER>

Authenticated by Raja Paladugu, M.D. On 5/29/04 4:43:13 PM

Upstate Lung & Critic[illegible]e Specialists, P.C
1091 Boiling Springs Road
Spartanburg, SC 29303
Phone: 864-573-6320
Fax: 864-573-6323

Gregory J. Feldman, M.D.
Joseph A. Boscia III, M.D.
David R. Erb, M.D

Fax

To: Lung + Chest Fax: 5429043

From: Date: 10-29-04

Re: Wm. Casey Pages: 4

CC:

☒ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Had Machine trouble
Sorry it took so long
to re-do -
Thanks
Janice

P.S. And the Plans -

GUNN 004215

****** ALLOW 2 LINES FOR PREDNISONE

Upstate Lung and Critical Care Specialists

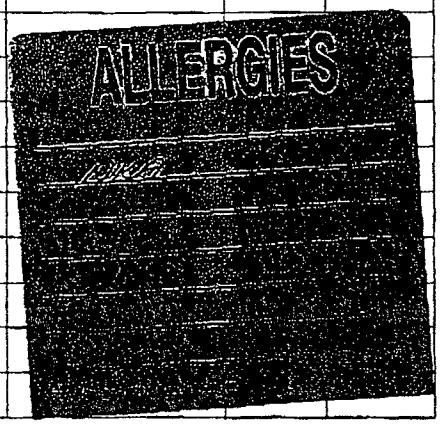
1091 Boiling Springs Road • Spartanburg, South Carolina 29303

NAME William Casey CHART# 11686

ALLERGIES NKA

ROUTINE MEDICATION LIST:

MEDICATION	Dose & Frequency Ordered by MD	Dose & Frequency Taken by Patient	State Date	Stop Date
Bextra	take 1 qd			
Ultram	PRN if needed			
Zanaflex	(takes PRN for sleep) 6/25			
Lortab	(2 tabs a day) 6/25			
Had 6 shot's in back from pain center)				
Lipitor	1 qd			



Date Reviewed and Updated / By Whom

6:804 KMS	/	/	/	/
6x2504 KMS	/	/	/	/
/	/	/	/	/
/	/	/	/	/

UL-109

GUNN 004216

Upstate Lung And Critical Care Specialists, P.C.

F

Name: Casey William M. Chart# 11686 Date 8/17/04

Wt _____ Ht _____ B/P _____ H/R _____ RR _____ Temp _____ FiO2 _____

Cough _____ Smoking _____
Sputum _____ Nausea _____
Dyspnea _____ Vomiting _____
Wheeze _____ Diarrhea _____
Edema _____ Chest Pain _____
Palpitations _____ Pain _____
Oriented _____ ETOL _____
New Allergies _____
Last Chest X-Ray _____

Present Illness + reason for visit _____
ND

Physical Exam: ✓ WNL/NEG ✖ ABN/POS

* General Appearance _____
* Skin/Turgor _____
* ENT _____
* Sinus _____
* Mouth _____
* Neck _____
* Heart: Rhythm _____
  Murmurs _____
  Gallop _____
  Tones _____
* Abdomen _____
* Chest/Lungs:
  Breath Sounds _____
  Wheezes _____
  Rales _____
  Effort _____
  Symmetry _____
* Extremities:
* Mobility: Gait _____
  Reflexes _____
  Aides _____
* Mental Status _____

LAB ORDER: Spirometry ___ EKG ___ Sinus ___ CBC ___ Glu ___ PT ___ INR O_2Sat Rest
Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG'S ___ Bun ___ Cre K+ Theo
O_2Sat Rest ___

Office Treatment _____

Education _____

Diagnosis _____ Plan _____

Prescriptions

Next Appt. ___ Wks ___ Months W/GJF JAB DRE Signature _____ Staff _____
Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK _____ Other _____

GUNN 004217

Upstate Lung And Critical Care Specialists, P.C. F

Name: Casey William M Chart# 11686 Date 7-7-04

Wt 171 Ht _____ B/P 144/88 H/R 85 RR _____ Temp _____ FiO2 .21

Cough Some Smoking Quit 2wks Present Illness + reason for visit feels tightness
Sputum occ/brown Nausea + on chest. Also SOB soreness @
Dyspnea E xertion Vomiting 0 chest tube site. Sts has trouble
Wheeze some Diarrhea 0 to sleep on that side, feels
Edema feet Chest Pain@Chesttube sit. like heart is racing @ times
Palpitations + Pain _____
Oriented yes ETOL _____
New Allergies _____
Last Chest X-Ray _____

Feels better overall

Physical Exam: ✓ WNL/NEG ✖ ABN/POS

- General Appearance _____
- Skin/Turgor _____
- ENT _____ post. scarring/bump
- Sinus _____
- Mouth _____
- Neck _____
- Heart: Rhythm _____
  - Murmurs _____
  - Gallop _____
  - Tones _____ RR Mean 100's
- Abdomen _____
- Chest/Lungs:
  - Breath Sounds _____ Clear
  - Wheezes _____
  - Rales _____
  - Effort _____
  - Symmetry _____
- Extremities: _____
- Mobility: Gait _____
  - Reflexes _____
  - Aides _____
- Mental Status _____

LAB ORDER: Spirometry ___ EKG ___ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O_2Sat Rest 98
Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG'S ___ Bun ___ Cre ___ K+ ___ Theo ___
O_2Sat Rest _____

Office Treatment Referred to Pulm. Rehab — Home PRN

Education _____

Diagnosis Aplastic Cells Plan D/C pt. to home
S/P pneumothorax

Prescriptions _____

Next Appt. ___ Wks ___ Months W/GJF JAB DRE Signature _____ Staff _____
Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK _____ Other _____

GUNN 004218

SPIROMETRY REPORT — UPSTATE LUNG AND CRITICAL CARE — TEST DATE: 07/07/04
PB100 SW Rev: J-J — TIME: 15:02

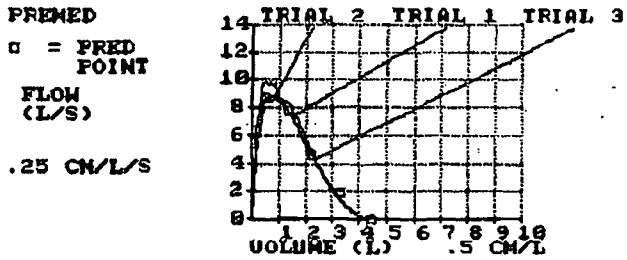
Patient Name: William Casey — PreMed Time: 15:03
tient ID: 11686 — Age: 45 — Height (in): 68 — Weight (lbs): 171 — Sex: Male — Race Correction: No — Smoker: Yes
rometric Pressure (mmHg): 760 — Temp (deg F): 70 — BTPS Correction: 1.110 — Sensor: FS200 — Insp Code: None
Last Cal Date: 07/07/04

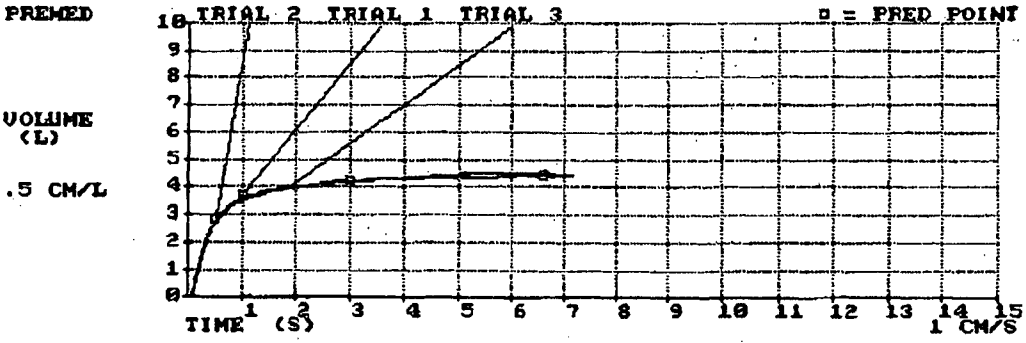
FVC TEST DATA - Clinical Format — BEST TEST SUMMARY — Knudson 83 Adult Predicted Normals

Measurement		PreMed	Pred	%Pred	PostMed	%Pred	%Change
FVC	(L)	4.47	4.45	100%			
FEV1	(L)	3.61	3.66	99%			
%FEV1	(%)	80.76	82.42	98%			
FEF25%-75%	(L/S)	3.57	3.85	93%			
PEF	(L/S)	9.98	8.67	115%			
FEV3	(L)	4.26	4.24	100%			
FET	(S)	4.95					

HAS Consumed / ADVAIR
USED yesterday, NOT TODAY

Variability: PreMed: FVC = 0.0%(0ml) FEV1 = 0.3%(10ml) PEF = 10.7%





Interpretations:
Lung Age: 47 years
PREMED: Testing indicates normal spirometry.
Comments:

GUNN 004219

1 of 3 pg 1

TELEPHONE CALL BACK - UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

DATE 06/25/04 TIME: ___ AM/PM CHART# 11686 BY DF

_____ / _____ called RE: William Casey
(caller name/relation)

TELEPHONE# _____ PT PHONE# _____

DATE OF LAST VISIT _____ NEXT APPT DATE _____ DOB [redacted]/58

#1: NEED DRUG REFILL (For patient doing well and no reason not to refill)

Drug Name: _____ Strength: _____ Freq: _____

Name of Pharmacy: _____ Pharmacy Telephone# _____

Drug Called in: _____ / ____ am/pm BY _____ _____
(Staff) (Doctor)

#2: PATIENT COMPLAINT

Pt and sister here this visit. Pt came back for a return follow-up visit. Patient's sister started asking questions to Dr. Boscia re: the rigid Bronch. Sister (carol Casey) wanted to know "Why the urgency of doing a bronch". Explained to patient that something was seen on the xray but he was unable to see it c the fibroptic-bronch but something was there.

Nursing Interventions/Advice Pt stated he did not have a prm with what Dr. Boscia had done. He reports he came to the hospital with pain in his chest reports ~~pain~~ no pain. Pt reported that all he wanted was something that

M.D. Signature

Call 911 _____ Go to ER _____ Appointment given in office _____

Referral(s) _____ Instructions Accepted Yes ___ No ___

JUN 28 2004 _____ / _____ _____ By: Boscia
(Date/Time) (Staff) (Doctor)

CALLED
JUN 28 2004

GUNN 004220

(2)

TELEPHONE CALL BACK - UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

DATE ___/___/___ TIME: ___ AM/PM CHART# _____ BY _____

_____/_____ called RE: _____
(caller name/relation)

TELEPHONE# _____ PT PHONE# _____

DATE OF LAST VISIT _____ NEXT APPT DATE _____ DOB _____

#1: **NEED DRUG REFILL** (For patient doing well and no reason not to refill)

Drug Name: _____ Strength: _____ Freq: _____

Name of Pharmacy: _____ Pharmacy Telephone# _____

Drug Called in: _____/___ am/pm BY _____ _____
(Staff) (Doctor)

#2: **PATIENT COMPLAINT**

would stop him from pacing All the time and be able to sleep at night. He reported that he has to take the Xanaflex prn just to sleep but he did not want to just be put to sleep he just wanted to rest and stop pacing Pt reported he was able to rest sit and watch TV before All this happened now he just finds himself pacing. Dr. Boscia told patient he was notable to answer all his questions because the procedure he did should Not we caused all these prns. Dr. Boscia Suggested

Nursing Interventions/Advice

Call 911 _____ Go to ER _____ Appointment given in office _____

Referral(s) _____ Instructions Accepted Yes ___ No ___

_____/_____ _____ Boscia
(Date/Time) (Staff) (Doctor)

GUNN 004221

3

TELEPHONE CALL BACK - UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

DATE ____/____/____ TIME: ____ AM/PM CHART# _____ BY _____

_____/_____ called RE: _____
(caller name/relation)

TELEPHONE# _____ PT PHONE# _____

DATE OF LAST VISIT _____ NEXT APPT DATE _____ DOB _____

#1: NEED DRUG REFILL (For patient doing well and no reason not to refill)

Drug Name: _____ Strength: _____ Freq: _____

Name of Pharmacy: _____ Pharmacy Telephone# _____

Drug Called in: _____/____ am/pm BY _____ _____
(Staff) (Doctor)

#2: PATIENT COMPLAINT

to them that they should talk to his partner who performed the other procedures. Patient's sister quickly said that she ~~dead~~ to see that they were not going to get any answers here. Encouraged her to make an appointment to see Dr. Feldman next week. She shook her head "no" that she would have "someone" contact us. At one point during the visit Mr. Casey stated "I don't want no parts of this, I just want to be able to rest + stop pacing." At one point the sister talked about all the expenses of the hospital bill.

Nursing Interventions/Advice

Call 911 _____ Go to ER _____ Appointment given in office _____

Referral(s) _____ Instructions Accepted Yes ___ No ___

_____/_____ _____ Boscia
(Date/Time) (Staff) (Doctor)

GUNN 004222

Patient was given an Prescription for Ambien And was Advised not to take this medication in conjunction with Cortab And Zanaflex.

DiAnn Foster

6:25:04 William Casey

1. Why such urgency of flexible bronch?

Boscia: "Window of opportunity"

-had CT before discharge

-Pt. went to hospital orginally for chest pain

Boscia: "Pain predates us. He had the pain before this procedure."

Pt. Sister: "He is having pain from this procedure!"

6:25:04 William Casey

Boscia: "I want to be firm! Don't take lactab, Zantac + Ambien together. It will suppress your respirations!"

William Casey: "The only question I have for you is what can you do to help me stop walking in circles?"

M.D. Signature

JUN 28 2004

RTR

GUNN 004224

Upstate Lung And Critical Care Specialists, P.C. (1)

Name: Casey William M. Chart# 11686 Date 6/25/04 B

Wt 172 Ht 68 B/P 130/90 H/R 90 RR ____ Temp ____ FiO2 RA

Cough occ
Sputum occ
Dyspnea 0
Wheeze occ
Edema 0
Palpitations occ
Oriented yes
New Allergies ____
Last Chest X-Ray ____

Smoking +
Nausea 0
Vomiting 0
Diarrhea 0
Chest Pain tightness
Pain Chronic back
ETOL Pain
Pain Level 3

Present Illness + ~~reason for visit~~ Gets tired easily
continues to have some
chest tightness. Reports
chron. back pain
continues to have trouble
resting - Sister reports
he is pacing and he cannot
sit down because he hurts

Physical Exam: ✓ WNL/NEG ✗ ABN/POS

- * General Appearance ✓ pt. c/o pacing floors
- * Skin/Turgor ✓ Could not sleeping
- * ENT ✓
- * Sinus ✓ See notes
- * Mouth ✓
- * Neck ✓
- * Heart: Rhythm ✓
  - Murmurs ✓
  - Gallop ✓
  - Tones ✓
- * Abdomen ✓
- * Chest/Lungs: ✓ Clear
  - Breath Sounds ✓
  - Wheezes ✓
  - Rales ✓
  - Effort ✓
  - Symmetry ✓
- * Extremities: ✓
- * Mobility: Gait ✓
  - Reflexes ✓
  - Aides ✓
- * Mental Status ✓

LAB ORDER: Spirometry ___ EKG ___ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O_2Sat Rest
Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG'S ___ Bun ___ Cre ___ K+ ___ Theo 96%
O_2Sat Rest ___

Office Treatment ____

Education ____

Diagnosis Chronic Pain
Anxiety

Plan Rtn i Feldmann
in 2 weeks
Ambien for sleep

Prescriptions ____

Next Appt ___ Wks ___ Months W/GIF IAB DRE Signature ____ Staff ____
Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK ____ Other ____

UL-121 Rev 8/03

GUNN 004225

(2)

Pt. Told not to take Xanaflex + Ambien

C Ambien

R

(1)

TELEPHONE CALL BACK - UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

DATE 6/22/04 TIME: ___ AM/PM CHART# 11686 BY MEH

_______________ / _______ called RE: William Carey
(caller name/relation)

TELEPHONE# ______________ PT PHONE# ______________

DATE OF LAST VISIT ______ NEXT APPT DATE ______ DOB ______

#1: NEED DRUG REFILL (For patient doing well and no reason not to refill)

Drug Name: ______ Strength: ______ Freq: ______

Name of Pharmacy: ______ Pharmacy Telephone# ______

Drug Called in: ______ / ______ am/pm BY ______ ______
(Staff) (Doctor)

#2: PATIENT COMPLAINT Call came 6/17/04 @ 4:30

Pt. called [illegible]
He [illegible]
[illegible] him [illegible]
[illegible] not [illegible]
I could not [illegible]
[illegible]. Asked [illegible]
[illegible]

Nursing Interventions/Advice: [illegible]
It was [illegible] to [illegible]
[illegible]
use. (over)

CALLED
JUN 22 2004

Call ... given in office

Referral ... AUG 22 2004 ... Accepted Yes ___ No ___

(Date/Time) (Staff) (Doctor)

... with: Diane Foster RN

GUNN 004227

(2)

Pt. said he was taking Zanaflex
so many as needed to "pass out"
@ night." Pt was warned not to
do that. Zanaflex not given by
this office.

(1)

Upstate Lung And Critical Care Specialists, P.C.

Name: William M. Casey Chart# 116816 Date 10-11-04

Wt 165 Ht 68" B/P 112/82 H/R 117 RR 18 Temp 100.° FiO2 RA

Cough + Smoking +
Sputum brown Nausea 0
Dyspnea 0 Vomiting 0
Wheeze 0 Diarrhea 0
Edema 0 Chest Pain 0
Palpitations 0 Pain Chest tube site 10/10
Oriented + ETOL
New Allergies 0
Last Chest X-Ray 10/6/04 UslCCS

Present Illness + reason for visit PN

Sweating all night
Coughing up brown phlegm

went to move cocc pm. (750)
8:45 - felt nauseated. vomited before went to bed "Phenergan, coke"
"some trouble Pedroom" (cough)

Physical Exam: ✓ WNL/NEG ✗ ABN/POS

* General Appearance	WNL	# PT will stay one sister felt tired, don't feel warm,
* Skin/Turgor	✓	feet + sister will Correct him + Change his gown.
* ENT	✓	
* Sinus	✓	
* Mouth	✓	
* Neck	✓ RS VD	
* Heart: Rhythm	RR	
Murmurs	SEM	
Gallop	✓	
Tones	✓	
* Abdomen	NT	
* Chest/Lungs:		
Breath Sounds	↓BSS	2 cm IV wash in over
Wheezes	0	
Rales	0	
Effort	0	
Symmetry		
* Extremities:		
* Mobility: Gait	✓	WNL
Reflexes	✓	
Aides	✓	
* Mental Status	X	AXOX3 - would not/cannot get down any more

"pt. states he is not 1 of 6 couples on parade spots." pt still be really doesn't cough

(very large clot per neb) with Phenergan, speech, (clear)

"CXR pa lat today" (same as 4/5 with blunted CP angle)

transcribed Lasix

TAKEN

LAB ORDER: Spirometry ___ EKG ___ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O2Sat Rest
Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG'S ___ Bun ___ Cre ___ K+ ___ Theo 9670
O2Sat Rest ___

Office Treatment nurse note over. —Hall

Education

Seen By Dr Brown

Diagnosis Resp
Cocc - spondy pna
S/P pneumothorax

Plan 2 pack (Amoxil)
Prog - cont

Prescriptions

Next Appt 2 Wks ___ Months W/GIF IAB (2) DRE Signature [signature] Staff HOW
Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK Other

(2)

Pt. told me he had talked to
A person of whom he saw their picture
while in my office about his condition.
I told him I wish he had not done
that because we do not speak of
any of our Pts with friends & family.
I would tell me free if he ask that
I did not know you.

Harold

TELEPHONE CALL BACK - UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

DATE 6/11/04 TIME: ___ AM/PM CHART# 11686 BY MEH

_____/_____ called RE: William Casey
(caller name/relation)

TELEPHONE# _____ PT PHONE# _____

DATE OF LAST VISIT _____ NEXT APPT DATE _____ DOB _____

#1: NEED DRUG REFILL (For patient doing well and no reason not to refill)

Drug Name: _____ Strength: _____ Freq: _____

Name of Pharmacy: _____ Pharmacy Telephone# _____

Drug Called in: _____/____am/pm BY _____ _____
(Staff) (Doctor)

#2: PATIENT COMPLAINT

Pt's sister called to report her brother was in severe pain @ chest tube site. was taking percocet 5mg 2-3 @ a time every 4 hrs with no relief. Pt. has appt. with Pain Center on 6/17/04 if not sooner. Dr. Bosica ordered oxycontin 20mg 1 BID only amount until Pain Center could see (Rx Written by my 13 pills) I talked with sister in front of Diann Foster RN of danger if Pt can't to take pain meds he had with oxycontin. Sister told nurse she would remove

Nursing Interventions/Advice

Call 911 _____ Go to ER _____ Appointment given in office _____

Referral(s) _____ Instructions Accepted Yes ___ No ___

_____/_____ _____ _____
(Date/Time) (Staff) (Doctor)

GUNN 004231

RZ

TELEPHONE CALL BACK - UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

DATE 6/11/04 TIME: ___ AM/PM CHART# _____ BY MEH

_____ / _____ called RE: William Cosey
(caller name/relation)

TELEPHONE# _____ PT PHONE# _____

DATE OF LAST VISIT _____ NEXT APPT DATE _____ DOB _____

#1: NEED DRUG REFILL (For patient doing well and no reason not to refill)

Drug Name: _____ Strength: _____ Freq: _____

Name of Pharmacy: _____ Pharmacy Telephone# _____

Drug Called in: _____ / ____ am/pm BY _____ _____
(Staff) (Doctor)

#2: PATIENT COMPLAINT

All pain meds from his home & only leave with him what he could take ~~get~~ have CD. Our office will call to see if appt with Pain Centre can be done

Nursing Interventions/Advice _____

Rx was picked up by M.D. Signature JUN 14 2004

Call 911 _____ Go to ER _____ Appointment given in office _____

Referral(s) _____ Instructions Accepted Yes ___ No ___

_____ / _____ _____ _____
(Date/Time) (Staff) (Doctor)

UL-124

GUNN 004232

TELEPHONE CALL BACK - UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

DATE 6/8/04 TIME: ___ AM/PM CHART# 11686 BY MEH

_____/_____ called RE: _____
(caller name/relation)

TELEPHONE# _____ PT PHONE# _____

DATE OF LAST VISIT _____ NEXT APPT DATE _____ DOB _____

#1: NEED DRUG REFILL (For patient doing well and no reason not to refill)

Drug Name: _____ Strength: _____ Freq: _____

Name of Pharmacy: _____ Pharmacy Telephone# _____

Drug Called in: _____/____ am/pm BY _____ _____
(Staff) (Doctor)

#2: PATIENT COMPLAINT

Nursing In

UPSTATE LUNG AND CRITICAL CARE SPECIALISTS, P.C.
1091 BOILING SPRINGS ROAD
SPARTANBURG, SC 29303
TELEPHONE (864) 573-6320
1419 N. LIMESTONE ST.
GAFFNEY, SC 29340
TELEPHONE (864) 487-9931
☐ Gregory J. Feldman, MD 15836 ☐ Joseph A. Boscia III, MD 22330 ☐ David R. Erb, MD 653599

NAME William Casey DATE 6/9/04
ADDRESS

LABEL DRUG NAME, STRENGTH & QUANTITY ☐ YES ☐ NO

		STRENGTH	QUANTITY	REFILL
1	Rx H. will DC CUT SIG H. work for 10 days RX RHT 10 weeks			
2	Rx Until mother SIG EVAL/DATA next APPT DATE	STRENGTH	QUANTITY	REFILL
3	Rx AUG. 17, 04 @ 10:30 SIG Hfa RX	STRENGTH	QUANTITY	REFILL 2

M.D. Dispense as Written M.D. Signature
DEA
UL-105

Call 911 _____ Go to ER _____ Appointment given in office _____

Referral(s) _____ Instructions Accepted Yes ___ No ___

_____/_____ _____ _____
(Date/Time) (Staff) (Doctor)

Armen Printing Co., Inc.

GUNN 004233

F

Upstate Lung And Critical Care Specialists, P.C.

Name: Casey, William Chart# 11686 Date 6/8/04

Wt 168 Ht 5'8" B/P 154/92 H/R 82 RR ____ Temp ____ FiO2 ____

Cough + Smoking + Present Illness + reason for visit HFU

Sputum ⊖ Nausea ⊖

Dyspnea ⊖ Vomiting ⊖ C/O nonproductive coughing.

Wheeze little Diarrhea ⊖ little wheezing, some CBS & pain & back pain.

Edema ⊖ Chest Pain ⊖ Sore

Palpitations ⊖ Pain back

Oriented + ETOL ____

New Allergies ⊖

Last Chest X-Ray ____ CK 0 + 10 (6)

Patient has been instructed on the DANGERS of Smoking and the importance of Stopping.

Dated: 6/8/04 BY: KMS

Physical Exam: ✓ WNL/NEG ✖ ABN/POS

- * General Appearance ✓ Pneumothorax
- * Skin/Turgor ✓ 9 - is now removed
- * ENT ✓
- * Sinus ✓
- * Mouth ✓
- * Neck ✓
- * Heart: Rhythm ✓
  - Murmurs ✓
  - Gallop ✓
  - Tones ✓
- * Abdomen Soft Nipples
- * Chest/Lungs: Back Pain
  - Breath Sounds ✓
  - Wheezes few
  - Rales ✓
  - Effort ✓
  - Symmetry ✓ - Cardiopulm
- * Extremities: ✓ exam
- * Mobility: Gait ✓
  - Reflexes ✓
  - Aides ✓ Pain under control
- * Mental Status ✓

LAB ORDER: Spirometry ___ EKG ✓ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O_2Sat Rest

Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG'S ___ Bun ___ Cre ___ K+ ___ Theo 94/1

O_2Sat Rest ___

Office Treatment ____

Education MUST QUIT SMOKING RTC 4 weeks

Diagnosis Referral to PA: Peter Plan Next Appt. 8/17/04

1) Pneumothorax Paid 29.00

2) Back pain Advair

3) Tobacco Abuse counseled

Prescriptions

Next Appt. ___ Wks ___ Months W/GJF JAB DRE Signature ____ Staff KSmith

Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK ____ Other ____

GUNN 004234

UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

PATIENT NAME: William Casey
ACCOUNT #:
DATE:
JOB #: 199

CHEST X-RAY:

FINDINGS: PA and lateral of the chest were obtained today. The heart, lungs, and bony structures are normal.

IMPRESSION:
1. Normal chest x-ray.

Joseph A. Boscia, MD

JAB:umt01
D: 06/11/04
R: 06/14/04
T: 06/15/04

GUNN 004235

CAROLINAS CENTER For Advanced Management of Pain

Comprehensive Evaluation and Medical Management | Diagnostic and Therapeutic Injections | Implantable Pain Control Systems | Neuroablative Procedures

Dr. Feldman wants Appt ASAP (this week)

NEW PATIENT REFERRAL FORM

Patient Name: William Casey

D.O.B.: [redacted] 1958 SS#: [redacted]

Address: 240 Lightwood Farm Road

City: Woodruff State: SC Zip: 29388

Home Phone #: 486-9131 Alt. Phone #: Carol Casey 680-9648 sister

Reason for referral: ☐ Consult Only

☑ Consult & TX

☐ Injection Only: _____ (type)

☐ Others: _____ (type)

Diagnosis: Bulging Disk, Disabling pain MRI of Back @ MBH

Insurance: BCBS (please send a copy of the card)

IS THIS A WORKMAN'S COMPENSATION INJURY? ☐ YES ☐ NO

IF YES: Carrier Information: _____

Adjuster/Case Manager: _____ Phone: _____

Referring Physician: Gregory Feldman

Office Address: 1091 Boiling Springs Rd

Office Phone#: 573-6370 Fax: 573-6323

Contact Person/Extension: Natalie Smith

PLEASE FAX MEDICAL RECORDS TO (864) 583-0390 WITH THIS REFERRAL FORM. APPOINTMENTS CANNOT BE MADE UNTIL BOTH ARE RECEIVED!

THE FOLLOWING PATIENT HAS AN APPOINTMENT WITH DR. _____

ON _____ AT _____. Scheduled by: _____

International Spinal Injection Society | Society for Advance Practice in Pain Management | American Pain Society

Carolinas Center for Advanced Management of Pain

88 McDowell Street, Asheville, NC 28801, 828-232-1955

64 Bear Drive, Greenville, SC 29605, 864-295-6399

279 East Kennedy Street, Spartanburg, SC 29302, 864-583-0053

Upstate Lung and Critical Care Specialists

HEALTH HISTORY

(Confidential)

Name Wm Mark Casey Today's Date June 8, 2004

Age 45 Birthdate [redacted]58 Sex M Date of last physical examination May 4, 2004

Who is your primary/referring physician? Dr Frank Gonda

What is the reason for the visit? follow up w/ DR Feldman

SYMPTOMS: Check (√) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☑ Back ☐ Legs
- ☑ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

RESPIRATORY
- ☐ Short of breath ☐ Cough
- ☐ Cough up blood ☑ Wheeze
- ☐ Loud snoring ☐ Excessive sleepiness

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Acid Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting

CARDIOVASCULAR
- ☑ Chest pain
- ☑ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Blood clots

EYE,EAR,NOSE,THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes
- ☐ Vision-Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Prostate difficulties
- ☐ Other

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ Other

Date of list menstrual period_____

Date of list Pap smear _____

Have you had a mammogram? _____

Date of mammogram____

Are you pregnant? _____

Number of children ____

CONDITIONS: Check (√) symptoms you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☑ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☑ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS: List medications you are currently taking including inhalers and over the counter medicines.

PLEASE BRING WITH YOU

Name	Strength	Times Per Day	Name	Strength	Times Per Day
Baytrin	20 mg	1			
Ultram	50 mg	2 X 4			
Zanaflex		1			
Loratab	10	1 X 2			

PHARMACY NAME: CVS Reidville Rd PHONE _____

ALLERGIES

HOSPITALIZATION

YEAR	HOSPITAL	REASON for HOSPITALIZATION and OUTCOME
2000	Spthg Regnal Chest Pain	
1996	Hemorrhoid. Surgery	
	many back	

Have you ever had a blood transfusion? ☐ Yes ☒ No
If yes, please give approximate dates? _____

PHYSICIANS THAT YOU ROUTINELY VISIT:

NAME	ADDRESS	PHONE NUMBER
Dr Frank Gonda	Boiling Springs	

PULMONARY HISTORY

Are you a smoker ☐ No ☐ Yes If yes, how many packs? less than 1/2 pack How many years? 25 If you have quit, how many years did you smoke? _____ Packs per day? _____ How long did you quit? _____
Does anyone else in your home smoke? ☒ No ☐ Yes

Do you have a chronic cough? ☒ No ☐ Yes If yes, how long have you had it? _____ Did you cough anything up? ☐ No ☐ Yes What color are you coughing up? Have you ever coughed up blood? ☐ No ☐ Yes If yes, when?

Do you get short of breath if you walk or climb steps? ☒ No ☐ Yes At rest? ☐ No ☐ Yes At other times? ☐ No ☐ Yes If yes, when? _____

Do you ever notice yourself wheezing? ☐ No ☒ Yes If yes, what make the wheezing worse? _____

When was your last Chest X-ray? 6-6-04 Where? Spartanburg Regional

Have you ever had a skin test for TB (Tuberculosis) ☐ No ☐ Yes If yes, When? ? _____

Have you ever been exposed to TB ☐ No ☐ Yes If yes, When? NO Have you had skin test since being exposed? ☐ No ☐ Yes If yes, what kind? _____

Do you have indoor pets? ☐ No ☒ Yes If yes, what kind? Cocker Spaniel

Have you been or are you exposed to dust or fumes ☐ No ☒ Yes If yes, what kinds? Michelin - Heptane

Have you traveled out of the Upstate area? ☐ No ☒ Yes If yes, Where?

GUNN 004238

SYMPTOMS:	SOCIAL HISTORY	OCCUPATIONAL CONCERNS
Check ($) which substances you use and how much you use ☐ Caffeine 6 yes ☐ Street Drugs ☒ Tobacco 1/2 pack ☐ Alcohol social ☐ Other	☐ Married ☒ Divorced ☐ Widowed ☐ Single ☐ Number of Children 2 ☐ Hobbies Golf	OCCUPATION: Michelin Tire Building tires Check ($) if your work exposes you to: ☐ Stress ☒ Heavy Lifting ☐ Hazardous Substances ☐ Other

FAMILY HISTORY

Parent's living? ☐ Yes ☒ No, ☐ Father's Age/Cause of Death 73 - fatal emphysema

☐ Mother's Age/Cause of Death 72 - pulmonary embolism in hosp. - likely to renal + cardiac complications

Siblings living? ☒ Yes ☐ No, ☐ Brother's Age/Cause of Death 43 - radiation burn to pulmonary artery & bronchial tube resulting in rupture + bleed

☐ Sister's Age/Cause of Death

Any additional Pulmonary family problems?

Immunization History
Flu Vaccine
Pneumonia Vaccine

Do you have any other medical concerns that you would like to discuss with your doctor? ☐ Yes ☐ No

Wm Mark Casey
Signature

6-8-04
Date

1. Doing well - see OP
S/P pneumonectomy
(1) dyspnea on exertion
(unable to perform heavy labor → very abnormal breathing
(residual)
c 2

CAROLINAS CENTER For Advanced Management of Pain

Comprehensive Evaluation and Medical Management | Diagnostic and Therapeutic Injections | Implantable Pain Control Systems | Neuroablative Procedures

M.D. Signature

JUN 28 2004

June 17, 2004

Gregory J. Feldman, M.D.
1091 Boiling Springs Road
Spartanburg, SC 29303

RE: CASEY, William

Dear Dr. Feldman:

Thank you referring Mr. Casey to our pain clinic. He was seen about three and one-half years ago, after being referred by his family physician, Dr. Gonda. He was diagnosed with mechanical low back pain. I ordered an MRI scan of his lower back, but the patient never returned.

Today, the patient's clinical features have not really changed except for Mr. Casey appearing to be more depressed. He is also having some epigastric pain but on examination, this looks as if it is coming from his chest wall. I think he may benefit from being seen by a gastroenterologist. As far as his low back pain is concerned, it is purely mechanical, and his MRI is practically normal with two slightly bulging disks that are obviously not his source of pain. He received an epidural steroid injection by a radiologist at Mary Black, which did not help. Firstly, according to the picture that I have seen, they never got the needle into the epidural space and, secondly, the patient did not have pain that can be alleviated with an epidural steroid injection. I discussed treatment options with Mr. Casey, and, again, I think he would benefit from diagnostic and, hopefully, therapeutic lumbosacral joint injections. If this would provide relief for only a short period of time, then we would set him up for specific therapy for his pain.

Also, I believe Mr. Casey would benefit from seeing a psychologist or psychiatrist to treat his anxiety and depression. At this point, however, we will not address this issue.

Again, thank you again for allowing me to participate in the consultation and treatment of this patient.

Sincerely,

Y. Eugene Mironer, M.D.

YEM/ss/mds
cc: Frank E. Gonda, M.D.

(Dictated, not read)

RECEIVED
JUN 28 2004
BY:

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

Note: Document is draft unless signed.
<END FOOTER>

M.D. Signature
JUN 08 2004

CONSULT
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
ACCOUNT NUMBER: 414900306
DATE OF SERVICE:
ATTENDING PHYSICIAN: KOSER, ANDRAS
ROOM:

HISTORY OF PRESENT ILLNESS: This 46-year-old smoking male presented to the hospital for chest pain. An initial chest x-ray on admission showed what appears to be a foreign body in the left mainstem bronchus. I am being asked to comment on this. This patient complains of pain in his chest that is sharp that goes directly straight to his back. There is a history of cough. No history of hemoptysis.

PAST MEDICAL HISTORY: includes hypercholesterolemia. No history of hypertension or diabetes.

SOCIAL HISTORY: He has a 25 pack year smoking history. He works at Michelin.

FAMILY HISTORY: Is noncontributory.

REVIEW OF SYSTEMS: Includes all mentioned in history of present illness. Also, he has chronic back pain, occasional headaches, occasional constipation. All other review of systems are negative.

PHYSICAL EXAMINATION: He appears well in no acute respiratory distress. Blood pressure is 150/90, pulse is 84. Pupils react to light. The oral mucosa is moist without thrush. Neck is supple. Heart is regular. Lungs are clear bilaterally. Abdominal exam reveal no hepatosplenomegaly. Extremities are without clubbing, cyanosis or edema. Skin is intact with no rashes. Joints are not inflamed. Neurologically, cranial nerves II through XII are intact without focality.

Chest x-rays been reviewed in it does show what appears to be an irregular metallic foreign body in the left mainstem bronchus.

IN SUMMARY: 46-year-old gentleman with what appears to be a foreign body in the left mainstem bronchus. He has consented to fiber-optic bronchoscopy which would be the

most reasonable next step. Will perform fiber-optic bronchoscopy to see if this foreign body is removable. If it is not removable or granulated in, than rigid bronchoscopy in the operating room will be performed. Risks, benefits, and alternatives were discussed with Mr. Casey and he agrees to proceed with bronchoscopy.

DICTATED BY: JOSEPH A BOSCIA III, M.D.
D:05/28/2004 14:26:33
T:06/03/2004 11:25:39/lb
65506/64110

cc:
ANDRAS KOSER, M.D., Admitting Physician

%%END
Authenticated by Joseph A. Boscia, MD. On 6/07/04 5:08:48 PM

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

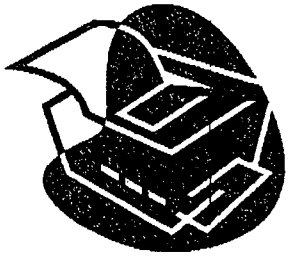
11686

OP REPORTS [redacted] **M.D. Signature**

UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

1091 Boiling Springs Road
Spartanburg, SC 29303
Ph: (864) 573-6320
Fax: (864) 573-6323

Gregory J. Feldman, M.D.
Joseph A. Boscia, M.D.
David R. Erb, M.D.
Charles R. Mason, P.A.-C



FAX TRANSMISSION

To: Lung dchest — From: Lori -Medical Records
Fax: 585-2102 — Pages: 8
Phone: — Date: 10/22/04
Re: William Mark Casey — cc:

☐ Urgent ☑ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

If you do not receive all pages indicated, please call me.

Thank you

NP
William Mark Casey II

10/22/2004 13:42 8645736323 UPSTATE LUNG PAGE 01

Upstate Lung And Critical Care Specialists, P.C.

me: William M. Casey Chart# 11686 Date 10-11-04

Wt 165 Ht 68" B/P 112/82 H/R 117 RR 18 Temp 100.° FiO2 RA

Cough + Smoking + Present Illness + reason for visit PV
Sputum brown Nausea 0
Dyspnea 0 Vomiting 0 Sweating all night
Wheeze 0 Diarrhea 0 Coughing up brown phlegm
Edema 0 Chest Pain 0
Palpitations 0 Pain Chest tube
Oriented + ETOL sick 10/10 went to move car. (750)
New Allergies 0 8:45 - felt nauseated. went home
Last Chest X-Ray 10/6/04 USLCCS went to bed "freezing, cold."
"some taking Pseudomon" (Cipro)
sister felt head, didn't feel warm.
pos some drainage c site of CT.
can't describe specifically the drainage
don't want get confused.
"Can't play golf today" (nurse says it's not a bluish cast playing)
nauseated last night
taking

Physical Exam: ✓ WNL/NEG ✖ ABN/POS

* General Appearance	WNL	pt well developed, well nourished, in no acute distress
* Skin/Turgor	✓	
* ENT	✓	Normocephalic, atraumatic, PERRLA, EOMI, conjunctiva clear, sclera anicteric, nares patent, no lesions or masses, hearing grossly intact, oropharynx clear, mucous membranes moist, good dentition
* Sinus	✓	
* Mouth	✓	
* Neck	✓	JVD
* Heart: Rhythm	RR	
Murmurs	SEM	
Gallop	✓	
Tones	✓	
Abdomen	NT	
* Chest/Lungs:		(very diffuse clear pan rales)
Breath Sounds	↓BSS	↓ BS throughout bilateral, especially bases
Wheezes	0	
Rales	0	"pt. sputum be sent 1 of 6 cough - very purulent sputum" pt states he really doesn't cough
Effort	✓	
Symmetry		
* Extremities:		
* Mobility: Gait	✓	no deficits
Reflexes	✓	
Aides	✓	
* Mental Status	X	ANXIOUS - would not/could not sit down during exam

LAB ORDER: Spirometry ___ EKG ___ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O_2Sat Rest
Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG'S ___ Bun ___ Cre ___ K+ Theo 96%
O_2Sat Rest ___

Office Treatment nurse note over. -Stat Rx

Education

Seen By Dr Bowen

Diagnosis Resp Plan 2 Packs (Cipro)
Cough - Sputum prod. prog - cont
S/P pneumothorax

Prescriptions

Next Appt. 2 Wks ___ Months W/GJF IAB DRE Signature Staff HRW
Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK Other

GUNN 004245

Upstate Lung And Critical Care Specialists, P.C.

13

ame: Casey William M. Chart# 11686 Date 6/25/04

Wt 172 Ht 68 B/P 130/90 H/R 90 RR ____ Temp ____ FiO2 RA

Cough occ
Sputum occ
Dyspnea ø
Wheeze occ
Edema ø
Palpitations occ
Oriented yes
New Allergies ___
Last Chest X-Ray ____

Smoking +
Nausea ø
Vomiting ø
Diarrhea ø
Chest Pain tightness
Pain Chronic back
ETOL Pain
Pain Level 3

Present Illness + reason for visit Gets tired easily continues to have some chest tightness. Reports chronic back pain continues to have trouble resting - Sister reports he is pacing. And he cannot sit down because he hurts

Physical Exam: ✓ WNL/NEG * ABN/POS

* General Appearance — pt. c/o pacing floors
* Skin/Turgor — could not sleeping:
* ENT — See notes.
* Sinus
* Mouth
* Neck
* Heart: Rhythm
  - Murmurs
  - Gallop
  - Tones
* Abdomen
* Chest/Lungs:
  - Breath Sounds — Clear
  - Wheezes
  - Rales
  - Effort
  - Symmetry
* Extremities:
* Mobility: Gait
  - Reflexes
  - Aides
* Mental Status

LAB ORDER: Spirometry ___ EKG ___ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O_2Sat Rest
Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG'S ___ Bun ___ Cre ___ K+ ___ Theo 96%
O_2Sat Rest ___

Office Treatment ____

Education ____

Diagnosis — Chronic Pain
Emotions

Plan — Rx Vicodin & Feldene
in 2 weeks
Antivan for sleep

Prescriptions

Next Appt. ___ Wks ___ Months W/GJF JAB DRE Signature ____ Staff DYoakum
Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK ____ Other ____

PAGE 05 UPSTATE LUNG 8645736323 10/22/2004 13:42

Upstate Lung And Critical Care Specialists, P.C.

F

ame: Casey William M. Chart# 11680 Date 8/17/04

wt _____ Ht _____ B/P _____ H/R _____ RR _____ Temp _____ FiO2_____

Cough_____ Smoking _____
Sputum _____ Nausea _____
Dyspnea_____ Vomiting _____
Wheeze _____ Diarrhea _____
Edema _____ Chest Pain_____
Palpitations _____ Pain _____
Oriented_____ ETOL _____
New Allergies ____
Last Chest X-Ray _____

Present Illness + reason for visit _____

NC SMOC

Physical Exam: ✓ WNL/NEG ✖ ABN/POS

* General Appearance _____
* Skin/Turgor _____
* ENT _____
* Sinus _____
* Mouth _____
* Neck _____
* Heart: Rhythm _____
  Murmurs _____
  Gallop _____
  Tones _____
* Abdomen _____
  Chest/Lungs:
  Breath Sounds ____
  Wheezes _____
  Rales _____
  Effort _____
  Symmetry _____
* Extremities:
* Mobility: Gait _____
  Reflexes _____
  Aides _____
* Mental Status _____

LAB ORDER: Spirometry ___ EKG_____ Sinus ___ CBC ___ Glu___ PT ___ INR O_2Sat Rest
Lung Vol ___ DLCO ___ U/A _____ CXR___ ABG'S ___ Bun ___ Cre K+ Theo
O_2Sat Rest __

Office Treatment _____

Education _____

Diagnosis_____ Plan _____

Prescriptions

Next Appt. ___ Wks ___ Months W/GIF JAB DRE Signature _____ Staff _____
Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK _____ Other _____

PAGE 02 UPSTATE LUNG 8645736323 10/22/2004 13:42 Akman Printing Co., Inc. 05/03

GUNN 004247

Upstate Lung And Critical Care Specialists, P.C. F

me: Casey William m Chart# 11686 Date 7-7-04

Wt 171 Ht ____ B/P 144/88 H/R 85 RR ____ Temp ____ FiO2 .21

Cough Some Smoking quit 2wks Present Illness + reason for visit feels tightness
Sputum Occ/brown Nausea + in chest. Also c/o soreness @
Dyspnea ↑ Exertion Vomiting 0 chest tube site. Sts has to lay on that side, feels
Wheeze some Diarrhea 0 like heart is racing @ times
Edema feet Chest Pain@Chesttube site
Palpitations + Pain
Oriented ups ETOL
New Allergies
Last Chest X-Ray

Feels better, complains just slurry/tired

Physical Exam: ✓ WNL/NEG ✖ ABN/POS

* General Appearance
* Skin/Turgor
* ENT
* Sinus
* Mouth
* Neck
* Heart: Rhythm
  Murmurs
  Gallop
  Tones
  Abdomen FC/V mass RUQ
* Chest/Lungs:
  Breath Sounds clear
  Wheezes
  Rales
  Effort
  Symmetry
* Extremities:
* Mobility: Gait
  Reflexes
  Aides
* Mental Status

LAB ORDER: Spirometry ___ EKG ___ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O_2Sat Rest 98
Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG'S ___ Bun ___ Cre ___ K+ ___ Theo ___
O_2Sat Rest ___

Office Treatment Referred to Pul Rehab — Home PRN

Education

Diagnosis Aplastic Anemia Plan Pul rehab
CP pneumothorax

Prescriptions

Next Appt. ___ Wks ___ Months W/GIF JAB DRE Signature ____ Staff ____
Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK ____ Other ____

PAGE 03 UPSTATE LUNG 8645736323 10/22/2004 13:42

GUNN 004248

SPIROMETRY REPORT — UPSTATE LUNG AND CRITICAL CARE — TEST DATE: 07/07/04
PB100 SW Rev: J-J — TIME: 15:02

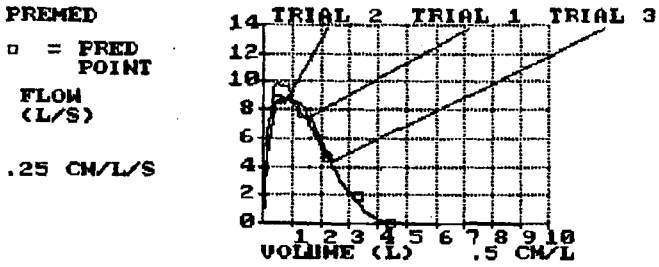
ent Name: William Casey — PreMed Time: 15:03
nt ID: 11686 — Age: 45 — Height (in): 68 — Weight (lbs): 171 — Sex: Male — Race Correction: No — Smoker: Yes
Barometric Pressure (mmHg): 760 — Temp (deg F): 70 — BTPS Correction: 1.110 — Sensor: FS200 — Insp Code: None
Last Cal Date: 07/01/04

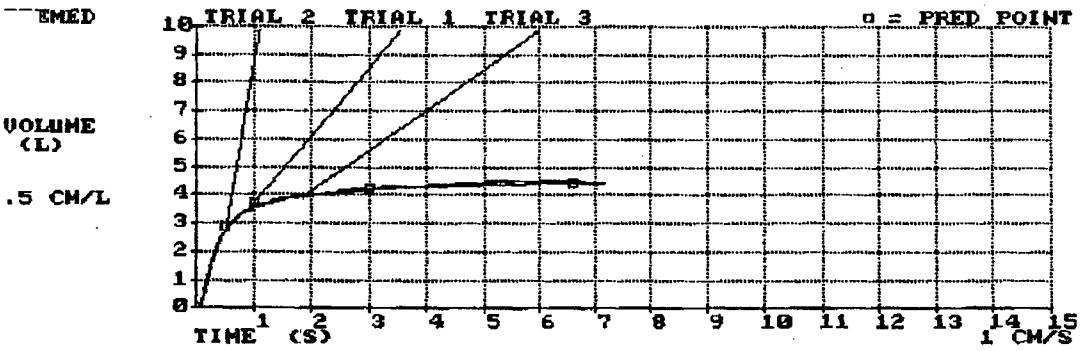
FVC TEST DATA - Clinical Format — BEST TFST SUMMARY — Knudson 83 Adult Predicted Normals

Measurement		PreMed	Pred	%Pred	PostMed	%Pred	%Change
FVC	(L)	4.47	4.45	100%			
FEV1	(L)	3.61	3.66	99%			
%FEV1	(%)	80.76	82.42	98%			
FEF25%-75%	(L/S)	3.57	3.85	93%			
PEF	(L/S)	9.98	8.67	115%			
FEV3	(L)	4.26	4.24	100%			
FET	(S)	4.95					

HAS Consumed / Advair used yesterday, not today

Variability: PreMed: FVC = 0.0%(0ml) FEV1 = 0.3%(10ml) PEF = 10.7%





Interpretations:
Lung Age: 47 years
PREMED: Testing indicates normal spirometry.
Comments:

GUNN 004249

F

Upstate Lung And Critical Care Specialists, P.C.

me: Casey, William Chart# 11686 Date 6/8/04

Wt 168 Ht 5'8" B/P 154/92 H/R 82 RR ____ Temp ____ FiO2 ____

Cough +	Smoking +	Present Illness + reason for visit HFU	
Sputum ø	Nausea ø		
Dyspnea ø	Vomiting ø	C/O nonproductive coughing,	
Wheeze little	Diarrhea ø	little wheezing, some chest	
Edema ø	Chest Pain ø some	pain + back pain.	
Palpitations ø	Pain back		
Oriented +	ETOL ____		
New Allergies ø			
Last Chest X-Ray ____ CXR 0+10 (6)		Patient has been instructed on the DANGERS of Smoking and the importance of Stopping.	

Dated: 6/8/04 BY: KMS

Physical Exam: ✓ WNL/NEG ✖ ABN/POS

* General Appearance	✓	
* Skin/Turgor	✓	Pneumothorax
* ENT	✓	R - is now minimal
* Sinus	✓	
* Mouth	✓	
* Neck	✓	
* Heart: Rhythm	✓	
Murmurs	✓	dizziness
Gallop	✓	
Tones	✓	
Abdomen	soft	Both lungs
Chest/Lungs:		
Breath Sounds	____	
Wheezes	few	
Rales	____	- Coughing
Effort	____	
Symmetry	____	dyspnea
* Extremities:		
* Mobility: Gait	✓	Pain under to the
Reflexes	____	
Aides	____	
* Mental Status	____	

LAB ORDER: Spirometry ___ EKG ✓ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O_2Sat Rest

Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG'S ___ Bun ___ Cre ___ K+ ___ Theo 94%

O_2Sat Rest ___

Office Treatment ____

Education must quit smoking

Diagnosis Referral to PA pulmonary — Dr. Carter

Prescriptions

1) Pneumothorax Prod. 2g QD
2) Both lungs Albuterol
3) Follow Xrays weekly

2 weeks f/u next appt. 8/17/04

Next Appt. ___ Wks ___ Months W/GJF JAB DRE Signature ____ Staff KSmith

Next Visit: Spiro L/V DLCO PA PAL Sinus Dexa BLDWK ____ Other ____

PAGE 07 UPSTATE LUNG 8645736323 10/22/2004 13:42

GUNN 004250

UPSTATE LUNG AND CRITICAL CARE SPECIALISTS

PATIENT NAME: William Casey
ACCOUNT #:
DATE:
JOB #: 199

CHEST X-RAY:

FINDINGS: PA and lateral of the chest were obtained today. The heart, lungs, and bony structures are normal.

IMPRESSION:
1. Normal chest x-ray.

Joseph A. Boscia, MD

JAB:umt01
D: 06/11/04
R: 06/14/04
T: 06/15/04

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

OP REPORTS

PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
PROCEDURE DATE: 6/3/04
ACCOUNT NUMBER: 415400048
ROOM: ICU

M.D. Signed on-Line

PROCEDURE PERFORMED: Rigid bronchoscopy with laser bronch.

ENDOSCOPIST: Dr. Feldman.

INDICATIONS FOR PROCEDURE: 45 year old had been worked up by Dr. Paladugu and my partner, Dr. Boscia, with the finding of abnormal granulation tissue and abnormal subsegment in the left upper lobe corresponding to what appeared to be a crown foreign body on chest x-ray. The patient is now undergoing procedure in attempt to removal of chest x-ray abnormality suggestive of a crown; the patient does have a history of a missing crown.

After general anesthesia was induced, the patient was intubated with a rigid bronchoscope, size 16, without any difficulty. Careful inspection of the tracheobronchial tree was undertaken. The entire tracheobronchial tree was examined, there was no finding of a foreign body, however, a quite abnormal subsegment in the left upper lobe which appeared to be a pouch/granulation tissue has been identified. Laser of the area has been done with 45 watts over a 2-second period. Granulation tissue has been vaporized with the appearance of what appeared to be crown lying on the surface. With using 35 watts energy of the laser, there was no possibility of removal of the crown because it was deeply imbedded, and laser energy was applied to the center of the crown [illegible] However, below the surface there has been no further foreign body

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

NC

M.D. Signed on-Line

OP REPORTS
PATIENT NAME: CASEY, WILLIAM
DOB: [redacted]/1958
MEDICAL RECORD #: 146220
PROCEDURE DATE: 5/28/2004
ACCOUNT NUMBER: 414900306
ROOM:

PROCEDURE(S) PERFORMED: Bronchoscopy.

REASON FOR PROCEDURE: 45 year-old male with what appears to be a foreign body.

MEDICATIONS: Versed 10 mg IV (intravenous), Fentanyl 100 mcg IV (intravenous), topical lidocaine.

DESCRIPTION OF PROCEDURE: After informed consent was obtained, the right nostril was anesthetized with topical lidocaine. The bronchoscope was advanced to the trachea without difficulty. Trachea as well as right segmental and subsegmental bronchi were normal, patent, without bronchial pathology. However, upon entering the left main stem bronchus, the distal end where the take off of the left upper lobe starts on the medial wall, there is a very erythematous area that was easily friable. No observable foreign body was noted. The airway post the erythematous take off of the left upper lobe was normal. The bronchoscope was withdrawn. The patient tolerated the procedure well.

DICTATED BY: JOSEPH A BOSCIA III, M.D.

D:05/28/2004 14:37:52
T:06/03/2004 21:43:08/lf
65517/64371

cc: ANDRAS KOSER, M.D., Admitting Physician

Note: Document is draft unless signed

GUNN 004253

Cardiology Consultants

Joseph R. Dorchak, M.D., F.A.C.C.
James R. Story, M.D., F.A.C.C.
F. Michael Eickman, M.D., F.A.C.C.
Barry L. Huey, M.D., F.A.C.C.
David G. Ike, M.D., F.A.C.C.
Larry E. Kibler, M.D., F.A.C.C.
Nalin K. Srivastava, M.D., F.A.C.C.
David J. Rodak, M.D., F.A.C.C.
Alejandro N. Lopez, M.D., F.A.C.C.
Kristen P. Nawabi, M.D.
John J. Gallagher, M.D., F.A.C.C.
Robin Simpkins, R.N., A.N.P., A.C.N.P.

NUCLEAR STRESS STUDY

NAME: CASEY, WILLIAM M.

DOB: [redacted]/58

DATE: AUGUST 2, 2004

CLINICAL HISTORY:
Mr. Casey is a 45-year-old patient of Dr. Gonda. The patient has also seen Dr. Srivastava. This study is ordered by Dr. Wilson Smith for evaluation of chest pain. The patient had an abnormal calcium score by CT. The patient also had a normal catheterization in the year 2000.

DESCRIPTION OF STUDY:
Resting images were obtained after the administration of 10 mCi of Cardiolite. The patient then underwent Bruce protocol stress testing completing 9 minutes of exercise achieving 10.1 mets and 87 percent of the predicted maximum heart rate. At peak exercise, 25 mCi of Cardiolite were administered.

FINDINGS:
The raw images revealed no significant lung uptake.

The SPECT images revealed normal perfusion on stress and rest images. There was no evidence for ischemia.

The gated images revealed normal systolic function with a calculated ejection fraction of 58 percent. There were no regional wall motion abnormalities present.

IMPRESSION:
Normal study.

COMMENT:
Previous Cardiolite in July of 2000 revealed inferior ischemia. This was subsequently found to be a false-positive study. This study is normal.

David G. Ike, M.D., F.A.C.C.
Cardiology Consultants, P.A.
DGI:MSM

Date 8-9-04 By AS
DOLV 7-29-00 DONV 8-12-04

cc: Nalin K. Srivastava, M.D.
Frank E. Gonda, M.D.
Wilson P. Smith, Jr., M.D.

1083 Boiling Springs Road • Spartanburg, SC 29303-2298 • (864) 583-8647 • Fax: (864) 542-2227

SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
DRS. DAVIS, LOWRY, WREN, NELSON, RAINER, LAPHAM, MIMS, CALDWELL & BURKS

CASEY WILLIAM MR#: (0002)00014-62-20 Pin.No.:0421101061 Admitted: 29JUL04
45 YRS MALE DOB: [redacted]/1958 Page: 1
Dr. SMITH WILSON P INTERIM Printed: 04AUG04
Location: - PRIVATE OUT PT VISIT ANEMIA NOS 0204

CHEMISTRY

----------REFERENCE LAB TESTS----------

Procedure:	TIBC @	IRON @	% SATURATION @	
Units:	ug/dL	ug/dL	%	
29JUL04 1340	434 Hf	87 f	20 f	
TIBC.....				Reference Range: 250-400
IRON.....				Reference Range: 40-190

TIBC should be ordered with iron for optimal utility.

% SATURATION.. Reference Range: 15-50

8/4/04
WV

Symbols:
H = High, f = Footnote.
@ = TIBC, IRON, % SATURATION Performed at QUEST DIAGNOSTIC LAB - 33608 ORTEGA HIGHWAY, SAN JUAN CAPRISTRANO, CA. 92690

Patient Name:CASEY WILLIAM Location: PRIVATE OUT PT VISIT END OF CHART.

Send to: WILSON P SMITH MD Fax to: 864-582-3750
LUNG & CHEST
2030 NORTH CHURCH PLACE
SPARTANBURG SC 293030000

REVIEWED BY_____DATE_____
(DO NOT FILE IF NOT COMPLETE)

FINAL

Admission - 5/28/04
XR 9:53AM - Cat scan 6:05 PM
overnight - discharge - 5/29/04

Surgery - 6/3/04
ICU - 6/3, 4, 5/04
Step down - 1 day - 4T

PRINTED BY: FM20261
DATE 6/11/2004

YAG Laser

D. Joseph
Jay Grace
Psychologist
PTSD

Family med
61512

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: CASEY,WILLIAM
ORDERING PHYSICIAN: KOSER,ANDRAS
LOC: 4W-434-A
Pt. Type:IP

DOB: [redacted]/58

UNIT #: 000146220
CI#: 1216733
AN#:S0414900306

Exam
60220 CT LUNG WITHOUT CONTRAST
71250

Date: 05/28/04 1805
Ord Diag: Chest Pain NOS 786.50

Chest CT scan 5/28/2004.

Indication: Evaluate for possible foreign body. Patient works in construction and apparently on a chest x-ray had a metallic foreign body.

The chest x-ray cannot be located for comparison. Spiral images were obtained through the chest without contrast. There are no metallic foreign bodies evident other than snaps and monitoring leads on the patient's skin. The lungs are free of nodules and infiltrates. There is left anterior descending coronary artery calcification. No other abnormalities are evident of the noncontrasted mediastinum.

Impression:

1. Negative for opaque foreign body.

2. Left anterior descending coronary artery calcification.

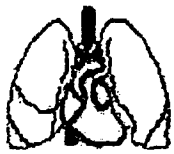
Read By: Peter Ryan, M.D.
Released By: Peter Ryan, M.D.

LMB

FINAL

PRINTED BY: FM20261
DATE 6/11/2004

GUNN 004257



CASEY, WILLIAM M

50 Y old Male, DOB: [redacted]/1958
419 QUAIL RIDGE CIRCLE, BOILING SPRINGS, SC-29316-6119
Home: 864-814-2617
Guarantor: CASEY, WILLIAM M Insurance: BCBS PPC
PCP: FRANK E GONDA

12/08/2008 Charles M. Fogarty, MD

Current Medications
Tricor 145 mg 1 tab(s) qd by Dr. Ganda has not taking any latly
Vytorin 10 mg-40 mg 1 tab(s) qd not taking
mirtazapine 45 mg 1 tab(s) once a day (at bedtime)
Adderall XR 20 mg 1 cap(s) tid
Lortab 10 500 mg-10 mg 1 tab(s) Q6H
Ambien 10 mg 1 tab q/hs/prn

Past Medical History
Chest wall pain
Back pain
Hyperlipidemia
Difficulty with multitasking, concentrating, s/post pneumomediastinum/pneumothorax

Social History
Marital status: Divorced.
Education level: College one year.
Occupation: disabled from his Lungs.
Alcohol: reports, socially.
Other MDs: Primary care Dr. Ganda.

Allergies
NKMA

Review of Systems
CONSTITUTIONAL:
no Fever/Chills. no Night sweats.
ENT:
no Nasal discharge. no Sore throat.
RESPIRATORY:
no Shortness of breath. no Cough, Dry. no Wheezing. c/o Pleuritic Chest Pain, left chest wall.
CARDIOLOGY:
no Leg edema. no Dizziness.
GASTROENTEROLOGY:
c/o Nausea. no Vomiting.
Reviewed by: Theresia Meyers

CC
1. States still feelling the same, chest wall pain with exertion and back pain

HPI
Interim History:

Mr. Casey he reports no significant change in his chest wall pain or back pain. This is mainly related to movement or exertion. It is relieved by Lortab.

He continues to have difficulty in concentrating. He has to take notes to remember what is going to do later in the day. He is followed by a psychiatrist in Greenville and is on Adderall but still has difficulties with staying focused. He continues his regular followup with Dr. Gonda who is his primary care doctor.

Vital Signs
Wt: 182.6, BP: 124/80, HR: 99, O2 sat: 96%, FIO2: .21, FVC: 3.97, FEV1: 3.23, FEV1/FVC%: 81%, Ht: 68, BMI: 27.76.

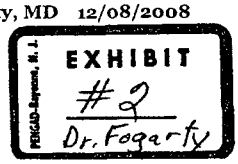
Physical Examination

on exam the patient is no acute distress. The patient has not been paying as much attention by his own admission to oral hygiene and he has teeth are in only fair repair On exam today. The pupils are symmetric. Next her wrist pain. Trachea midline. No wheezes rales or rhonchi. The patient's chest wall pain increases with anterior-posterior compression suggesting a mass a skilled etiology. Fremitus is symmetric. Heart tones regular. No murmur or gallop. No abdominal organomegaly. No cyanosis edema or clubbing. Coordination normal range..

Assessments
the patient appears stable in terms of his lung function. He needs to followup with a dentist; The deterioration in his oral hygiene and condition of his teeth over the last year is rather striking but consistent with his lack of attention.. His overall functional status does not appear any worse or any better than on his last visit and we deferred his continued treatment to his primary care doctors..

Treatment

1. Others
Continue Lortab 10 tablet, 500 mg-10 mg, orally, 120, 1 tab(s), Q6H, 30 days, Refills 5
he continues with chronic chest wall and back pain. He does not appear to



be overusing or misusing his Lortab and we will continue to write refills as indicated.

Labs
Spirometry FVC - 3.97/86%, FEV1 - 3.23/86%, %FEV1 - 81%, Gaffney,Jamie12/8/2008 1:16:45 PM > The vital capacity is lower normal range crit is down slightly from the June value of 4.2 but stillin the lower normal range. FEV1 is 3.23. 6% of predicted also normal range. This

Procedure Codes
SPIROMETRY

Follow Up
6 Months

Electronically signed by CHARLES FOGARTY,MD PA on 12/22/2008 at 08:10 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 29303-2799
Tel: 864-582-6858
Fax: 864-542-9043

Lung and Chest Medical Associates
MultiSpiro A

ID: 77168 Casey, William Mark
Ethnic: CAUCASIAN Height: 68.0 in. Sex: MALE Age: 50 Weight: 182.0 lb

COMMENTS:
PRE-BD COMMENTS:

LAST CALIBRATED: Mon Dec 8,2008 7:33:27 am

TYPE	Test Date and Time	Exp.Time	Normals	Test#
Pre-BD:	Mon Dec 8,2008 1:16:40 pm	3.7 secs	KNUDSON/IMTS	1

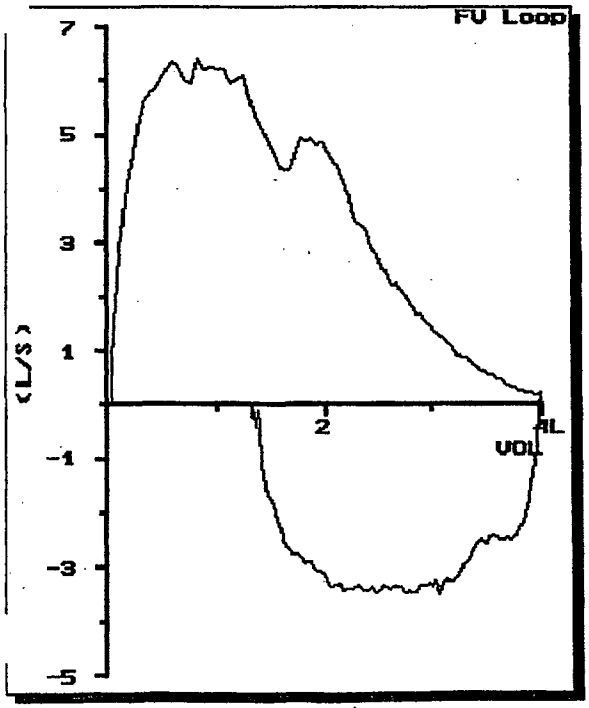
Expiratory	Actual	Predicted	% of pred
FVC	3.97 L	4.64 L	85.59 %
FEV 0.5	2.49 L	2.98 L	83.63 %
FEV 1.0	3.23 L	3.74 L	86.32 %
FEV 3.0	3.90 L	4.37 L	89.19 %
FEV 0.5/FVC	62.64 %	64.11 %	97.71 %
FEV 1.0/FVC	81.31 %	80.63 %	100.85 %
FEV 3.0/FVC	98.17 %	94.21 %	104.20 %
PEF	6.35 L/S	8.50 L/S	74.70 %
FEF 25-75%	3.31 L/S	3.76 L/S	88.14 %
FEF 75-85%	0.92 L/S	0.94 L/S	97.96 %
FEF 25	6.17 L/S	7.87 L/S	78.35 %
FEF 50	4.66 L/S	4.44 L/S	105.00 %
FEF 75	1.31 L/S	1.72 L/S	76.02 %
FEF .2-1.2	5.98 L/S	7.07 L/S	84.53 %

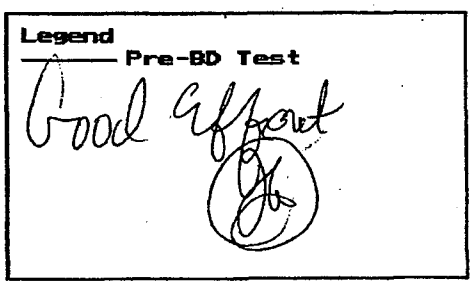
Inspiratory	Actual
IVC	2.67 L
FIV1	2.59 L
PIF	3.60 L/S
FIF50	3.47 L/S
FEF50/FIF50	134.34 %

Interpretation:

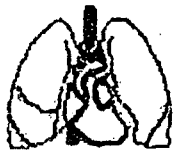
NORMAL

MAX FVC = 3.97L TEST # 1
MAX FEV-1 = 3.23L TEST # 1





GUNN 004260



CASEY, WILLIAM M

49 Y old Male, DOB: [redacted]/1958
419 QUAIL RIDGE CIRCLE, BOILING SPRINGS, SC-29316-6119
Home: 864-814-2617
Guarantor: CASEY, WILLIAM M Insurance: BCBS PPC
PCP: FRANK E GONDA

06/11/2008 Charles M. Fogarty, MD

Current Medications
Tricor 145 mg 1 tab(s) qd by Dr. Ganda has not taking any latly
Vytorin 10 mg-40 mg 1 tab(s) once a day
Adderall XR 20 mg 1 cap(s) QAM
diazepam 10 mg 1 tab(s) TID
Lortab 10 500 mg-10 mg 1 tab(s) Q6H
Ambien 10 mg 1 tab q/hs/prn

Past Medical History
Chest wall pain
Hyperlipidemia
Difficulty with multitasking, concentrating, s/post pneumomediastinum/pneumothorax
Back pain
Neuro cognative impairment

Social History
Marital status: Divorced.
Education level: College one year.
Occupation: disabled from his Lungs.
Alcohol: reports, socially.
Other MDs: Primary care Dr. Ganda.

Allergies
NKMA

Review of Systems
CONSTITUTIONAL:
no Fever/Chills. no Night sweats.
ENT:
no Nasal discharge. no Sore throat.
RESPIRATORY:
no Shortness of breath. no Cough, Dry. no Wheezing. Chest Tightness c/o, Occasional, With activity.
CARDIOLOGY:
no Leg edema. no Dizziness.
GASTROENTEROLOGY:
no Nausea. no Vomiting. no Heartburn.
NEUROLOGY:
c/o Headache, some. Memory loss c/o.
ALLERGY:
no Runny nose. no Sinus congestion.
PSYCHOLOGY:
c/o Depression.
Reviewed by: Theresia Meyers

CC
1. 5-6 MO F/U
2. Some chest tightness with exertion
3. Short term memory loss
4. Back pain

HPI
Interim History:

Mr. Casey reports no major change. He continues to have problems getting through the day. He is easily distracted and has difficulty staying focused. He has difficulty concentrating. He forgets what he is set out to do. He feels that he is doing stupid things. He cuts the speaker on the stereo off and then wonders why the music is off. Occasionally he feels he is doing things that don't make sense when he is thought it through.

Separately,His chest wall discomfort is intermittent. He continues to have back pain.

Vital Signs
Wt: 192.7, BP: 130/100, HR: 116, O2 sat: 95%, FIO2: .21, FVC: 4.20, FEV1: 3.42, FEV1/FVC%: 81%, Ht: 68, BMI: 29.30.

Physical Examination

Appears comfortable at rest. Pupils symmetric. Oropharynx clear. Trachea midline. No wheeze rales or rhonchi. Heart tones regular. No murmur gallop. No organomegaly. No edema clubbing. Coordination normal range..

Assessments
1. Back pain - 724.5 (Primary)
2. Hyperlipidemia - 272.4

Treatment
1. Back pain
Continue Lortab 10 tablet, 500 mg-10 mg, orally, 120, 1 tab(s), Q6H, 30 days, Refills 5

Labs
Spirometry FVC - 4.20/90%, FEV1 - 3.42/91%, %FEV1 - 81%, Gaffney,Jamie 6/11/2008 3:25:28 PM > The vital capacity is stable or slightly improved compared to December value. As in the lower normal range of 4.2 L. The FEV1 is also well preserved at 3.4 L.

Procedure Codes
SPIROMETRY

Follow Up
The patient was given a prescription for Lortab. Dr. Gonda is prescribing his other medications. He will check back with us in 6 months urinne meanwhile he was encouraged to have an outline for how he is going to plan the day in a week and take additional notes. He was advised is unlikely his chest wall pain is related to his heart although he remains concerned about heart disease. He is not smoking at present. He remains unable to return to work.

Electronically signed by CHARLES FOGARTY,MD PA on 12/22/2008 at 08:10 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 29303-2799
Tel: 864-582-6858
Fax: 864-542-9043

Lung and Chest Medical Associates
MultiSpiro A

ID: 77168 Casey, William Mark
nic: CAUCASIAN Height: 68.0 in. Sex: MALE Age: 49 Weight: 192.0 lb

COMMENTS:
PRE-BD COMMENTS:

LAST CALIBRATED: Wed Jun 11,2008 7:23:22 am

TYPE	Test Date and Time	Exp.Time	Normals	Test#
Pre-BD:	Wed Jun 11,2008 3:20:28 pm	4.5 secs	KNUDSON/IMTS	1

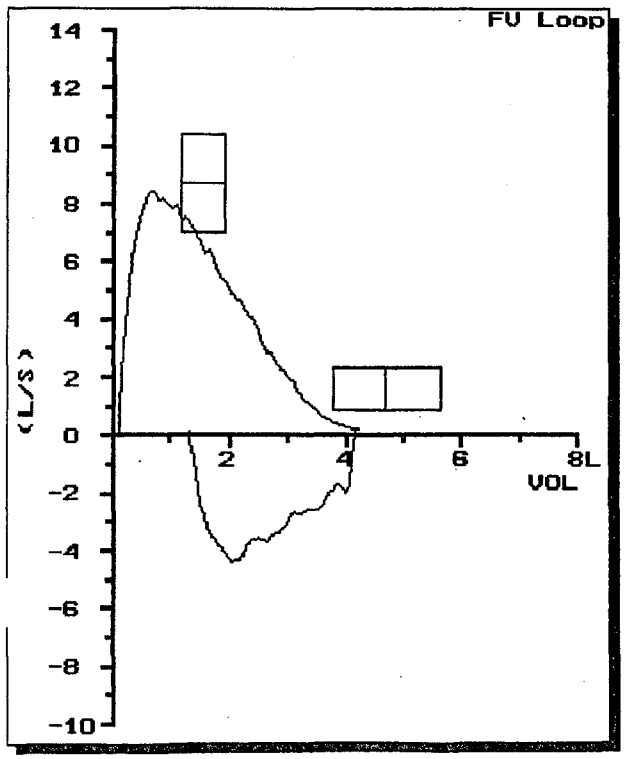
Expiratory	Actual	Predicted	% of pred
FVC	4.20 L	4.66 L	90.14 %
FEV 0.5	2.73 L	2.99 L	91.31 %
FEV 1.0	3.42 L	3.77 L	90.83 %
FEV 3.0	4.06 L	4.40 L	92.18 %
FEV 0.5/FVC	64.98 %	64.14 %	101.30 %
FEV 1.0/FVC	81.40 %	80.78 %	100.77 %
FEV 3.0/FVC	96.49 %	94.36 %	102.26 %
PEF	8.34 L/S	8.53 L/S	97.75 %
FEF 25-75%	3.60 L/S	3.79 L/S	94.81 %
FEF 75-85%	0.84 L/S	0.97 L/S	86.56 %
FEF 25	7.85 L/S	7.89 L/S	99.48 %
FEF 50	4.61 L/S	4.48 L/S	102.94 %
FEF 75	1.35 L/S	1.74 L/S	77.25 %
FEF .2-1.2	7.63 L/S	7.12 L/S	107.16 %

Inspiratory	Actual
IVC	2.89 L
FIV1	2.53 L
PIF	4.56 L/S
FIF50	3.61 L/S
FEF50/FIF50	127.57 %

Interpretation:

NORMAL

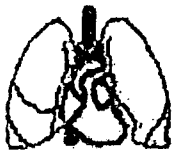
MAX FVC = 4.27L TEST # 2
MAX FEV-1 = 3.42L TEST # 1



Legend
Pre-BD Test

Good Effort
DG

GUNN 004263



CASEY, WILLIAM M

49 Y old Male, DOB: [redacted]/1958
419 QUAIL RIDGE CIRCLE, BOILING SPRINGS, SC-29316-6119
Home: 864-814-2617
Guarantor: CASEY, WILLIAM M Insurance: BCBS PPC
PCP: FRANK E GONDA

01/02/2008 Charles M. Fogarty, MD

Current Medications
None

Past Medical History
Chest wall pain
Hyperlipidemia
Difficulty with multitasking, concentrating, s/post pneumomediastinum/pneumothorax; neurocognitive impairment
Back pain

Allergies
NKMA

CC
1. Xrays

HPI
Interim History:
Mr. Casey is here to obtain some x-rays with a piece of metal in front of or in back of his chest per the letter from Mr. Thompson. He is still puzzled as to why the doctors felt there was a metal object in his chest when he does not have any recollection of ever having had anything go down into his windpipe.

Assessments
1. Back pain - 724.5 (Primary)

Treatment
1. Back pain
We showed Mr. Casey the frontal view of the x-ray taken today which shows a metallic object which appears to be overlying the left upper chest. We then showed Mr. Casey the side view which makes it clear that in fact the front to is potentially misleading in so far as a metallic object is actually outside the chest as evident on the lateral view.

Diagnostic Imaging
X ray : Chest PAL Front and side views of the chest were taken with a small metallic object takes to the back of his chest to simulate what might have happened if he had been lying on top of a small metallic object with his portable chest film was taken in May 2004.

Follow Up
Keep Exisitng

Electronically signed by CHARLES FOGARTY,MD PA on 12/22/2008 at 08:10 AM EST

Sign off status: Pending

Lung and Chest Medical Associates

2030 North Church Place
Spartanburg, SC 29303-2799
Tel: 864-582-6858
Fax: 864-542-9043

Patient: CASEY, WILLIAM M DOB: [redacted]/1958 Progress Note: Charles M. Fogarty, MD 01/02/2008

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

Lung and Chest Medical Associates
MultiSpiro A

ID: 77168 Casey, William Mark
ınic: CAUCASIAN Height: 68.0 in. Sex: MALE Age: 49 Weight: 184.0 lb

COMMENTS:
PRE-BD COMMENTS:

LAST CALIBRATED: Wed Dec 19,2007 7:30:36 am

TYPE	Test Date and Time	Exp.Time	Normals	Test#
Pre-BD:	Wed Dec 19,2007 2:12:35 pm	4.5 secs	KNUDSON/IMTS	1

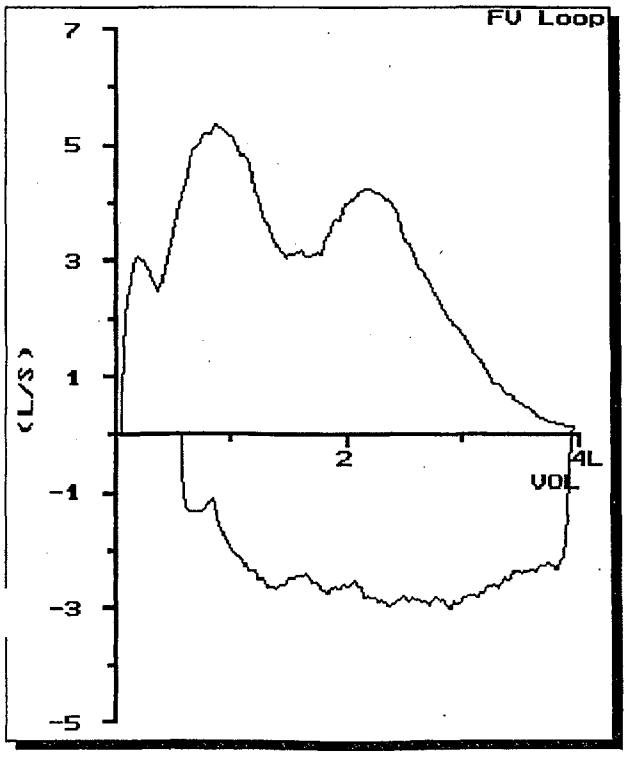
Expiratory	Actual	Predicted	% of pred
FVC	3.95 L	4.66 L	84.58 %
FEV 0.5	2.07 L	2.99 L	69.10 %
FEV 1.0	3.20 L	3.77 L	84.96 %
FEV 3.0	3.82 L	4.40 L	86.89 %
FEV 0.5/FVC	52.40 %	64.14 %	81.70 %
FEV 1.0/FVC	81.14 %	80.78 %	100.44 %
FEV 3.0/FVC	96.93 %	94.36 %	102.73 %
PEF	5.27 L/S	8.53 L/S	61.81 %
FEF 25-75%	3.23 L/S	3.79 L/S	85.05 %
FEF 75-85%	1.02 L/S	0.97 L/S	105.93 %
FEF 25	5.05 L/S	7.89 L/S	64.00 %
FEF 50	3.93 L/S	4.48 L/S	87.87 %
FEF 75	1.68 L/S	1.74 L/S	96.47 %
FEF .2-1.2	3.97 L/S	7.12 L/S	55.81 %

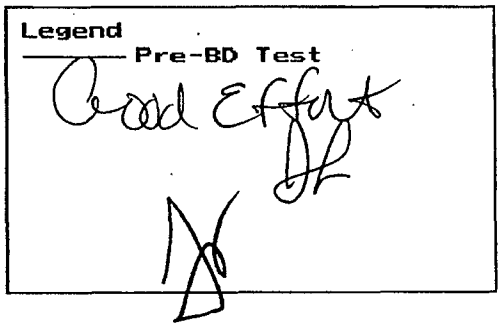
Inspiratory	Actual
IVC	3.39 L
FIV1	2.56 L
PIF	3.08 L/S
FIF50	2.95 L/S
FEF50/FIF50	133.45 %

Interpretation:

NORMAL

MAX FVC = 4.01L TEST # 2
MAX FEV-1 = 3.20L TEST # 1





GUNN 004266

BURTS, TURNER, RHODES & THOMPSON
ATTORNEYS AT LAW
260 NORTH CHURCH STREET
SPARTANBURG, S.C. 29306

SAM BURTS (1907 - 1982)
NOEL TURNER
RICHARD H. RHODES
RAY E. THOMPSON, JR.
M. NOEL TURNER, III

MAILING ADDRESS
P.O. BOX 3408 29304
PHONE: 864-585-8166
FAX: 864-583-6927

December 27, 2007

VIA HAND DELIVERY

Charles M. Fogarty, MD
Lung and Chest Medical Associates
2030 N. Church Place
Spartanburg, SC 29303

RE: William Mark Casey
DOB: [redacted]/58

Dear Dr. Fogarty:

My client, William Mark Casey, is still trying to understand why Dr. Joseph Boscia and Dr. Gregory Feldman felt there was a metal object in his chest that needed bronchoscopies to get it out. I think it would be helpful to Mr. Casey to understand if you showed him how a piece of metal laying underneath him or on top of him appeared on his plain chest film.

Would you consider taking a front to back x-ray with a piece of metal underneath his body or on top of his body that would give the impression that the piece of metal is actually inside his chest? Also, would you consider taking a side view chest film that shows the metal object is really outside of his body? Although we will probably never know the proper identification of the piece of metal that appears in the May 28, 2004 portable chest x-ray, please presume it is a small screw or the back of an earring. I am enclosing along with this letter the back of an earring that appears to be of similar size to the metal object in the x-ray taken of Mr. Casey on May 28, 2004. Obviously, I do not want to request anything that would create a further health risk to Mr. Casey and I would defer that judgment to you. I think this would help Mr. Casey to understand and visualize what I have been unsuccessful in trying to explain to him.

With warm regards,

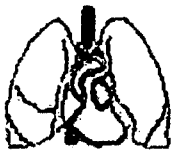
I remain,
BURTS, TURNER, RHODES & THOMPSON

By: _____
RAY E. THOMPSON, JR.

2 Jan 08
PT. would like us to proceed c CXR

RET:ar
Enclosure

GUNN 004267



CASEY, WILLIAM M

49 Y old Male, DOB: [redacted]/1958
419 QUAIL RIDGE CIRCLE, BOILING SPRINGS, SC-29316-6119
Home: 864-814-2617
Guarantor: CASEY, WILLIAM M Insurance: BCBS PPC
PCP: FRANK E GONDA

12/19/2007 Charles M. Fogarty, MD

Current Medications
Tricor 145 mg 1 tab(s) once a day
Lortab 10 500 mg-10 mg 1 tab(s) Q6H
Vytorin 10 mg-40 mg 1 tab(s) once a day

Past Medical History
Chest wall pain
Hyperlipidemia
Difficulty with multitasking, concentrating, s/post pneumomediastinum/pneumothorax; neurocognitive impairment
Back pain

Social History
Marital status: Divorced.
Education level: College one year.
Alcohol: reports, socially.
Other MDs: Primary care Dr. Ganda.

Allergies
NKMA

Review of Systems
CONSTITUTIONAL:
no Fever/Chills. no Night sweats.
ENT:
no Sore throat. no Sinus pain.
RESPIRATORY:
no Shortness of breath. no Cough, Dry. Wheezing c/o, Occasional. Chest Tightness c/o, Occasional, With activity.
CARDIOLOGY:
no Heart Trouble. no Leg edema. no Dizziness.
GASTROENTEROLOGY:
c/o Nausea, some. no Vomiting.
ALLERGY:
no Runny nose. no Sinus congestion.

CC
1. Some chest tightness with exertion
2. Back pain

HPI
Interim History:

Mr. Casey reports continued troubles with the organizing his stay and remembering what he is supposed to do unless he takes notes or special effort to concentrate. He finds that his mood fluctuates. He is discouraged in that he does he should be capable of doing more.

Vital Signs
Wt: 184, BP: 120/86, HR: 115, O2 sat: 94%, FIO2: .21, FVC: 3.95, FEV1: 3.20, FEV1/FVC%: 81%, Ht: 68, BMI: 27.97.

Physical Examination

no acute distress at rest. Pupils symmetric. Oropharynx clear. Teeth good repair. Trachea midline. No jugular venous distention. No carotid bruit. Chest expands symmetrically. Heart tones regular no murmur gallop no edema or clubbing coordination normal range.

Assessments
1. Hyperlipidemia - 272.4 (Primary)
2. Back pain - 724.5

Treatment
1. Back pain
Continue Lortab 10 tablet, 500 mg-10 mg, orally, 40, 1 tab(s), Q6H, 10 day(s)

2. Others
With reference to the patient's difficulty concentrating and staying focused he was encouraged too take simple measures such as using a daytime her and less to keep on task. Review this at the start and end of the day. he is followed by Dr. Frank Gonda and we will defer any additional medicine/pharmacologic therapy to Dr. Gonda .He remains worried about his heart although his current chest pain is more consistent with chest wall pain he was encouraged take fish oil capsules on general principles since he does have a hyperlipidemia

Diagnostic Imaging
X ray : Chest PAL Meyer,Theresia 12/19/2007 2:58:27 PM > p.m. b the

chest showed clear lung fields bradycardic contours unremarkable. No localized infiltrates.

Labs
Spirometry FVC - 3.95/85%, FEV1 - 3.20/85%, %FEV1 - 81%, lawter,jamie 12/19/2007 2:20:11 PM > She from a tree shows a vital capacity and the lower normal range. Extraocular rates are normal range.

Preventive Medicine
Immunizations: Influenza , 2007, decline.

Procedure Codes
SPIROMETRY
CHEST X-RAY PAL

Electronically signed by CHARLES FOGARTY,MD PA on 12/22/2008 at 08:09 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 29303-2799
Tel: 864-582-6858
Fax: 864-542-9043

Patient: CASEY, WILLIAM M **DOB:** [redacted]/1958 **Age:** 48 Y **Sex:** Male **Telephone Encounter**
Phone: 864-814-2617 **Primary Insurance:**
Address: 419 QUAIL RIDGE CIRCLE, BOILING SPRINGS, SC 293166119
Encounter Date:
Provider: SMITH,MD PA, WILSON P

Answered by	Thompson, Maria	Date: 09/07/2007 Time: 02:44 PM
Caller	Angela- Burts Law Firm	
Reason	needs med. records after 08-05	
Message	needs updated medical records on Mark Casey. They have up until August 2005. Double check release expiration, get signed and send updates to Burts Law Firm. MT	
Action Taken	Thompson,Maria 9/7/2007 2:48:03 PM >	

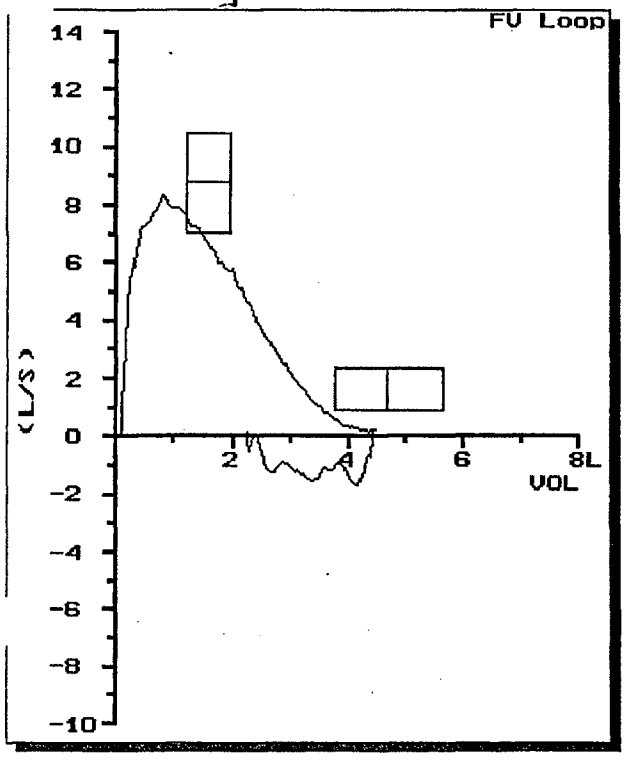
Lung and Chest Medical Associates
MultiSpiro A

ID: 77168 Casey, William Mark
Ethnic: CAUCASIAN Height: 68.0 in. Sex: MALE Age: 48 Weight: 197.0 lb

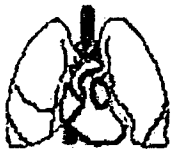
COMMENTS:
PRE-BD COMMENTS:

LAST CALIBRATED: Thu Jun 28,2007 7:30:08 am

TYPE	Test Date and Time		Exp.Time	Normals	Test#
Pre-BD:	Thu Jun 28,2007 3:36:49 pm		6.8 secs	KNUDSON/IMTS	2
Expiratory	Actual	Predicted	% of pred	Inspiratory	Actual
FVC	4.47 L	4.69 L	95.43 %	IVC	2.25 L
FEV 0.5	2.78 L	3.01 L	92.50 %	FIV1	1.27 L
FEV 1.0	3.50 L	3.79 L	92.26 %	PIF	1.88 L/S
FEV 3.0	4.14 L	4.43 L	93.41 %	FIF50	1.67 L/S
				FEF50/FIF50	257.76 %
FEV 0.5/FVC	62.21 %	64.17 %	96.94 %		
FEV 1.0/FVC	78.24 %	80.93 %	96.68 %	Interpretation:	
FEV 3.0/FVC	92.50 %	94.50 %	97.88 %		
				NORMAL	
PEF	8.20 L/S	8.57 L/S	95.77 %		
FEF 25-75%	3.17 L/S	3.83 L/S	82.86 %	MAX FVC = 4.47L TEST # 2	
FEF 75-85%	0.66 L/S	0.99 L/S	67.14 %	MAX FEV-1 = 3.51L TEST # 1	
FEF 25	7.52 L/S	7.91 L/S	95.02 %		
FEF 50	4.31 L/S	4.51 L/S	95.47 %		
FEF 75	1.07 L/S	1.76 L/S	60.60 %		
FEF .2-1.2	7.42 L/S	7.17 L/S	103.48 %		



Legend
Pre-BD Test



CASEY, WILLIAM M

48 Y old Male, DOB: [redacted]/1958
419 QUAIL RIDGE CIRCLE, BOILING SPRINGS, SC-29316-6119
Home: 864-814-2617
Guarantor: CASEY, WILLIAM M Insurance: BCBS PPC
PCP: FRANK E GONDA

06/28/2007

Charles M. Fogarty, MD

Current Medications
Combivent 90 mcg-18 mcg/inh 2 puff(s) QID
Lipitor 20 mg 1 tab(s) once a day (at bedtime)
Tricor ? 1 tab(s) once a day
Lortab 10 500 mg-10 mg 1 tab(s) Q6H

Past Medical History
Chest wall pain
Hyperlipidemia
Difficulty with multitasking, concentrating, s/post pneumomediastinum/pneumothorax

Allergies
N.K.D.A.

CC
1. 6 MO F/U

Labs
Spirometry

Procedure Codes
SPIROMETRY

Electronically signed by CHARLES FOGARTY,MD PA on 12/22/2008 at 08:09 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 29303-2799
Tel: 864-582-6858
Fax: 864-542-9043

Patient: CASEY, WILLIAM M **DOB:** [redacted]/1958 **Age:** 48Y **Sex:** Male **Telephone Encounter**
Phone: 864-814-2617 **Primary Insurance:**
Address: 419 QUAIL RIDGE CIRCLE, BOILING SPRINGS, SC 293166119
Encounter Date:
Provider: FOGARTY,MD PA, CHARLES M

Answered by Pearson, Nicole

Date: 01/03/2007
Time: 03:04 PM

Refills

Start Lortab 10 500 mg-10 mg, 120, 1 tab(s) QID , Refills=5

GUNN 004273

Spiro

CMF WPS MLA EBK JDC RVM Beth Darla Lab

Lung and Chest Medical Associates Sptbg. ✓ Greer ____

ame: Wm. H. Casey Chart#: 7168 Date: 1-3-07

Wt 197 Ht ____ B/P 139/100 H/R 120 RR ____ Temp ____ 02Sat 97 FiO2 .21

Cough / Smoking
Sputum / Nausea
Dyspnea / Vomiting
Wheeze / Diarrhea
Edema / Chest Pain
Palpitations / Pain
Oriented / ETOH
New Allergies / Fever/chills

Present Illness + reason for visit: having some chest tightness. ↑ BP lately
Worse w/ exertion & worry
refill needed for Lortab!
Lortab 10 ms
ambien 10 ms
tramadol 50 ms
Still unable to organize self, plan day to day. Heart fluttering

When was your last DEXA Bone Densometry Testing done?

Seeing new doctors? no For: ____

Hospitalizations or major life changes since last visit: no

Meds. Review based on: ____ in bottle ____ on list ____ from memory

PHYSICAL EXAM: WNL/NEG ABN/POS

*General Appearance___
*Skin Turgor___
*ENT___
*Mouth___
*Sinus___
*Neck___
*Chest/Lungs: Breath Sounds ___
Wheezes___
Rales___
Effort___
Symmetry___
eart: Rhythm___
Murmurs___
Gallop___
Tones___
*Abdomen___
*Extremities___
*Mobility: Gait___
Reflexes___
Aides___
*Mental Status___

Cursed for disabled but not on basis of neuro cognitive impairment

WNL
memory, executive function not tested

LAB ORDER: Spirometry ___ EKG ___ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O2Sat Rest ___
Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG's ___ Bun ___ Cre ___ K+ ___ Theo ___ 02Sat Exercise ___

Office Treatment: ____

Education: Does pt want to quit smoking? Yes/No Other: ____

Materials/counseling given: ____

PFTs WNL

Diagnosis: ____ Plan ____

___Abn CXR(lung fluid),793.1
___Anticoagulant Circulating,28615
___COPD,496
___Cough,786.2
___Dyspnea,786.09
___Fatigue(general),780.79
___Fever,780.6
___ILD,515
___Monitoring(drug name_____),V58.1
___Rhinitis,477.9
___Sleep Apnea/Disorders (nec), 780.53

1. Neuro cog. deficits impairment s/p laser lysis & pneumomediastinum + air emboli
2. Chronic CW Pain - Lortab, exercise help
3. H-HTN - N, added salt

Prescriptions: ____

ext appt: ___Weeks ___Months W/ CMF WPS EBK MLA JDC RVM PA NP Signature ____ Staff ____
Next Visit: Spiro L/V DLCO PA PAL Sinus DEXA BLDWK ____ Other ____

RTO 4 mo

GUNN 004274

Lung and Chest Medical Associates
MultiSpiro A

ID: 77168 Casey, William Mark
Ethnic: CAUCASIAN Height: 68.0 in. Sex: MALE Age: 48 Weight: 197.0 lb

COMMENTS:
PRE-BD COMMENTS:

LAST CALIBRATED: Wed Jan 3,2007 7:22:27 am

TYPE	Test Date and Time		Exp.Time	Normals	Test#
Pre-BD:	Wed Jan 3,2007	2:35:55 pm	7.4 secs	KNUDSON/IMTS	1

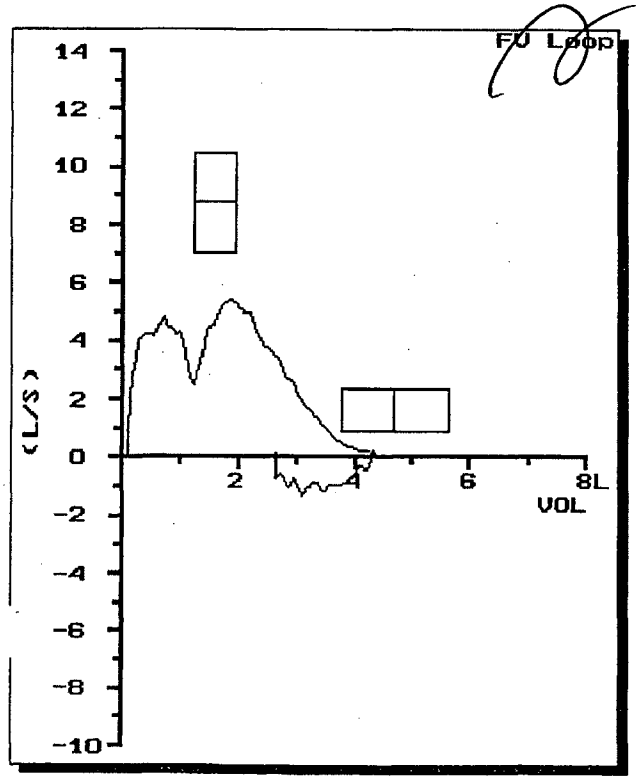
Expiratory	Actual	Predicted	% of pred
FVC	4.35 L	4.69 L	92.75 %
FEV 0.5	2.48 L	3.01 L	82.50 %
FEV 1.0	3.42 L	3.79 L	90.16 %
FEV 3.0	4.04 L	4.43 L	91.23 %
FEV 0.5/FVC	57.08 %	64.17 %	88.95 %
FEV 1.0/FVC	78.68 %	80.93 %	97.22 %
FEV 3.0/FVC	92.96 %	94.50 %	98.37 %
PEF	5.30 L/S	8.57 L/S	61.88 %
FEF 25-75%	3.11 L/S	3.83 L/S	81.22 %
FEF 75-85%	0.77 L/S	0.99 L/S	77.62 %
FEF 25	2.52 L/S	7.91 L/S	31.80 %
FEF 50	4.64 L/S	4.51 L/S	102.75 %
FEF 75	1.33 L/S	1.76 L/S	75.08 %
FEF .2-1.2	3.73 L/S	7.17 L/S	52.09 %

Inspiratory	Actual
IVC	1.73 L
FIV1	0.64 L
PIF	1.52 L/S
FIF50	1.35 L/S
FEF50/FIF50	344.62 %

Interpretation:

NORMAL

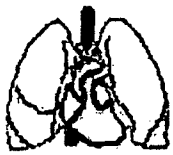
MAX FVC = 4.35L TEST # 1
MAX FEV-1 = 3.42L TEST # 1



Legend
Pre-BD Test

good effort

GUNN 004275



CASEY, WILLIAM M

48 Y old Male, DOB: [redacted]/1958
419 QUAIL RIDGE CIRCLE, BOILING SPRINGS, SC-29316-6119
Home: 864-814-2617
Guarantor: CASEY, WILLIAM M Insurance: BCBS PPC
PCP: FRANK E GONDA

01/03/2007

Charles M. Fogarty, MD

Current Medications
None

CC
1. 6 MO F/U

Vital Signs
Wt: 197.2, BP: 159/106, HR: 120, O2 sat: 97%, FIO2: .21, FVC: 4.35, FEV1: 3.42, FEV1/FVC%: 78.68%, Ht: 68, BMI: 29.98.

Labs
Spirometry FVC - 4.35/92%, FEV1 - 3.42/90%, %FEV1 - 78.68%, Marce 1/3/2007 2:46:02 PM >

Procedure Codes
SPIROMETRY

Electronically signed by CHARLES FOGARTY,MD PA on 12/22/2008 at 08:09 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 29303-2799
Tel: 864-582-6858
Fax: 864-542-9043

BURTS, TURNER, RHODES & THOMPSON
ATTORNEYS AT LAW
260 NORTH CHURCH STREET
SPARTANBURG, S.C. 29306

SAM BURTS (1907 - 1982)
NOEL TURNER
RICHARD H. RHODES
RAY E. THOMPSON, JR.
M. NOEL TURNER, III

MAILING ADDRESS
P.O. BOX 3408 29304
PHONE: 864-585-8166
FAX: 864-583-6927

December 27, 2007

VIA HAND DELIVERY

Charles M. Fogarty, MD
Lung and Chest Medical Associates
2030 N. Church Place
Spartanburg, SC 29303

RE: William Mark Casey
DOB: [redacted]/58

Dear Dr. Fogarty:

My client, William Mark Casey, is still trying to understand why Dr. Joseph Boscia and Dr. Gregory Feldman felt there was a metal object in his chest that needed bronchoscopies to get it out. I think it would be helpful to Mr. Casey to understand if you showed him how a piece of metal laying underneath him or on top of him appeared on his plain chest film.

Would you consider taking a front to back x-ray with a piece of metal underneath his body or on top of his body that would give the impression that the piece of metal is actually inside his chest? Also, would you consider taking a side view chest film that shows the metal object is really outside of his body? Although we will probably never know the proper identification of the piece of metal that appears in the May 28, 2004 portable chest x-ray, please presume it is a small screw or the back of an earring. I am enclosing along with this letter the back of an earring that appears to be of similar size to the metal object in the x-ray taken of Mr. Casey on May 28, 2004. Obviously, I do not want to request anything that would create a further health risk to Mr. Casey and I would defer that judgment to you. I think this would help Mr. Casey to understand and visualize what I have been unsuccessful in trying to explain to him.

With warm regards,

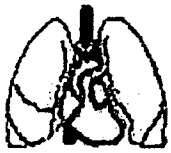
I remain,
BURTS, TURNER, RHODES & THOMPSON

2 Jan 08
Pt. would like us to proceed c CXR

By: _____
RAY E. THOMPSON, JR.

RET:ar
Enclosure

GUNN 004277



CASEY, WILLIAM M

47 Y old Male, DOB: [redacted]/1958
419 QUAIL RIDGE CIRCLE, BOILING SPRINGS, SC-29316-6119
Home: 864-814-2617
Guarantor: CASEY, WILLIAM M Insurance: BCBS PPC
PCP: FRANK E GONDA

07/07/2006 Charles M. Fogarty, MD

Current Medications
None

CC
1. Med refill

Electronically signed by CHARLES FOGARTY,MD PA on 12/22/2008 at 08:08 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 29303-2799
Tel: 864-582-6858
Fax: 864-542-9043

CHARLES M. FOGARTY, MD 08691 WILSON P. SMITH, JR., MD 10510 E. BERT KNIGHT III, MD 08397
J. DOUGLAS CLARK, MD 19596 RICO V.I. MENDOZA, MD 23158
CINDY A. EDWARDS, FNP F1885 J.P. ELM, FNP F2380 NICOLE H. JACKSON, FNP F2972
NICOLE L. CROCKFORD, PA A945 CHARLENE MCCRAW, ACNP-C AC450
2030 North Church Place, Spartanburg, SC 29303 Telephone (864) 582-6858
2755 South Highway 14, Suite 2300, Greer, SC 29650 Telephone (864) 849-9500

NAME William Casey DATE 28 Jun 07

ADDRESS

LABEL DRUG NAME, STRENGTH, & QUANTITY ☐ YES ☐ NO

		STRENGTH	QUANTITY	REFILL
1	Rx Lortab SIG 1 q 4-6 prn	10	#20	5
2	Rx SIG			
3	Rx SIG			

M.D. _____ M.D. CM Fogarty
Dispense as written Substitution Permitted
DEA _____ DEA AF2743268

LC-104

GUNN 004279

C. McCraw

CMF WPS MLA EBK JDC RVM ~~Beth~~ Darla Lab

Lung and Chest Medical Associates Sptbg. ✓ Greer ____

Name: Wm M. Casey **Chart#:** 77168 **Date:** 7/7/06

Wt____ Ht____ B/P____ H/R____ RR____ Temp____ 02Sat____ FiO2____

___Cough ___Smoking
___Sputum ___Nausea
___Dyspnea ___Vomiting
___Wheeze ___Diarrhea
___Edema ___Chest Pain
___Palpitations ___Pain
___Oriented ___ETOH
___New Allergies ___Fever/chills

When was your last DEXA Bone Densometry Testing done?

Seeing new doctors?

Present illness + reason for visit: pt moving furniture to new house
Continues c chest wall pain and
Lortab to take edge of pain and
allows pt keep active - do house
hold chores.
Still having difficult c planning day -
writes down notes to self
continues to forget what is
important
and remember what he needs

Hospitalizations or major life changes since last visit:

Meds. Review based on: ____ in bottle ____ on list ____ from memory

PHYSICAL EXAM: WNL/NEG ABN/POS

*General Appearance Frustrated. Works c (ons Video
*Skin Turgor games to help memory function
*ENT Appears positive - trys to manipulate
*Mouth pupils.
*Sinus
*Neck
*Chest/Lungs: Breath Sounds
Wheezes Clear
Rales
Effort
Symmetry
*Heart: Rhythm
Murmurs
Gallop NRS3
Tones
*Abdomen
*Extremities
*Mobility: Gait pain on leading forward
Reflexes perception, tenderness also R + L
Aides scapular
*Mental Status asked some questions over x 2

LAB ORDER: Spirometry____ EKG____ Sinus____ CBC____ Glu____ PT____ INR____ O2Sat Rest____
Lung Vol____ DLCO____ U/A____ CXR____ ABG's____ Bun____ Cre____ K+____ Theo____ 02Sat Exercise____

Office Treatment:

Education: Does pt want to quit smoking? Yes/No Other:

Materials/counseling given:

Diagnosis: Neuro Cognitive Impairment
___Abn CXR(lung fluid),793.91
___Anticoagulant Circulating,28615
___COPD,496
___Cough,786.2
___Dyspnea,786.09
___Fatigue(general),780.79
___Fever,780.6
___ILD,515
___Monitoring(drug name_____),V58.1
___Rhinitis,477.9
___Sleep Apnea/Disorders (nec), 780.53

Chest Wall Pain

rescriptions: R + L Ortho 10 (Pt does not feel she needs
120 q d mentor function)

Next appt: ___Weeks___Months W/ CMF WPS EBK MLA JDC RVM PA NP Signature ____ Staff____
Next Visit: Spiro L/V DLCO PA PAL Sinus DEXA BLDWK____ Other____

✓

GUNN 004280

(864) 849-9

Mary Lou Applebaum, MD PC
E. Bert Knight, III, MD PC
J. Douglas Clark, MD PC

Charles M. Fogarty, MD PA
Wilson P. Smith, Jr., MD PA

Rico V. Mendoza, MD PC
Beth V. Edwards, PA-C

Fax (Insurance) 585-0999 CMF WPS EBK MLA JDC BE RVM

Acct #	Voucher #	SSN #	DOB	AGE	Dr.	Appt Date & Time
77168	282505	[redacted]	[redacted]/58	47	FOGARTY,	02/09/06 1:45

Patient

WILLIAM M CASEY

WOODRUFF SC 29388

NEXT APPT _____ WKS MONTHS OTHER _____

PROCEDURES AT NEXT APPT:

Prev Dx Code	Description of Diagnosis Code	Insurance	Referring Dr.
786.09	DYSPNEA -RESPIRATORY !!! GET DIAGNOSIS FR !!! GET DIAGNOSIS FR	BCBS PPC - - -	PRI 0 SELF REFERRAL SEC COPAY: .00
		Balance on Account	Dr.'s Signature
		45.00	CO-PAY $45

Description	CPT	Description	CPT	Description	CPT (HCPCS)
LAB		**OFFICE VISITS**		**OFFICE SURGERY** Use 25 Mod	
Routine Venipuncture	36415	**Consult, New, Estab.**		Ear wax removal	69210
Theophylline Level	80198	Problem Focused	99241	Laryngoscopy	31575
Glucose	82947	Expanded	99242	Thoracentesis - simple	32000
HBG A1C	83036	Detailed	99243	w/ catheter	32002
BUN	84520	Moderate Comprehensive	99244	**INJECTIONS - 90782 Units**	
Creatinine	82540	High Comprehensive	99245	Kefzol	J0690
K+	84132	**New Patient**		Gentamicin	J1580
HBG's	85018	Problem Focused	99201	Insulin, Reg	J1820
HCT	85014	Expanded	99202	Vitamin B12	J3420
UA	81002	Detailed	99203	Benadryl	J1200
PT	85610	Moderate Comprehensive	99204	Brethine	J3105
CBC-Automated	85025	High Comprehensive	99205	Decadron	J1100
ABG's, simultaneous	82803	IME non-treating	99456	Depo Medrol	J1030
Arterial Puncture	36600	IME non-treating, 2 areas	99457	Epinephrine	J0170
Iood Occult Stool	82270	**Established Patient**		Lasix	J1940
Rapid Strep	87081	Nurse Visit	99211	Phenergan	J2550
Z Stat Rapid Flu	87449QW	Problem Focused	99212	Cortisol Stimul.	J0835
		Expanded	99213	Triamin/Anst, 5mg	J3302
PFT's - 25 MODIFIER IN OFFICE		Detailed	99214	Rocephin	J0696
Pulse Oximetry	94760	Comprehensive	99215	Xolair, 5mg	J2357
Pulse Oximetry, multiple	94761	Prolonged Attendance	99354/55		
Spirometry	94010	IME est. pt.	99455		
Bronchospasm	94060	**CARDIOLOGY**		**MISCELLANEOUS**	
Broncho Challenge	94070	EKG w/ interpretation	93000	SUPPLIES & MATERIALS	
Lung Volumes:		Pulse Ox during exercise	94761	Surgical tray	(A4550)
Thoracic Gas Vol.	94260	Exercise w/ treadmill	93015	Duoderm	99070 (A4204)
Airway Resistance	94360	6 minute walk test	94620	Tegaderm	99070 (A4205)
DLCO	94720			Medical Testimony	99075
X RAYS				Medical Conference	99155
Sinus – 1-3 views	70210				
Chest – PA	71010				
PA & Lateral	71020	**OFFICE THERAPY/IMMUNIZATIONS**		~~Smoke Tobacco Counseling~~	
Chest Lateral-Decubitus	71035	Aerosol Instruction Init.	94664	~~3-10 min.~~	~~G0375~~
Rib – 2 Projections	71100	Nebulizer Tx. init & sub.	94640	~~greater than 10~~	~~G0376~~
Thoracic Spine-2 views	72070	Pneumo Vac 90471/G0009	90732		
Lumbar – Spine	72100	Flu Vac 90472/G0008	90658		
		PPD	86580	**SNF HOSPICE**	
		Tetanus Toxoid	90703		
				Yes___	Yes___ No___
		Allergy Shots - Single Ant.	95115		
		Allergy Shot - Multiple Ant.	95117		
		UNITS		No___	DR.___
		Prolastin, 10mg	J0256		
		IV Infusion - to 1 HR.	90780		

GUNN 004281

4587

CHARLES M. FOGARTY, MD 086917 WILSON P. SMITH, JR., MD 10510 E. BERT KNIGHT III, MD 8397
MARY LOU APPLEBAUM, MD 12969 J. DOUGLAS CLARK, MD 19596 RICO V. I. MENDOZA, MD 23156
BETH V. EDWARDS, PA-C A465 NICOLE L. CROCKFORD, PA A945
J. P. ELM, FNP F2380 CINDY A. EDWARDS, FNP F1885 CHARLENE MCCRAW, ACNP-C AC68077
2030 North Church Place, Spartanburg, SC 29303 Telephone (864) 582-6858
2755 South Highway 14, Suite 2300, Greer, SC 29650 Telephone (864) 849-9500

NAME [illegible] DATE

ADDRESS

LABEL DRUG NAME, STRENGTH, & QUANTITY ☐ YES ☐ NO

	Rx / SIG	STRENGTH	QUANTITY	REFILL
1	Rx [illegible] 1 po 2 qd SIG Vit D		1	1y
2	Rx SIG day	STRENGTH	QUANTITY	REFILL
3	Rx SIG	STRENGTH	QUANTITY	REFILL

M.D. _____ Dispense as written
M.D. _____ Substitution Permitted
DEA _____ DEA _____

LC-104

CHARLES M. FOGARTY, MD 086917 WILSON P. SMITH, JR., MD 10510 E. BERT KNIGHT III, MD 8397
MARY LOU APPLEBAUM, MD 12969 J. DOUGLAS CLARK, MD 19596 RICO V. I. MENDOZA, MD 23156
BETH V. EDWARDS, PA-C A465 NICOLE L. CROCKFORD, PA A945
J. P. ELM, FNP F2380 CINDY A. EDWARDS, FNP F1885 CHARLENE MCCRAW, ACNP-C AC68077
2030 North Church Place, Spartanburg, SC 29303 Telephone (864) 582-6858
2755 South Highway 14, Suite 2300, Greer, SC 29650 Telephone (864) 849-9500

NAME William Casey DATE 2/12/06

ADDRESS

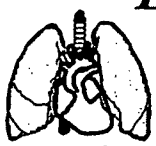
LABEL DRUG NAME, STRENGTH, & QUANTITY ☐ YES ☐ NO

	Rx / SIG	STRENGTH	QUANTITY	REFILL
1	Rx Lortab SIG 1 q 4h pca	10	150	5
2	Rx SIG	STRENGTH	QUANTITY	REFILL
3	Rx SIG	STRENGTH	QUANTITY	REFILL

M.D. _____ M D [illegible]

GUNN 004282

Lung and Chest Medical Associates



Charles M. Fogarty, M.D.
Wilson P. Smith, Jr., M.D.
Mary Lou Applebaum, M.D.
Beth V. Edwards, PA-C

E. Bert Knight, III, M.D.
J. Douglas Clark, M.D.
Rico V. I. Mendoza, M.D.
J.P. Elm, F.N.P.
Cindy A. Edwards, F.N.P.

WILLIAM CASEY
77168
02-16-06

OFFICE NOTE

Chief Complaint

William Casey continues to have difficulty concentrating/multitasking. He has not had any further problems with nausea and vomiting since cutting back on his medication. He is followed by Dr. Gonda who increased the Lipitor to 20 mg daily and added Tricor. He continues to need two to three Lortab 5 a day for his pain which at this point appears to be chest wall in etiology.

Current Conditions

1. Difficulty with multitasking, concentrating, status post pneumomediastinum/pneumothorax.
2. Chest wall pain.
3. Hyperlipidemia.

Current Medicines

1. Combivent 1 puff four times daily as needed. (Rarely used since last visit.)
2. Lipitor 20 mg each evening.
3. Tricor each morning.
4. Ultram 50 mg four times daily as needed.
5. Lortab four times daily as needed.

Social History

The patient has been unable to work since his laser surgery and is applying for disability. No tobacco or alcohol.

Review of Systems

No additional findings on cardiorespiratory, GI or GU review.

Physical Examination
Vital Signs: Wt. 189.5, BP 136/72, HR 96, RR 20 and SaO_2 is 95% on room air.
General: No acute distress.
Skin: Normal turgor.
HEENT: Pupils symmetric.
Neck: No jugular venous distention.
(Continued to next page)

Physical Examination (Continued)
Chest: No wheezes, rales or rhonchi.
Cardiac: No murmur or gallop.
Abdomen: Not done.
Extremities: No edema or clubbing.
Neurological: Difficult staying focused and concentrating during our conversation evident.

Laboratory Data

The vital capacity is 4.17, 88% of predicted. FEV_1 3.46, 90% of predicted.

Impression/Discussion/Plan

The patient's lung function remains stable. His dilemma is that mentally he is not up to snuff as far as returning to his old job or returning the skills for a new equivalent job. He is now approaching two years out and it appears likely he has achieved his maximum improvement, i.e. it is unlikely as time goes forward that he will have improvement in his ability to concentrate and recall/perform make "executive type decisions"/thinking.

The patient's lung function is in a range where he probably does not need to use the Combivent although he still has it on hand. He was encouraged to continue to try to exercise to maintain muscle mass, balance and coordination. He was instructed in diet with attention to his cholesterol and salt intake. He will check back the end of this summer/fall as needed.

Charles Michael Fogarty,

Charles M. Fogarty, MD
CMF/ns
cc: Dr. Frank Gonda via fax 578-7098 **(No hard copy will be sent)**

TRANSMISSION VERIFICATION REPORT

TIME : 03/09/2006 10:07
NAME : LUNG AND CHEST MED
FAX : 8645850999
TEL : 8645826858
SER.# : BROD3J369422

DATE,TIME	03/09 10:06
FAX NO./NAME	5787098
DURATION	00:00:37
PAGE(S)	02
RESULT	OK
MODE	STANDARD ECM

GUNN 004285

Office Visit Confirmation Sheet **Today's Date** 2 . 16 . 06

- Patient Name William Mark Casey Doctor Name Dr Fogarty
- Appt. Time 3:30 Arrival Time 3:30 E-mail address
- Address [redacted] Woodruff SC 29388
- Home phone # 486-9893 Work Phone # [redacted] Other Phone #
- Emergency contact name: Carole Lynne Hyslop Phone #
- Patient's Employer Michelin - Insured's Employer
- Type of Insurance: 1. BC BS 2. 3.
- If you are currently a resident of a Skilled Nursing Facility, enter the name and phone #:

4591

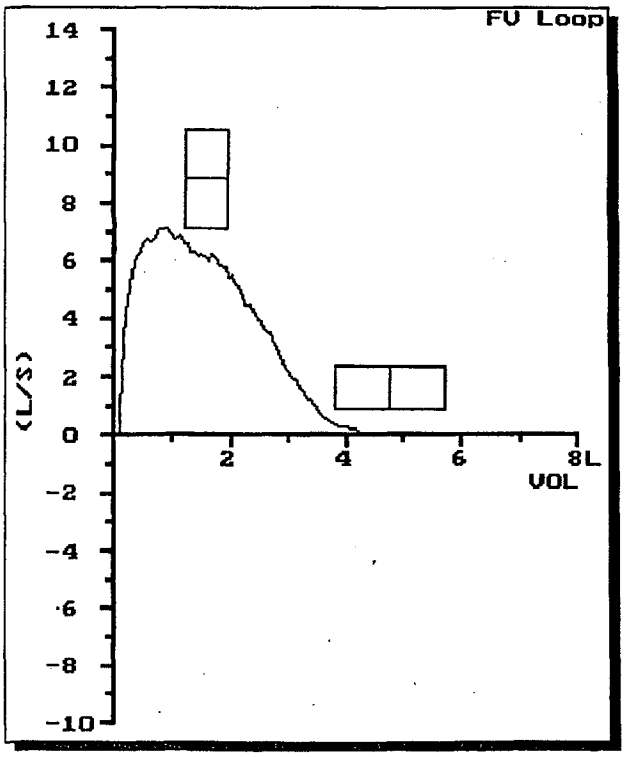
Lung and Chest Medical Associates
Multi Spiro B

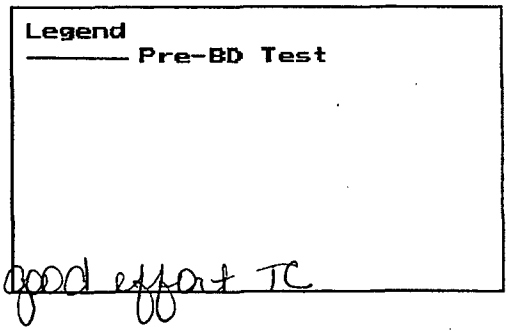
ID: 77168 Casey, William
nic: CAUCASIAN Height: 68.0 in. Sex: MALE Age: 47 Weight: 171.0 lb

COMMENTS:
PRE-BD COMMENTS:

LAST CALIBRATED: Thu Feb 16,2006 7:29:47 am

TYPE	Test Date and Time		Exp.Time	Normals	Test#
Pre-BD:	Thu Feb 16,2006 4:29:11 pm		4.9 secs	KNUDSON/IMTS	1
Expiratory	Actual	Predicted	% of pred	Inspiratory	Actual
FVC	4.17 L	4.73 L	88.18 %	IVC	0.00 L
FEV 0.5	2.73 L	3.04 L	89.76 %	FIV1	0.00 L
FEV 1.0	3.46 L	3.84 L	89.95 %	PIF	0.00 L/S
FEV 3.0	4.02 L	4.48 L	89.71 %	FIF50	0.00 L/S
				FEF50/FIF50	0.00 %
FEV 0.5/FVC	65.38 %	64.24 %	101.78 %		
FEV 1.0/FVC	82.86 %	81.23 %	102.00 %	Interpretation:	
FEV 3.0/FVC	96.43 %	94.79 %	101.73 %		
				NORMAL	
PEF	7.00 L/S	8.64 L/S	81.01 %		
FEF 25-75%	3.86 L/S	3.91 L/S	98.71 %	MAX FVC = 4.17L TEST # 1	
FEF 75-85%	0.94 L/S	1.04 L/S	90.83 %	MAX FEV-1 = 3.46L TEST # 1	
FEF 25	6.78 L/S	7.95 L/S	85.26 %		
FEF 50	4.79 L/S	4.59 L/S	104.45 %		
FEF 75	1.54 L/S	1.81 L/S	84.77 %		
FEF .2-1.2	6.54 L/S	7.26 L/S	90.15 %		





GUNN 004287

CHARLES M. FOGARTY, MD 08691 WILSON P. SMITH, JR., MD 10510 E. BERT KNIGHT III, MD 08397
MARY LOU APPLEBAUM, MD 12969 J. DOUGLAS CLARK, MD 19596
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2030 North Church Place, Spartanburg, SC 29303 Telephone (864) 582-6858
2755 South Highway 14, Suite 2300, Greer, SC 29650 Telephone (864) 849-9500

NAME Wm M. Casey DATE 9/1/06

ADDRESS

LABEL DRUG NAME, STRENGTH, & QUANTITY ☐ YES ☐ NO

		STRENGTH	QUANTITY	REFILL
1	Rx Lortab Ten SIG 1 q 4-6 Prn	10	120	5
2	Rx SIG	STRENGTH	QUANTITY	REFILL
3	Rx SIG	STRENGTH	QUANTITY	REFILL

CW's - Replaces Prego Rx

M.D. Fogarty
Dispense as written Substitution Permitted

DEA AF8837268 DEA

LC-104

GUNN 004288

TELEPHONE CALL BACK - LUNG & CHEST MEDICAL ASSOCIATES

Date 8/1/05 Call Time 1032 am/pm VM r'cvd time: 1035 By: AB

Chart #: 77168 Chart pull time : _____ Chart del. Time: _____ Callback time: _____

Caller: PATIENT ☐ PT. FAMILY ☐ PHARMACY ☐ HOME HEALTH ☐ HOSPICE ☐ INS. CO. ☐ DME CO. ☐ SPR

VM — Caller Name | Wm. Mark Casey — Patient Name | _____ Phone No. | _____ Fax No.

Pt. of: CMF WPS EBK MLA JDC RVM Last Appt. 7/19/05 Next Appt. TO
Pt. Address (Proximity to office): 7-21-05 cmk

#1: DRUG REFILL ☐ Yes- patient stable/routine medicine ☐ No – see #2 below

Pharmacy: _____ Phone #: _____ Fax #: _____

CHARLES M. FOGARTY, MD 08691• WILSON R SMITH, MD 10510• E. BERT KNIGHT III, MD 08397
MARY LOU APPLEBAUM, MD 12969 • J. DOUGLAS CLARK, MD 19596• RICO VI. MENDOZA, MD 23156
BRENDA SPRINKLE, PA-C A144 • CHARLENE McCRAW, A.C.N.P-C AC68077• BETH V. EDWARDS, PA-C A465
2030 North Church Place, Spartanburg, SC 29303 Telephone 582-6858
FAX: Side A 582-3750 FAX: Side B: 585-2102

Rx

NAME: DOB: DATE:

ADDRESS: [redacted]58

LABEL DRUG NAME, STRENGTH & QUANTITY ☐ YES ☐ NO

1 Rx _____ SIG _____ | STRENGTH | QUANTITY | REFILL

M.D. _____ Dispense as written DEA: _____

M.D. _____ Substitution Permitted DEA: _____

#2: PROBLEM ☐ COUGH ☐ SOB ☐ CHEST PAIN ☐ FEVER ☐ QUESTIONS ABOUT MEDS. ☐ NON-ROUTINE RX

Comment/Response: calling for test results – test last Thursday

copy of repats attached.

Made appt for Aug 4, 2005 11am w/Beth to discuss test results per Teresa CD. 8/4/05

PFT referral needed

Appt. Made ___/___/___ w/L&C ☐ Call 911 ☐ Go to ER ☐ L&C MD on call notified ☐ Call Family Physician

structions accepted?: ___ yes ___ no

_____ (Staff) _____ (Doctor) ___/___/___ (Date) _____ AM/PM (Time)

GUNN 004289

Lung and Chest Medical Associates

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J.P. Elm, F.N.P.

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Fax: (864) 582-3750

WILLIAM CASEY
77168
08-04-05

OFFICE NOTE

Chief Complaint

William Casey returns for follow up on his previous visit. Since we saw him he has had coronary calcium score and upper abdominal ultrasound.

Current Conditions

1. Chest pain.
2. Nausea and vomiting.
3. Persistent difficulty concentrating staying focused status post pneumomediastinum/pneumothorax complicating laser therapy in attempt for laser therapy for metallic artifact, which ultimately proved to be outside of chest.

Current Medicines

1. Advair 250/50 twice daily.
2. Combivent 1 puff four times daily as needed.
3. Ultram 50 mg four times daily as needed chest pain.
4. Lipitor 10 mg daily.
5. Lortab four times daily as needed.

Social History

No tobacco or alcohol.

Review of Systems

No additional findings on cardiorespiratory, GI or GU review.

Physical Examination
Vital Signs: Wt. 178, BP 120/74, HR 75, RR 22 and SaO_2 is 98% on room air.
General: No acute distress.
Skin: Normal turgor.
HEENT: Pupils symmetric.
Neck: No jugular venous distention.
(Continued to next page)

Physical Examination (Continued)
Chest: No wheezes, rales or rhonchi.
Cardiac: No murmur or gallop.
Abdomen: Bowel sounds present. The patient felt like he might have the heaves while in the office but no emesis. Bowel sounds present.
Extremities: No edema or clubbing.
Neurological: The patient had some readily apparent difficulty staying focused with answers to questions and had difficulties repeating numbers backward on a simple cognitive screen.

Laboratory Data

The ultrasound showed no pathological findings.

Impression/Discussion/Plan

The patient has been instructed in optimal use of aerosol therapy. The patient was instructed on diet with attention at maintaining muscle mass and achieving an ideal body weight. The patient is instructed in exercise to promote mucous clearance, maintain balance and muscle mass. The patient was given our cell phone number to call any time any interval problems develop before the next visit.

The patient is to continue his current regimen. He will check back with us this fall.

Charles M. Fogarty, MD
CMF/ns

Lung and Chest Medical Associates

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Mary Lou Applebaum, M.D.
Beth V. Edwards, PA-C

Fax: (864) 582-3750

WILLIAM CASEY
77168
07-21-05

OFFICE NOTE

Chief Complaint

William Casey returns for follow up on his 7/19 visit. At that time he was having dry heaves and nausea and this was felt possibly to be an interaction between the Strattera and the Cymbalta and he was advised to discontinue these. Since then he is better. He continues to have chest pain, a squeezing sensation. This can be present without exercise although exacerbated by exercise.

We should note that it was this symptom that led him to go to the emergency room May 2004. Although the presenting complaint was chest pain, a chest film showed a metallic fragment overlying the chest. This was misinterpreted as being in the chest and the patient underwent bronchoscopy. And when the bronchoscopy did not show definite abnormality, but rather an area of erythema, he was scheduled for a laser bronchoscopy. He had the laser bronchoscopy complicated by pneumomediastinum with a lengthy two hour anesthesia. Since then, although the patient recovered from his pneumomediastinum and bilateral pneumothoraces with chest tubes, intubation and mechanical ventilation, since then he has had continued difficulties concentrating, staying focused and with his general energy.

He is not smoking.

Current Medicines

1. Advair 250/50 twice daily.
2. Combivent 1 puff four times daily as needed.
3. Ultram 50 mg four times daily as needed chest pain.
4. Lipitor 10 mg daily.
5. Lortab four times daily as needed.

Social History

He has been out of work now for a year and probably will be out of health insurance and probably lose his job since he has been unable to hold gainful employment in the interim in large part because of his difficulties with concentrating, staying focused. Although the issue of his chest pain still remains unresolved.
(Continued to next page)

Family History

Coronary artery disease and hyperlipidemia.

Review of Systems

He did have a cardiac catheterization several years back but his CT during the May 2004 admission prior to his laser bronchoscopy was normal range except for incidentally noted coronary calcification. No additional findings on cardiorespiratory, GI or GU review.

Physical Examination
Vital Signs: Wt. 176.6, BP 153/91, HR 78, RR 20 and SaO_2 is 98% on room air.
General: No acute distress.
Skin: Normal turgor.
HEENT: Pupils symmetric.
Neck: No jugular venous distention.
Chest: No wheezes, rales or rhonchi.
Cardiac: No murmur or gallop.
Abdomen: Bowel sounds present. The patient felt like he might have the heaves while in the office but no emesis. Bowel sounds present.
Extremities: No edema or clubbing.
Neurological: The patient had some readily apparent difficulty staying focused with answers to questions and had difficulties repeating numbers backward on a simple cognitive screen.

Laboratory Data

The vital capacity is 4.65 or 98% of predicted. The forced expiratory volume is 3.76 or 97% of predicted.

Today's cardiogram is normal range. Interestingly the cardiogram while he was in the hospital with his chest pain in May of last year showed nonspecific ST T-changes.

Impression

1. Chest pain.
2. Nausea and vomiting.
3. Persistent difficulty concentrating staying focused status post pneumomediastinum/pneumothorax complicating laser therapy in attempt for laser therapy for metallic artifact, which ultimately proved to be outside of chest.

(Continued to next page)

WILLIAM CASEY
77168
07-21-05
Page Tree

Comment

With reference to the patient's GI symptoms they do seem improved since discontinuing the Strattera and this really did not help with his staying focused anyway. However he may still have some underlying pathology such as cholelithiasis or peptic ulcer disease and ultrasound of the gallbladder appears warranted. If symptoms persist we may consider an upper GI.

With reference to the patient's squeezing he does have risk factors for coronary artery disease in terms of his hyperlipidemia, family history and previous smoking and he did have coronary calcification incidentally noted on Spartanburg Regional Medical Center CT. A formal coronary calcium score may be indicated and if elevated may be an indication to proceed with more vigorous cardiac workup.

With reference to the patient's difficulty concentrating, he undoubtedly had air emboli given his lengthy duration of anesthesia and laser perforation of the endotracheal tree with resultant leakage of air into extra pleural and vascular extra pleural mediastinal and vascular spaces. Although he is fortunate not to have any gross motor deficit, he may well have a permanent neurologic deficit in which case the indication for taking medication may be moot and the patient may simply need to recognize that although he would like to go back to work, he may be chronically disabled by his neurologic impairment.

Plan

We will check back with the patient via phone with reference to his coronary calcium score and his gallbladder ultrasound. Further evaluation will proceed pending the results of above. Separately, we will review the patient's chart for him since he still has many questions about what happened during the hospital admission for his chest pain. We will review the patient's chart for him and try to put into lay language a summary of the chart with reference to what happened to him during the hospital admission for his chest pain last year.

Charles M. Fogarty, MD
CMF/ns
cc: Dr. Gonda

PIEDMONT IMAGING

Your Choice for MRIs & CT Scans

Name: Casey William Date of Scan: 7/25/05

Address: 240 Lightwood Farm Rd. Woodruff S.C 29388

Telephone: (864) 680-9648 Date of Birth: [redacted] 53

PROCEDURE

MULTISLICE HELICAL CT CORONARY ARTERY CALIUM SCORING (CACS)

TECHNIQUE

MultiSlice Helical 3.2 mm transaxial CT images were obtained at 1.5 mm intervals for evaluation of the proximal 6.0 cm of the coronary arteries. A computer-generated score is calculated based on the amount of calcification detected.

RESULTS

L MAIN 0.0 LAD 1.4 CIRCUMFLEX 0.0 R. CORONARY 0.0 TOTAL 1.4

CALCIUM SCORE GUIDELINES

Total Score	Plaque Burden	Risk Category	Probability of Significant CAD	Guidelines
____ 0-1	No identifiable atherosclerotic plaque	Very Low	Very Unlikely	Reassurance while stressing adherence to general guidelines on diet and exercise.
✓ 1-10	Minimal identifiable plaque	Low	Unlikely	Follow the general guidelines on cardiovascular risk reduction.
____11-100	Mild identifiable plaque	Moderate	Mild or minimal coronary stenosis likely	Risk factor medication is recommended, including daily aspirin and strict adherence to National Cholesterol Education Program or proposed modification.
____101-400	Moderate identifiable plaque	Moderately High	Moderate likelihood of significant stenosis	Aggressive risk factor modification is recommended with stress testing preparatory to an exercise program. Daily aspirin is advised. Strict adherence to National Cholesterol Education Program or proposed modification.
____ Over 400	Extensive plaque burden	High	High likelihood of significant coronary stenosis	Very aggressive risk factor modification is recommended (including aspirin and a statin medication) with stress imaging and possibly angiography.

Coronary artery calcification is a specific marker for coronary atherosclerosis. The amount of calcification correlates with severity of coronary atherosclerosis and the probability of obstructive disease. **A score of 0 indicates no coronary artery calcification and this implies the absence of significant angiographic coronary narrowing in 99% of cases. It does not absolutely rule out the presence of soft non-calcified plaque, especially in younger patients and those who smoke heavily.** A high score indicates a significant plaque burden and the relative risk for future cardiovascular events. It should be understood that calcification is not site specific for stenosis but rather indicates the extent of atherosclerosis in the coronary arteries overall.. The score may be used as a benchmark to measure subsequent disease development or assess preventative programs.
Thank you for your confidence in our center.

Sincerely,

Raul Ceballos, Jr. MD
Radiologist

684 North Pine St. • Spartanburg, South Carolina 29303
864-542-0033 • Fax 864-542-0025

SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
DRS. DAVIS, LOWRY, WREN, NELSON, RAINER, LAPHAM, MIMS, CALDWELL, BURKS & KIM

CASEY WILLIAM MR#: (0002)00014-62-20 Fin.No.:0520001651 Admitted: 19JUL05
46 YRS MALE DOB: [redacted]/1958 Page: 1
Dr. MENDOZA RICO INTERIM Printed: 21JUL05
Location: - PRIVATE OUT PT VISIT ABDMNAL PAIN UNSPCF SITE 0558

CHEMISTRY

--------- HEPATIC PROFILES ----------

Procedure:	TOT PROT	ALBUMIN	AST	ALT	ALK PHOS	BILI TOTAL	BILI DIR	BILI INDIR
Ref Range:	(6.1-8.0)	(3.5-4.9)	(12-33)	(8-39)	(36-108)	(.0-1.5)	(.0-.2)	(.2-1.4)
Units:	GM/DL	G/DL	IU/L	IU/L	IU/L	MG/DL	MG/DL	MG/DL
19JUL05 1600	6.9	4.4	14	18	80	.6	.1	.5

Patient Name:CASEY WILLIAM Location: PRIVATE OUT PT VISIT END OF CHART.

Send to: DR RICO MENDOZA
2030 NORTH CHURCH AVE
SPARTANBURG SC 29303

Fax to: 864-585-2102

Gunnos x

GUNN 004296

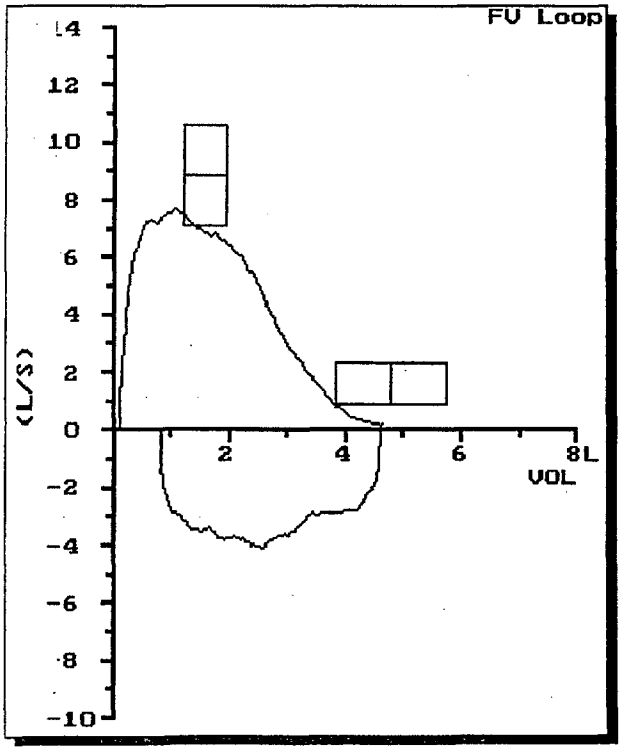
Lung and Chest Medical Associates
Multi Spiro B

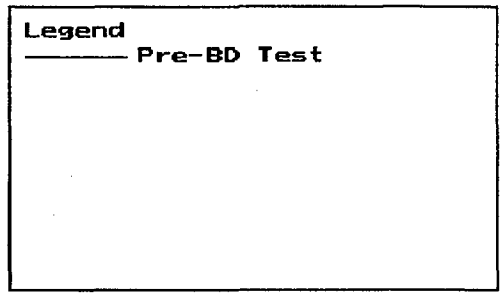
ID: 77168 Casey, William
Ethnic: CAUCASIAN Height: 68.0 in. Sex: MALE Age: 46 Weight: 171.0 lb

MENTS:
-BD COMMENTS:

LAST CALIBRATED: Thu Jul 21,2005 7:36:40 am

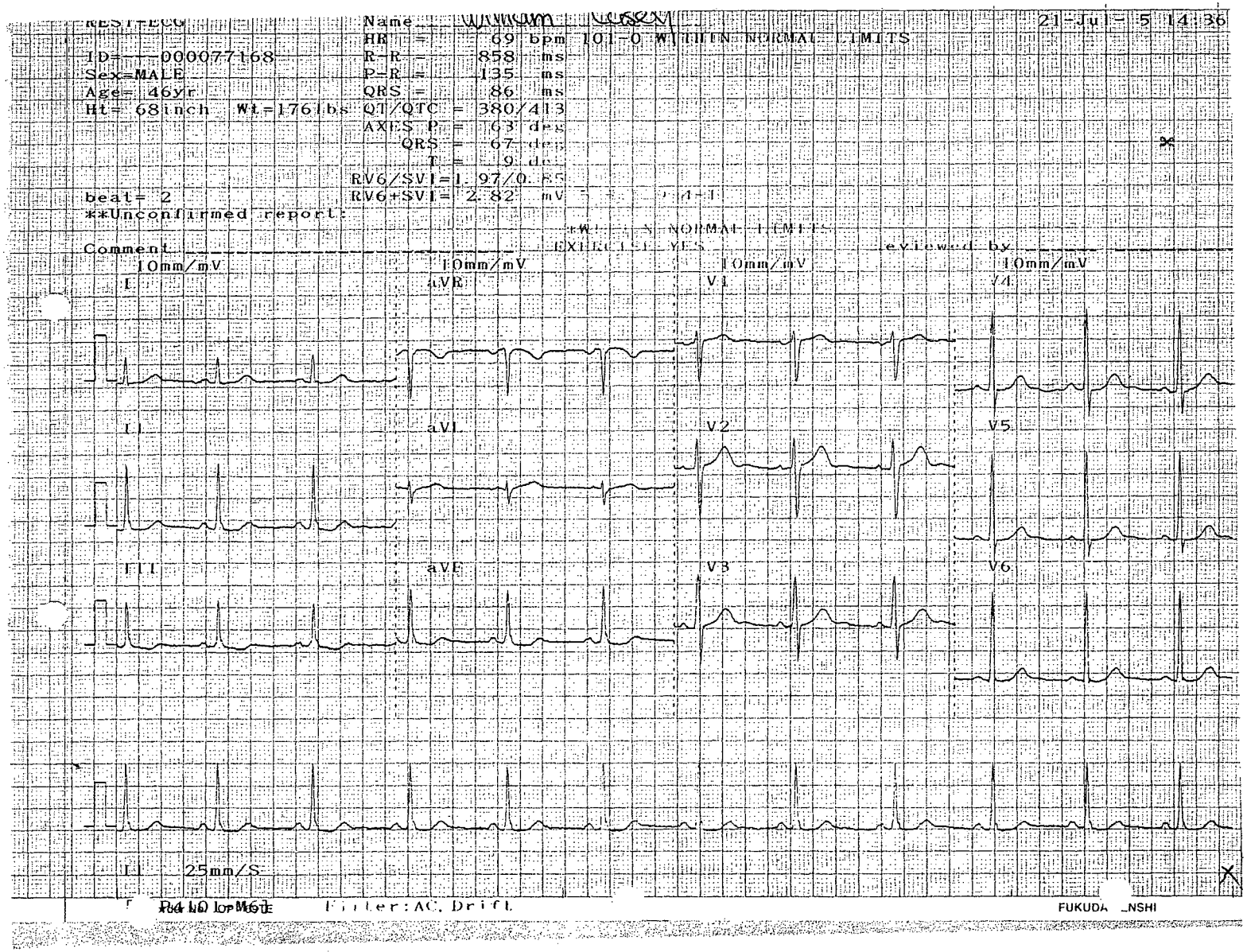
TYPE	Test Date and Time		Exp.Time	Normals	Test#
Pre-BD:	Thu Jul 21,2005 3:52:12 pm		5.9 secs	KNUDSON/IMTS	1
Expiratory	Actual	Predicted	% of pred	Inspiratory	Actual
FVC	4.65 L	4.75 L	97.88 %	IVC	3.86 L
FEV 0.5	2.96 L	3.05 L	97.12 %	FIV1	2.95 L
FEV 1.0	3.76 L	3.87 L	97.21 %	PIF	4.26 L/S
FEV 3.0	4.40 L	4.51 L	97.51 %	FIF50	3.97 L/S
				FEF50/FIF50	135.01 %
FEV 0.5/FVC	63.77 %	64.27 %	99.22 %		
FEV 1.0/FVC	80.82 %	81.38 %	99.31 %	Interpretation:	
FEV 3.0/FVC	94.58 %	94.94 %	99.62 %		
				NORMAL	
PEF	7.56 L/S	8.67 L/S	87.17 %		
FEF 25-75%	3.91 L/S	3.95 L/S	99.06 %	MAX FVC = 4.65L TEST # 1	
FEF 75-85%	0.86 L/S	1.06 L/S	81.57 %	MAX FEV-1 = 3.76L TEST # 1	
FEF 25	7.45 L/S	7.97 L/S	93.49 %		
FEF 50	5.37 L/S	4.62 L/S	116.05 %		
FEF 75	1.47 L/S	1.83 L/S	79.90 %		
FEF .2-1.2	7.00 L/S	7.31 L/S	95.75 %		





Good Effort! NB

GUNN 004297



4603

GUNN 004298

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BETH V. EDWARDS, PA-C A465 N[illegible] E L. CROCKFORD, PA-A945
J. P. ELM, FNP F2380, CINDY A. EDWARDS, FNP F[illegible]5 CHARLENE MCCRAW, ACNP-C AC68077
2030 North Church Place, Spartanburg, SC 29303 Telephone 582-6858

NAME	William Casey	DATE	7/19/07
ADDRESS			

LABEL DRUG NAME, STRENGTH, & QUANTITY ☐ YES ☐ NO

		STRENGTH	QUANTITY	REFILL
1	Rx Compazine SIG Take 1 tab PO QID pm	10mg	40	—
2	Rx SIG			
3	Rx SIG			

M.D. _____ Dispense as written
DEA _____

M.D. [signature] Substitution Permitted
DEA _____

LC-104

GUNN 004299

CBC, K+, Bun, Creat, Glu, extra gold tube, PAL, Spiro

CMF WPS MLA EBK JDC RVM Beth Darla Lab

Lung and Chest Medical Associates

Name: William Casey Chart#: 77168 Date: 7-19-05

Wt 174.9 Ht — B/P 129/89 H/R 85 RR 16 Temp 98.1 02Sat 93 FiO2 —

O Cough	O Smoking	Present Illness + reason for visit:
O Sputum	✓ Nausea	Doesnt want to see Goldman
OC Dyspnea	✓ Vomiting	
O Wheeze	O Diarrhea	
O Edema	O Chest Pain	Vomiting x 1 week - Chest sore - tight
O Palpitations	O Pain	Dry Heaves now
O Oriented	O ETOH	
O New Allergies	O Fever/chills	saw Dr Beauty at usual several years ago Sister

When was your last DEXA Bone Densometry Testing done? Sister gets them

Seeing new doctors? no For:

Hospitalizations or major life changes since last visit: yes 6-05 - sinus

Meds. Review based on: ___in bottle ___on list ___from memory

PHYSICAL EXAM:	WNL/NEG	ABN/POS	
*General Appearance			dry heaving x 1wk ocas vomit
*Skin Turgor			Can't take anything down
*ENT			
*Mouth			Chest hurts
*Sinus			
*Neck			No fever/chills some epigastric
*Chest/Lungs: Breath Sounds			pain
Wheezes			Cipro/Keflex/Prednisone/Lipitor/Ultram/Cortef
Rales			
Effort			
Symmetry			
*Heart: Rhythm			
Murmurs			
Gallop			
Tones			
*Abdomen			
*Extremities			
*Mobility: Gait			
Reflexes			
Aides			
*Mental Status			

LAB ORDER: Spirometry 5.02 3.40 EKG Sinus CBC Glu 121 PT INR O2Sat Rest 93%

Lung Vol DLCO U/A CXR ABG's Bun 39 Cr 1.1 K+ 4.2 Theo O2Sat Exercise

Office Treatment:

Education: Does pt want to quit smoking? Yes/No Other: PT no longer smoker extra gold

Materials/counseling given:

Diagnosis:		Plan
	NAFCE/Usual	✓ UGIS BW Sprue/Celiac
Abn CXR(lung fluid),793.1	? Stricture/Cancer site	✓ UA/Cs
Anticoagulant Circulating,28615		
COPD,496	PMD Hepatitis	Ice in diet cause
Cough,786.2		Stop Strictex/Cipro/Keflex
Dyspnea,786.09		
Fatigue(general),780.79		
Fever,780.6		
ILD,515		
Monitoring(drug name_____),V48.6		
Rhinitis,477.9		
Sleep Apnea/Disorders (nec), 780.53		

Prescriptions:

Next appt: ___Weeks___Months W/ CMF WPS EBK MLA JDC RVM PA NP Signature _____ Staff LH

Next Visit: Spiro L/V DLCO PA PAL Sinus DEXA BLDWK Other

GUNN 004300

Office Visit Confirmation Sheet **Today's Date** - -

- Patient Name William Mark Casey Doctor Name
- Appt. Time 3:30 Arrival Time 3:30 E-mail address
- Address
- Home phone # 9 Work Phone # Other Phone #
- Emergency contact name: Carole Lynne Hyslop Phone #
- Patient's Employer Michelin Tire Insured's Employer
- Type of Insurance: 1. BC/BS 2. 3.
- If you are currently a resident of a Skilled Nursing Facility, enter the name and phone #:

4606

Lung and Chest Medical Associates Spiro A

ID: 77168 Casey, William Mark

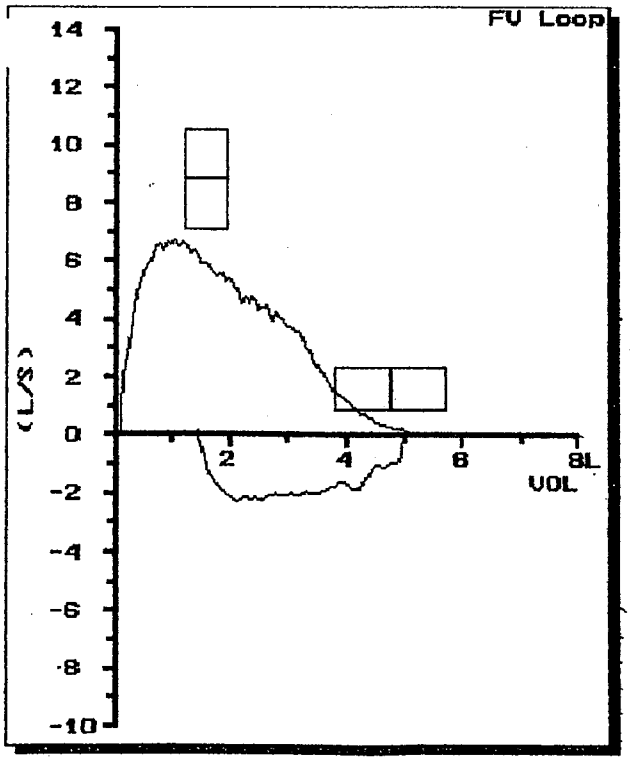
Ethnic: CAUCASIAN Height: 68.0 in. Sex: MALE Age: 46 Weight: 174.0 lb

MENTS:

-BD COMMENTS:

LAST CALIBRATED: Tue Jul 19,2005 7:34:36 am

TYPE	Test Date and Time		Exp.Time	Normals	Test#
Pre-BD:	Tue Jul 19,2005 11:57:55 am		6.3 secs	KNUDSON/IMTS	2
Expiratory	Actual	Predicted	% of pred	Inspiratory	Actual
FVC	5.02 L	4.73 L	106.19 %	IVC	3.61 L
FEV 0.5	2.75 L	3.04 L	90.50 %	FIV1	1.35 L
FEV 1.0	3.90 L	3.84 L	101.52 %	PIF	2.46 L/S
FEV 3.0	4.73 L	4.48 L	105.50 %	FIF50	2.20 L/S
				FEF50/FIF50	193.85 %
FEV 0.5/FVC	54.75 %	64.24 %	85.23 %		
FEV 1.0/FVC	77.66 %	81.23 %	95.61 %	Interpretation:	
FEV 3.0/FVC	94.18 %	94.79 %	99.35 %		
				NORMAL	
PEF	6.61 L/S	8.64 L/S	76.59 %		
FEF 25-75%	3.61 L/S	3.91 L/S	92.38 %	MAX FVC = 5.02L TEST # 2	
FEF 75-85%	0.90 L/S	1.04 L/S	87.31 %	MAX FEV-1 = 3.90L TEST # 2	
FEF 25	6.15 L/S	7.95 L/S	77.37 %		
FEF 50	4.26 L/S	4.59 L/S	92.85 %		
FEF 75	1.40 L/S	1.81 L/S	77.15 %		
FEF .2-1.2	5.82 L/S	7.26 L/S	80.13 %		



Legend

Pre-BD Test

Good effort

GUNN 004302

LUNG AND CHEST MEDICAL ASSOCIATES

2030 North Church Place, Spartanburg, SC 29303

CMF WPS EBK MLA JDC (RVM) BE

LAB REQUISITION

PATIENT NAME William Casey CHART # 7716 8 DATE 7-19-05

SEX RACE

DIAGNOSIS _____ M F C B A H O

	DESCRIPTION	RESULTS	NORMAL VALUE	REPEATED VERIFIED RESULTS	INITIALS
	Theophylline		10-20 Mcg/dl		
	Glucose	121	70-110 Mg/dl		
	BUN	29	5-25 Mg/dl		
	Creatinine	0.7	0.5-1.4 Mg/dl		
	K+	4.2	3.5-5.1 Meq/dl		
	PT		14-18 sec		
	INR		2.0-3.0 Coumadin therapy		
			2.5-3.5 Prostatic Heart Valves		
	CBC				
	UA				
	HgbA1C	%	< 7 %		
	Arterial Puncture				
	ABG's – Fi02				
	ABG's – PH		7.35-7.45		
	ABG's – PC02		35-45 mmHg		
	AGG's – P02		80-100 mmHg		
	AGG's - 02 Sat		95-98%		

URINALYSIS -- MACROSCOPIC			
COLOR	_____	Ph	_____
APPEARANCE	_____	PROTEIN	_____
GLUCOSE	_____	UROBILINOGEN	_____
BILIRUBIN	_____	NITRITE	_____
KETONES	_____	LEUKOCYTES	_____
SP. GR.	_____		

Rapid Strep Positive Negative

Z-Stat Flu Positive Negative

CMF _____ WPS _____ EBK _____ MLA _____ JDC _____ RVM _____ BE _____ Staff _____

Lab Requisition, 12-23-03

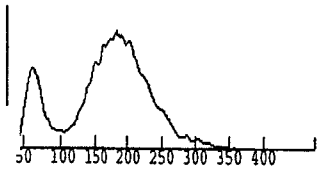
GUNN 004303

LUNG AND CHEST MED ASSOCIATES
2030 N CHURCH PLACE
SPARTANBURG SC 29303 JDC RVM BE
864-582-6858 CMF WPS EBK MLA

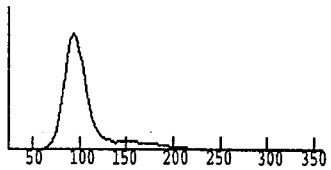
William Casey

: 77168 07-19-05
CVWB 09:58

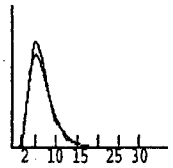
				Patient Limits 1	
WBC	13.7	H	x10^3/uL	4.5	11.0
LY	17.5	*L	%	20.5	51.1
MO	5.9	*	%	1.7	9.3
GR	76.6	*H	%	42.2	75.2
LY#	2.4	*	x10^3/uL	1.2	3.4
MO#	0.8	*H	x10^3/uL	0.1	0.6
GR#	10.5	*H	x10^3/uL	1.4	6.5
RBC	4.68		x10^6/uL	3.90	5.10
Hgb	14.8		g/dL	12.0	15.6
Hct	43.5		%	36.0	46.0
MCV	93.0		fL	85.0	98.0
MCH	31.7		pg	28.0	33.0
MCHC	34.0		g/dL	32.5	36.0
RDW	12.1		%	11.6	13.7
Plt	677.	H	x10^3/uL	130.	400.
MPV	7.1	L	fL	7.8	11.0



WBC HISTOGRAM



RBC HISTOGRAM



PLT HISTOGRAM

CMF (WPS) MLA EBK JDC RVM Beth Darla Lab

Lung and Chest Medical Associates

me: Wm. Casey Chart#: 7168 Date: 8/12/04

Wt 175 Ht ___ B/P 120/80 H/R 82 RR ___ Temp ___ 02Sat 96% FiO2 .21

0 Cough	0 Smoking
___ Sputum	___ Nausea
0 Dyspnea	___ Vomiting
___ Wheeze	___ Diarrhea
___ Edema	___ Chest Pain
___ Palpitations	✓ Pain back
✓ Oriented	___ ETOH
___ New Allergies	___ Fever/chills

Present Illness + reason for visit: Still gets tired c exertion — No fluid, dust pen

When was your last DEXA Bone Densometry Testing done? Times wgl 100 lb that he remembers

Seeing new doctors? ___ **For:** ___

Hospitalizations or major life changes since last visit: ___

Meds. Review based on: ___ in bottle ___ on list 100 lb that he from memory

PHYSICAL EXAM: WNL/NEG ABN/POS

*General Appearance___
*Skin Turgor___
*ENT___
*Mouth___
*Sinus___
*Neck___
*Chest/Lungs: Breath Sounds ___
Wheezes___
Rales___
Effort___
Symmetry___
*Heart: Rhythm___
Murmurs___
Gallop___
Tones___
*Abdomen___
*Extremities___
*Mobility: Gait___
Reflexes___
Aides___
*Mental Status___

LAB ORDER: Spirometry___ EKG___ Sinus___ CBC___ Glu___ PT___ INR___ O2Sat Rest___
Lung Vol___ DLCO___ U/A___ CXR___ ABG's___ Bun___ Cre___ K+___ Theo___ 02Sat Exercise___

Office Treatment: ___

Education: Does pt want to quit smoking? Yes/No Other: ___

Materials/counseling given ___

Diagnosis: ___ Plan ___

___Abn CXR(lung fluid),793.1
___Anticoagulant Circulating,28615
___COPD,496
___Cough,786.2
___Dyspnea,786.09
___Fatigue(general),780.79
___Fever,780.6
___ILD,515
___Monitoring(drug name_____),V48 6
___Rhinitis,477.9
___Sleep Apnea/Disorders (nec), 780.53

Prescriptions: ___

Next appt: ___Weeks___Months W/ CMF WPS EBK MLA JDC RVM PA NP Signature WM Staff ___

Next Visit: Spiro L/V DLCO PA PAL Sinus DEXA BLDWK___ Other ___

03/26/04

GUNN 004305

Office Visit Confirmation Sheet

!!! Please fill out all blanks each time you visit our office.

Patient Name William Mark Casey Today's Date Aug 12 04

Doctor Smith Appt. Time 11:45 Arrival Time 11:40

Reason for visit:(check one) ____Having problems ✓Regular follow-up

Please confirm your personal information for our records:

Address [illegible]

Home phone # [illegible] Work Phone # _____ Other Phone # _____

Emergency contact name: Carole Casey Phone # _____

Type of Insurance: 1. B/C B/S 2. _____ 3. _____

E-mail address: _____

4611

CMF WPS MLA EBK JDC RVM Beth Darla Lab

Lung and Chest Medical Associates

Name: Wm. Casey Chart#: 77168 Date: 11/10/04

Wt 180.6 Ht ___ B/P 163/97 H/R 92 RR 18 Temp ___ 02Sat 95 FiO2 .21

∅ Cough	✓ Smoking	Present Illness + reason for visit: "4-5 cigs/day"
___ Sputum	∅ Nausea	
DOE Dyspnea	∅ Vomiting	
∅ Wheeze	∅ Diarrhea	
∅ Edema	___ Chest Pain	→ only c exertion No dyspnea
___ Palpitations	___ Pain	
✓ Oriented	✓ ETOH some	when yard working or
∅ New Allergies	∅ Fever/chills	walking steps & hills is relieved.

When was your last DEXA Bone Densometry Testing done? ∅

Seeing new doctors? ∅ For: ___

Hospitalizations or major life changes since last visit: ∅

Meds. Review based on: ___ in bottle ___ on list ~~∅~~ from memory

PHYSICAL EXAM: WNL/NEG ABN/POS

*General Appearance___ Dr Grace does not
*Skin Turgor___ feel need to do
*ENT___ nothing to work
*Mouth___ no need to return to
*Sinus___ work
*Neck___ does not want to go.
*Chest/Lungs: Breath Sounds ___ Pain negative after
Wheezes___ working 2-2½ hrs.
Rales___ tender along sternum margin
Effort___
Symmetry___
*Heart: Rhythm___
Murmurs___
Gallop___
Tones___
*Abdomen___
*Extremities___
*Mobility: Gait___
Reflexes___
Aides___
*Mental Status___

LAB ORDER: Spirometry___ EKG___ Sinus___ CBC___ Glu___ PT___ INR___ O2Sat Rest___
Lung Vol___ DLCO___ U/A___ CXR___ ABG's___ Bun___ Cre___ K+___ Theo___ 02Sat Exercise___

Office Treatment: ___

Education: Does pt want to quit smoking? Yes/No Other: ___

Materials/counseling given: ___

Diagnosis: Pain transmitter Plan Zoloft 150 q D

___Abn CXR(lung fluid),793.1 Flexeril
___Anticoagulant Circulating,28615 Cortisone Injection
___COPD,496 Clostridium toxin
___Cough,786.2 in case of
___Dyspnea,786.09 chest pain
___Fatigue(general),780.79
___Fever,780.6
___ILD,515
___Monitoring(drug name_____),V48.6
___Rhinitis,477.9
___Sleep Apnea/Disorders (nec), 780.53

Prescriptions: ___

Next appt: ___Weeks___Months W/ CMF WPS EBK MLA JDC RVM PA NP Signature WPS Staff gs

Next Visit: Spiro L/V DLCO PA PAL Sinus DEXA BLDWK___ Other___

09/29/04

Office Visit Confirmation Sheet

!!! Please fill out all blanks each time you visit our office.

Patient Name wm MARK Casey Today's Date Nov 10

Doctor Smith Appt. Time 8:15 Arrival Time 8:15

Address [illegible]

Home phone # 426-9131 Work Phone # [illegible] Other Phone # _____

Emergency contact name: Carole Casey

Is the patient a resident of a skilled nursing facility? Yes _____ No ←

4613

MICHELIN TIRE MANUFACTURING
US.3 Facility Personnel
Post Office Box 5049
Spartanburg, SC 29304
864-599-3157, Office
864-599-3222, Fax

ATTENDING PHYSICIAN'S REPORT
(FOR EXTENDED LEAVES OF ABSENCE)

Date: July 29, 2004

Employee's Name: William Mark Casey

Address: _____

Date original medical leave of absence: May 28, 2004

Expected date of return to work: Aug 14, 2004

Physical findings (diagnosis): Chest pain w/ dyspnea
Cr Scan Chest shows coronary artery
Calcification

Treatment and/or recommendation: _____
Stress test
Absence from work until Aug 16, 2004

_____ M.D.

Address: _____

_____

Telephone: _____

NOTE: Michelin employees may receive full or 60% pay during Medical Leave of Absence. Verification of information regarding this request for leave would be greatly appreciated. To assure continuity in the employee's pay, this form must be returned promptly. Your cooperation would be appreciated.

LCF/SP/FORMS/DLEXTLV.DOC

GUNN 004309

CHARLES M. FOGARTY, MD 086917 WILSON P. SMITH, MD 10510 E. BERT KNIGHT III, MD 8397
MARY LOU APPLEBAUM, MD 12969 J. DOUGLAS CLARK, MD 19596
BRENDA SPRINKLE, PA-C A144 CHARLES MASON, PA-C A566
CHARLENE McCRAW, A.C.N.P.-C AC68077
2030 North Church Place Spartanburg, SC 29303 Telephone 582-6858

NAME William Casey DATE 7/29/04

ADDRESS

LABEL DRUG NAME, STRENGTH & QUANTITY ☐ YES ☐ NO

		STRENGTH	QUANTITY	REFILL
1	Rx Please Equine Mv SIG			
2	Rx Casey Sun Wash Sun SIG Medicaid Rx Aug 16	STRENGTH	QUANTITY	REFILL
3	Rx SIG Chest pain	STRENGTH	QUANTITY	REFILL

M.D. _____ M.D. _____
Dispense as Written Substitution Permitted

DEA _____ DEA _____

LC-105

Altman Printing Co., Inc.

GUNN 004310

LUNG AND CHEST MEDICAL ASSOCIATES
2030 North Church Place
Spartanburg, South Carolina 29303
Telephone: (864) 582-6858
Fax (864) 542-9043

Charles M. Fogarty MD
E. Bert Knight, III MD
Mary Lou Applebaum, MD
Wilson P. Smith, Jr., MD
J. Douglas Clark, MD
Rico V.I. Mendoza, MD

SCHEDULED PROCEDURES

DATE: 7/29/04

PATIENT NAME: Mark Casey

REFERRING DOCTOR: Wilson Smith

TYPE OF PROCEDURE: Cardiolite stress

HOSPITAL/AGENCY: Cardiology Consultants 583-8647

DATE OF APPOINTMENT: Mon. Aug 2, 2004 10:15

DOCTOR TO DO PROCEDURE _____

TIME TO BE AT HOSPITAL/AGENCY _____ AM/PM

TIME OF PROCEDURE Aug 2. 10:15 (AM)/PM

INSTRUCTIONS No meds morning of stress. Nothing to eat or drink post midnight the night before.

ANY QUESTIONS REGARDING THIS, PLEASE CALL OUR OFFICE (864) 582-6858.

SIGNED _____

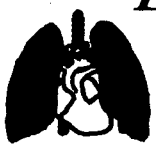
FORMS/SCHEDULED PROCEDURES 4/03

LC-1

Altman Printing Co., Inc.

GUNN 004311

Lung and Chest Medical Associates



Charles M. Fogarty, M.D.
J. Douglas Clark, M.D.
Rico V. I. Mendoza, M.D.
J.P. Elm, F.N.P.

Fax: (864) 585 - 2102

Wilson P. Smith, Jr., M.D.
E. Bert Knight, III, M.D.
Mary Lou Applebaum, M.D.
Beth V. Edwards, PA-C
Cindy Edwards, F.N.P.

Fax: (864) 582-3750

WILLIAM CASEY
7-29-04
77168

OFFICE NOTE

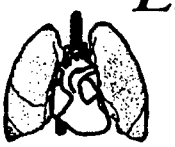
Mr. Casey returns for a follow up visit today. He is trying to resume activities. He has developed chest pain with exertion and so in view of the finding of coronary artery calcification on his CT scan and his exertional chest pain we will refer him for a Cardiolite stress test and consideration of pulmonary rehabilitation. EKG today is within normal limits and shows no acute changes.

WPS

Wilson P. Smith, Jr., M.D.
WPSjr/ns
cc: Dr. Gonda

8-2-04

Lung and Chest Medical Associates



Charles M. Fogarty, M.D.
J. Douglas Clark, M.D.
Rico V. I. Mendoza, M.D.
J.P. Elm, F.N.P.

Fax: (864) 585 - 2102

Wilson P. Smith, Jr., M.D.
E. Bert Knight, III, M.D.
Mary Lou Applebaum, M.D.
Beth V. Edwards, PA-C
Cindy Edwards, F.N.P.

Fax: (864) 582-3750

WILLIAM CASEY
77168
07-29-04

X-RAY: PA & lateral of chest. Chest x-ray shows normal heart size and clear lung fields.

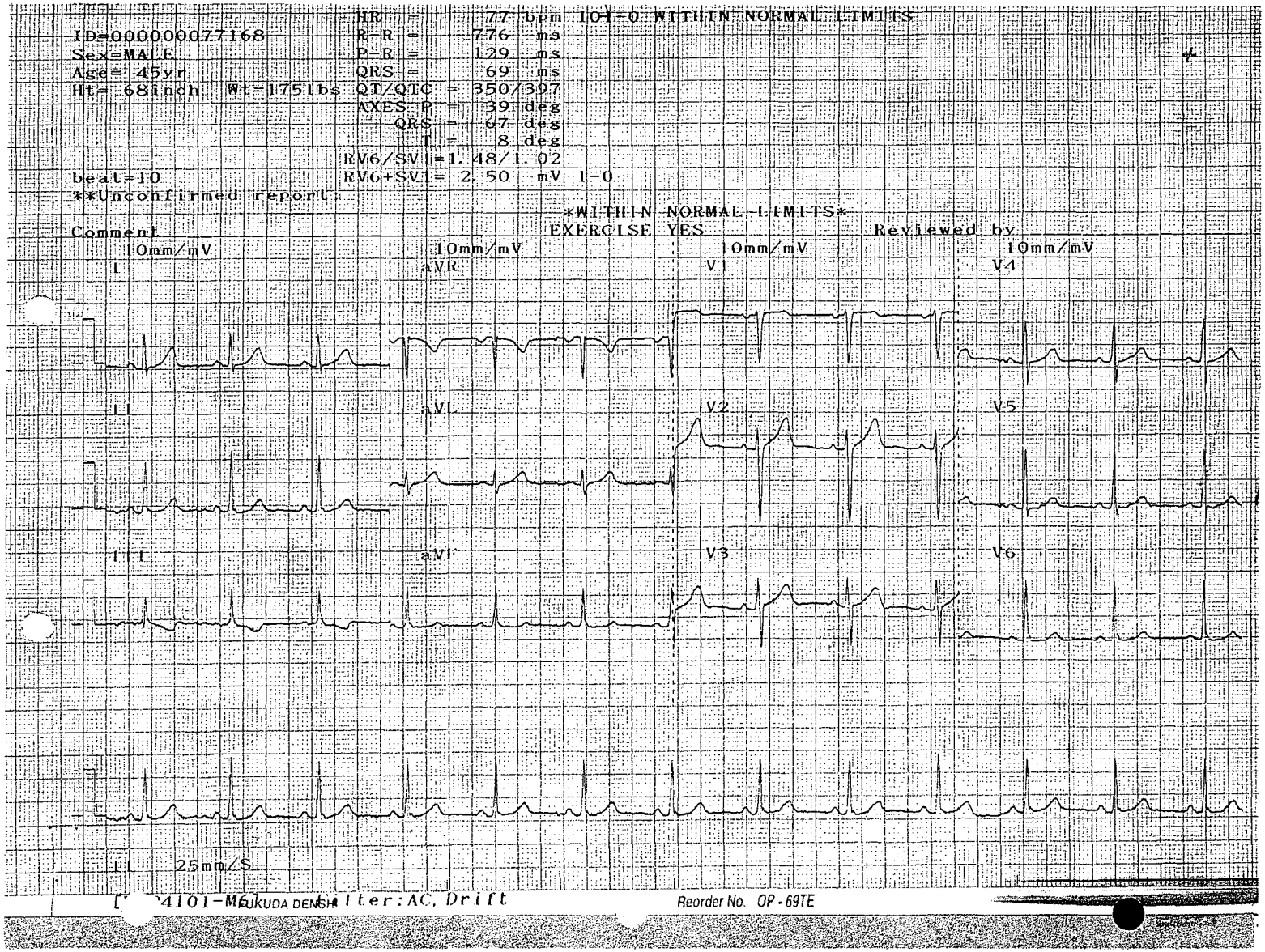
IMPRESSION: Normal chest.

Wilson P. Smith, Jr., M.D.
WPSjr/ns

2030 North Church Place, Spartanburg, South Carolina 29303 (864) 582-6858

Pulmonary Medicine | Critical Care | Bronchoscopy | Asthma Therapy | Sleep Disorders

GUNN 004313



4619

GUNN 004314

LUNG AND CHEST MEDICAL

030 N.CHURCH,ST CMF WPS EBK RVM SPARTANBURG,SC,29303 MLA JDC BE 864:582-6858

Sample ID # 77168 Date: 07-29-04

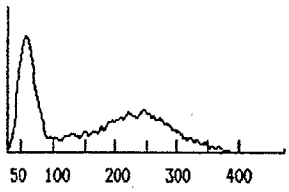
Patient Name: William Casey Time: 13:43 WPS

DOB: ___/___/___ AGE:____ SEX:____ OPR ID: OB

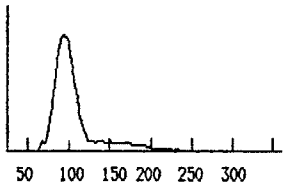
			Range #1				Range #1				Range #1
WBC	7.8	x10^3/uL	4.5- 11.0	RBC	4.54	x10^6/uL	3.90- 5.10	Plt	473. H	x10^3/uL	130.-400.
LY%	36.2	%	20.5-51.1	Hgb	14.2	g/dL	12.0-15.6	MPV	5.9 L	fL	7.4-10.4
MO%	4.2	%	1.7- 9.3	Hct	43.2	%	36.0-46.0				
GR%	59.6	%	42.2-75.2	MCV	95.2	fL	85.0- 98.0				
LY#	2.8	x10^3/uL	0.7- 4.9	MCH	31.2	pg	28.0-33.0				
MO#	0.3	x10^3/uL	0.1- 0.9	MCHC	32.8	g/dL	32.5-36.0				
GR#	4.6	x10^3/uL	1.5- 7.2	RDW	12.2	%	11.5-14.5				

7/30/04 WW

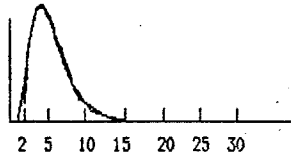
Sample ID # 77168 Analyzed Date & Time: 07-29-04 13:43



WBC HISTOGRAM



RBC HISTOGRAM



PLT HISTOGRAM

Sample ID # 77168 Analyzed Date & Time: 07-29-04 13:43

Microscopic Examination

Neutrophil	_____	Metamyelocyte	_____	Anisocytosis	_____	Retics	_____
Band	_____	Myelocyte	_____	Hypochromia	_____	Sedimentation Rate	_____
Lymphocyte	_____	Promyelocyte	_____	Polychromasia	_____		
Monocyte	_____	Blast	_____	Poikilocytosis	_____		
Eosinophil	_____	Atypical Lymphocyte	_____	Macrocytosis	_____		
Basophil	_____	NRBCs	_____	Microcytosis	_____		

Comments: _____

Requested by:_____

Reviewed by:_____

date:_____

GUNN 004315

CMF WPS MLA EBK JDC RVM Beth Darla Lab

Lung and Chest Medical Associates

Name: Wm Casey "Mark" Chart#: 77168 Date: 7/29/04

Wt 175.4 Ht ____ B/P 139/86 H/R 93 RR ____ Temp ____ 02Sat 95% FiO2 .21

- ø Cough
- ø Sputum
- ø Dyspnea
- ø Wheeze
- ø Edema
- ø Palpitations
- ✓ Oriented
- ___ New Allergies

- ø Smoking
- ø Nausea
- ø Vomiting
- ø Diarrhea
- ✓ Chest Pain
- ___ Pain
- ___ ETOH
- ___ Fever/chills

Present Illness + reason for visit: Chest tightness on exertion

When was your last DEXA Bone Densometry Testing done? ____

Seeing new doctors? ____ For: ____

Hospitalizations or major life changes since last visit: ____

Meds. Review based on: ____ in bottle ____ on list ____ from memory

PHYSICAL EXAM: WNL/NEG ABN/POS

*General Appearance___
*Skin Turgor___
*ENT___
*Mouth___
*Sinus___
*Neck___
*Chest/Lungs: Breath Sounds ___
Wheezes___
Rales___
Effort___
Symmetry___
*Heart: Rhythm___
Murmurs___
Gallop___
Tones___
*Abdomen___
*Extremities___
*Mobility: Gait___
Reflexes___
Aides___
*Mental Status___

PAL CXR

LAB ORDER: Spirometry ___ EKG ___ Sinus ___ CBC ___ Glu ___ PT ___ INR ___ O2Sat Rest ___
Lung Vol ___ DLCO ___ U/A ___ CXR ___ ABG's ___ Bun ___ Cre ___ K+ ___ Theo ___ 02Sat Exercise ___

Office Treatment: ____

Education: Does pt want to quit smoking? Yes/No Other: 4 days not smoke quit 4 week

Materials/counseling given: ____

Diagnosis: ____ Plan ____

- ___ Abn CXR(lung fluid),793.1
- ___ Anticoagulant Circulating,28615
- ___ COPD,496
- ___ Cough,786.2
- ___ Dyspnea,786.09
- ___ Fatigue(general),780.79
- ___ Fever,780.6
- ___ ILD,515
- ___ Monitoring(drug name_____),V48.6
- ___ Rhinitis,477.9
- ___ Sleep Apnea/Disorders (nec), 780.53

Chest pain → Stress pain dept candidate

Prescriptions: ____

Next appt: ___ Weeks ___ Months W/ CMF WPS EBK MLA JDC RVM PA NP Signature WM Staff AP

Next Visit: Spiro L/V DLCO PA PAL Sinus DEXA BLDWK ____ Other ____

03/26/04

GUNN 004316

Office Visit Confirmation Sheet

!!! Please fill out all blanks each time you visit our office.

Patient Name William Marie Casey Today's Date July 29

Doctor Smith Appt. Time 10:00 Arrival Time 10:10

Reason for visit:(check one) ____Having problems ✓ Regular follow-up

Please confirm your personal information for our records:

Address [redacted]

Home phone # _____ Work Phone _____ Other Phone # _____

Emergency contact name: Carole Lynn Casey Phone # [redacted]

Type of Insurance: 1. PIC - PS 2. _____ 3. _____

E-mail address: _____

4622

TELEPHONE CALL BACK - LUNG & CHEST MEDICAL ASSOCIATES

Date 8.13.04 Call Time 2:41 am/pm VM r'cvd time: 3:15 By: KB

Chart #: _____ Chart pull time : _____ Chart del. Time: _____ Callback time: _____

Caller: ☑ PATIENT ☐ PT. FAMILY ☐ PHARMACY ☐ HOME HEALTH ☐ HOSPICE ☐ INS. CO. ☐ DME CO. ☐ SPR

William Mark Casey

Caller Name Patient Name Phone No. Fax No.

Pt. of: CMF WPS EBK MLA JDC RVM Last Appt. __/__/__ Next Appt. __/__/__

Pt. Address (Proximity to office): _____

#1: DRUG REFILL ☐ Yes- patient stable/routine medicine ☐ No – see #2 below

Pharmacy: _____ Phone #: _____ Fax #: _____

CHARLES M. FOGARTY, MD 08691• WILSON R SMITH, MD 10510• E. BERT KNIGHT III, MD 08397
MARY LOU APPLEBAUM, MD 12969 • J. DOUGLAS CLARK, MD 19596• RICO VI. MENDOZA, MD 23156
BRENDA SPRINKLE, PA-C A144 • CHARLENE McCRAW, A.C.N.P-C AC68077• BETH V. EDWARDS, PA-C A465
2030 North Church Place, Spartanburg, SC 29303 Telephone 582-6858
FAX: Side A 582-3750 FAX: Side B: 585-2102

Rx

NAME: _____ DOB: [redacted]-58 DATE: _____

ADDRESS: _____

LABEL DRUG NAME, STRENGTH & QUANTITY ☐ YES ☐ NO

1	Rx _____	STRENGTH	QUANTITY / REFILL
	SIG _____		

M.D. _____ M.D. _____
Dispense as written Substitution Permitted
DEA: _____ DEA: _____

#2: PROBLEM ☐ COUGH ☐ SOB ☐ CHEST PAIN ☐ FEVER ☐ QUESTIONS ABOUT MEDS. ☐ NON-ROUTINE RX

Comment/Response: when is his appt w/ Dr. GRACE

LMAM for pt to R/S

KB WM

Appt. Made __/__/__ w/L&C ☐ Call 911 ☐ Go to ER ☐ L&C MD on call notified ☐ Call Family Physician

Instructions accepted?: ___ yes ___ no

KB _____ _____ __/__/__ _____AM/PM

(Staff) (Doctor) (Date) (Time)

GUNN 004318

SPARTANBURG
Regional Healthcare System

PULMONARY REHABILITATION PROGRAM
PHYSICIAN REFERRAL

This patient is referred to the Spartanburg Regional Healthcare System Pulmonary Rehabilitation Program:

Name: William Mark Casey Referral Date: 7-23-04

Address: Woodruff, SC 29388

Home phone: _____ Work phone: 680-5929 Date of Birth: [redacted]-58

Diagnosis: Shortness of breath & chest pain MRN: _____

Cardiac Clearance: (To be completed by physician prior to beginning pulmonary rehab).

- ☐ Perform cardiopulmonary exercise stress test. Your patient will be scheduled to begin pulmonary rehab after receiving results of the exercise stress test.
- ☐ Do not perform cardiopulmonary exercise stress test. Attach documentation to support cardiac clearance.

Comments: _____

CONSULTS:

Physical Therapy

Reason for referral: Evaluation/Treatment of postural deficits, thoracic mobility deficits, musculoskeletal dysfunction and/or pain, gait deficits.
Evaluation/instruction in: proper body mechanics for ADL's and lifting, postural correction and strengthening techniques, therapeutic exercise, stretching, and osteoporosis education.

Occupational Therapy

Reason for referral: Evaluation of activities of daily living, functional training in self care and home management, training in energy conservation, work simplification, and adaptive techniques for daily living.

Respiratory Therapy

Reason for referral: Evaluation of Home and Exercise Oxygen System Requirements.
Evaluation/instruction in: Breathing retraining, Airway Clearance Techniques, Proper use inhaled medications.

Education/Classes:

Anatomy & Physiology of COPD; Pursed Lip/Diaphragmatic breathing techniques; Respiratory medications; Infection control techniques; Effective coughing techniques; Panic control/relaxation techniques; Nutrition assessment.

DURATION/FREQUENCY: 3 Days per week for 6 Weeks

PROGRESS DOCUMENTATION/OUTCOME MEASURES:

- Pre and post program sub-maximal treadmill test, 6 minute walk, Dyspnea Index, Pulmonary Functional Status Scale (PFSS), Tennetti Assessment Tool.
- Monitoring: Pulse oximetry, blood pressure, heart rate, respiratory rate, Borg RPE, Pain scale, weight.
- Discharge summary with report to referring physician

POTENTIAL FOR REHABILITATION? (Please circle): **Excellent Good Fair**

ATTENDING PHYSICIAN: (print or type): Dr. William Don Smith

PHYSICIAN'S SIGNATURE Wm Don Smith DATE: 7/23/04

RETURN TO: Jack Robinson, RRT
Jenny Crocker, RRT
299 E. Pearl Street
Spartanburg, SC 29303

PHONE: (864) 560-4250
FAX: (864) 560-4245
email: jrobinson@srhs.com

Account : 77168
CASEY, WILLIAM M

WOODRUFF SC 29388
me: (
ork: (864) 680-5929
Empl: E MICHELIN TIRE CORP

E-Mail :
Soc Sec # : [redacted]
Patient ID : "MARK"
Patient ID2:

D.O.B. : [redacted] 1958 45yr Sex : M
Accnt Date : 07/08/04 Status : 72
DOL Visit : 07/14/04 Marital : D
Bill Type : 11 Race : C
Ref Dr : 257 0 SELF REFERRAL
Doctor : 2 WILSON P SMITH, MD, PA
Last Diags : (1) 780.52 (2) 786.05
insomnia, other

Discount : 0 % Class:
Budget Pmt : 0.00 WP ID: wp77168.0
Collection : 0 days Priority : 0

Patient #: 77168.0 GUARANTOR INSURANCE COVERAGE [CASEY,WILLIAM]

Policyholder: WILLIAM M CASEY
Carrier : BCBS BCBS
Plan # : 1455 BCBS PPC
Dates-From: To :

SSN : [redacted]
Policy # : MIH[redacted]
Managed Plan

Attn : PPC
Phone :
Fax :
Elig :
Auth :

Deductible : 0.00
Visit Copay : 0.00 [35]
Group : MICHELIN
Insured: WILLIAM M CASEY
User Note : PRI

Plan#	Plan Name	Effective Dates	Assign	Note
1455.0	BCBS PPC	-	MY	PRI

GUNN 004320

TRANSMISSION VERIFICATION REPORT

TIME : 07/23/2004 15:06
NAME : LUNG&CHEST MEDICAL
FAX : 8645823750
TEL : 8645826858
SER.# : BROJ2N537248

DATE,TIME	07/23 15:05
FAX NO./NAME	5604245
DURATION	00:00:28
PAGE(S)	02
RESULT	OK
MODE	STANDARD ECM

faxed to pul. rehab

GUNN 004321

TELEPHONE CALL BACK - LUNG & CHEST MEDICAL ASSOCIATES

Date 7/22/04 Call Time 1:17 am/pm VM r'cvd time: 1:50 By: KB

Chart #: 7168 Chart pull time : _____ Chart del. Time: _____ Callback time: _____

Caller: ☑ PATIENT ☐ PT. FAMILY ☐ PHARMACY ☐ HOME HEALTH ☐ HOSPICE ☐ INS. CO. ☐ DME CO. ☐ SPR

"William" Mark Casey _____ _____

Caller Name Patient Name Phone No. Fax No.

Pt. of: CMF WPS EBK MLA JDC RVM Last Appt. 7/14/04 Next Appt. 7/29/04

Pt. Address (Proximity to office): _____

#1: **DRUG REFILL** ☐ Yes- patient stable/routine medicine ☐ No – see #2 below

Pharmacy: _____ Phone #: _____ Fax #: _____

CHARLES M. FOGARTY, MD 08691• WILSON R SMITH, MD 10510• E. BERT KNIGHT III, MD 08397
MARY LOU APPLEBAUM, MD 12969 • J. DOUGLAS CLARK, MD 19596• RICO VI. MENDOZA, MD 23156
BRENDA SPRINKLE, PA-C A144 • CHARLENE McCRAW, A.C.N.P-C AC68077• BETH V. EDWARDS, PA-C A465
2030 North Church Place, Spartanburg, SC 29303 Telephone 582-6858
FAX: Side A 582-3750 FAX: Side B: 585-2102

Rx

NAME: DOB: DATE:

ADDRESS:

LABEL DRUG NAME, STRENGTH & QUANTITY ☐ YES ☐ NO

	STRENGTH	QUANTITY	REFILL
1 Rx			
SIG			

M.D. _____ MD. _____
Dispense as written Substitution Permitted
DEA. _____ DEA. _____

Refer to Pul Rehab

#2: **PROBLEM** ☐ COUGH ☐ SOB ☐ CHEST PAIN ☐ FEVER ☐ QUESTIONS ABOUT MEDS. ☐ NON-ROUTINE RX

Comment/Response: pt started trying to do some things this morning "to build stamina" and started having some chest pain after ~ 1hr 15 min – pt talked for several minutes re: his inability to tolerate activity – not even lifting heavy objects – pt says with his chronic back pain and now pain in upper body, he's just upset – afraid he's going to do some damage to the injured lung

Appt. Made __/__/__ w/L&C ☐ Call 911 ☐ Go to ER ☐ L&C MD on call notified ☐ Call Family Physician

Instructions accepted?: ✓ yes __ no

JF (Staff) _____ (Doctor) 7/22/04 (Date) 4:55 AM/PM (Time)

GUNN 004322

MICHELIN TIRE MANUFACTURING
US.3 Facility Personnel
Post Office Box 5049
Spartanburg, SC 29304
864-~~599-3157~~, Office ~~599-3157~~ 599-3157
864-~~599-3222~~, Fax ~~599-3222~~ 599-3222

ATTENDING PHYSICIAN'S REPORT
(FOR EXTENDED LEAVES OF ABSENCE)

Date: 7/14/04

Employee's Name: William Casey

Address: Woodruff SC 29388

Date original medical leave of absence: 5/28/04

Expected date of return to work: August 17, 2004

Physical findings (diagnosis):

post traumatic stress disorder after
s/p Lt. Lateral wrist surgery x 1 year

Treatment and/or recommendation:

Refer to Psychologist for Evaluation

W. L. Lyle M.D.

Address: 2030 N Church Place
Spartanburg SC 29303

Telephone: 864-582-6855

NOTE: Michelin employees may receive full or 60% pay during Medical Leave of Absence. Verification of information regarding this request for leave would be greatly appreciated. To assure continuity in the employee's pay, this form must be returned promptly. Your cooperatic would be appreciated.

LCF/SP/FORMS/DLEXTLV.DOC

GUNN 004323

Lung and Chest Medical Associates

Charles M. Fogarty, M.D.
J. Douglas Clark, M.D.
Rico V. I. Mendoza, M.D.
J.P. Elm, F.N.P.

Wilson P. Smith, Jr., M.D.
E. Bert Knight, III, M.D.
Mary Lou Applebaum, M.D.
Beth V. Edwards, PA-C
Cindy Edwards, F.N.P.

Fax: (864) 585 - 2102

Fax: (864) 582-3750

WILLIAM CASEY **dob: [redacted]/58**
77168 **SS#: [redacted]**
07-14-04

HISTORY AND PHYSICAL

REFERRING PHYSICIAN: Self-referred.

History Mr. Casey is a 45-year-old male who presents for evaluation of chest difficulties that began in May of this year when he presented to the emergency room at Spartanburg Regional Medical Center with a complaint of chest pain. A PA chest x-ray taken at that time suggested the possibility of a foreign body. He works for Michelin Tire Company. He underwent a bronchoscopy, which was felt to be abnormal but no foreign body was identified. A subsequent CT scan done the same day did not confirm any abnormality. However it does mention that there is left anterior descending coronary artery calcifications. In 2000 he had a stress test and catheterization which was normal. Following this underwent a rigid bronchoscopy in attempt to identify foreign body and remove it. During that procedure he had a perforation of the bronchial wall by a laser which resulted in pneumomediastinum and respiratory distress. He required intubation and heavy sedation and was able to be extubated the following day. Since that time he notes fatigue during the day. He continues to have dyspnea and chest pain with exertion. He has become very anxious. His sister accompanying him for the interview notes that he seems to have experienced a change in his ability to tolerate stress and appears much more anxious and restless than she has known him to be in the past. He is a previous smoker for about 12 years but has not smoked in the past three weeks. He does snore but feels he sleeps well. He denies any hemoptysis, chronic cough or weight loss. He still has the chest pain.

Past Medical History Previous hemorrhoid surgery in 1994 and a hospitalization for evaluation of chest pain in 2000 for which he underwent cardiac catheterization.

Current Medications

1. Lipitor 20 mgs a day.
2. Bextra 20 mgs daily.
3. Tramadol 50 mgs two tablets four times a day for pain.
4. Advair twice daily.
5. Combivent four times a day.

Allergies: No known drug allergies.

Family History His father died of a heart attack. He has a sibling who died of cancer.

Social History He is divorced. He completed one year of college. He drinks occasional alcohol. He likes to play golf. He has been unable to play since his injury.
(Continued to next page)

Review of Systems Shows some arthritis which he manages with the Bextra. He has an elevated cholesterol for which he is on the Lipitor. He had an episode of rectal bleeding 10 years ago. He notes that he gets up three to four times during the night for micturition. He has disk problems and arthritis in his lower back.

Physical Examination
General: Middle-aged white male.
Vital Signs: BP 136/87, HR 100, Wt. 171, and SaO_2 is 95% on room air.
HEENT: Unremarkable. There is no jugular venous distention, cervical or supraclavicular adenopathy. The throat is clear.
Chest: Clear to auscultation.
Cardiac: Regular rate and rhythm without murmur or gallop.
Abdomen: Soft and nontender.
Extremities: No clubbing, cyanosis or edema.
Neurological: Motor strength appears 5/5 in all extremities. Cranial II through XII nerves are intact.

Laboratory Data

Pulmonary function studies show normal vital capacity and flow rates with a vital capacity of 4.7 liters, which is 99% of predicted and forced expiratory volume that is 98% of predicted. There was no change with bronchodilator. Flow volume loop showed no evidence of upper airway obstruction. Maximum voluntary ventilation was reduced at about 70 to 77% of predicted.

Impression

1. His pulmonary function is normal and chest x-ray does not show any evidence of sequelae of his bronchial perforation. The patient brought his outside films and he did not bring a recent follow up film. Pulmonary function studies are normal. I do not find any evidence for airway obstruction that would account for his problems. But I wonder if he suffers from a posttraumatic stress disorder related to his injury and intensive care unit experience. I would like to refer him to a psychologist for further evaluation. On his return we will get a follow up chest x-ray and a diffusion capacity and in view of his CT scan suggesting left anterior descending coronary artery calcification I believe a repeat stress test might be in order.

Wilson P. Smith Jr., MD
WPSjr/ns

cc: Dr. Joseph Grace

TRANSMISSION VERIFICATION REPORT

TIME : 08/09/2004 11:38
NAME : LUNG&CHEST MEDICAL
FAX : 8645823750
TEL : 8645826858
SER.# : BROJ2N537248

DATE,TIME	08/09 11:37
FAX NO./NAME	5601510
DURATION	00:00:34
PAGE(S)	02
RESULT	OK
MODE	STANDARD ECM

GUNN 004326

WPS

NAME ALERT

#77168

NG & CHEST MEDICAL ASSOCIA

PATIENT NAME William M Casey DATE 7/14/09

PHYSICAL EXAM:

MP BP 136/87 Pulse 103 RESP HT WT 171 lb O2SAT OXIMETER 95 %

HEENT:	WNL
SKIN:	
NECK:	
LUNGS:	Clear
HEART:	RRR
BREASTS:	
ABDOMEN:	Soft
EXTREMITIES:	WNL
NEUROLOGICAL	Motor 5/5

LAB DATA:

X-RAYS: DATE _____ PFT'S: DATE _____ ABG'S: DATE _____

VALUE _____ VALUE _____

OTHER LABS: _____

IMPRESSION/DIAGNOSIS:

1. HTN
2. Post traumatic stress
3. Dictation
4. Coronary catheterization
5.

PLAN:

1. Refer to Psychologist
2. Stress test
3.
4.
5.

NEWPT EXAM 8/19/97 DOCTOR NURSING STAFF

GUNN 004327

Office Visit Confirmation Sheet

!!! Please fill out all blanks each time you visit our office.

Patient Name William Mark Casey Today's Date July 14

Doctor Smith Appt. Time 10 00 Arrival Time 10 00

Reason for visit:(check one) ___Having problems ___Regular follow-up

Please confirm your personal information for our records:

Address _____

Home phone # [redacted] Work Phone # [redacted] Other Phone # _____

Emergency contact name: Carole Lynn Casey Phone # [redacted]

Type of Insurance: 1. Blue Cross Blue Shield 2. _____ 3. _____

E-mail address: _____

4633

Lung and Chest Medical Associates
Multi Spiro B

ID: 77168 Casey, William
nic: CAUCASIAN Height: 68.0 in. Sex: MALE Age: 45 Weight: 171.0 lb

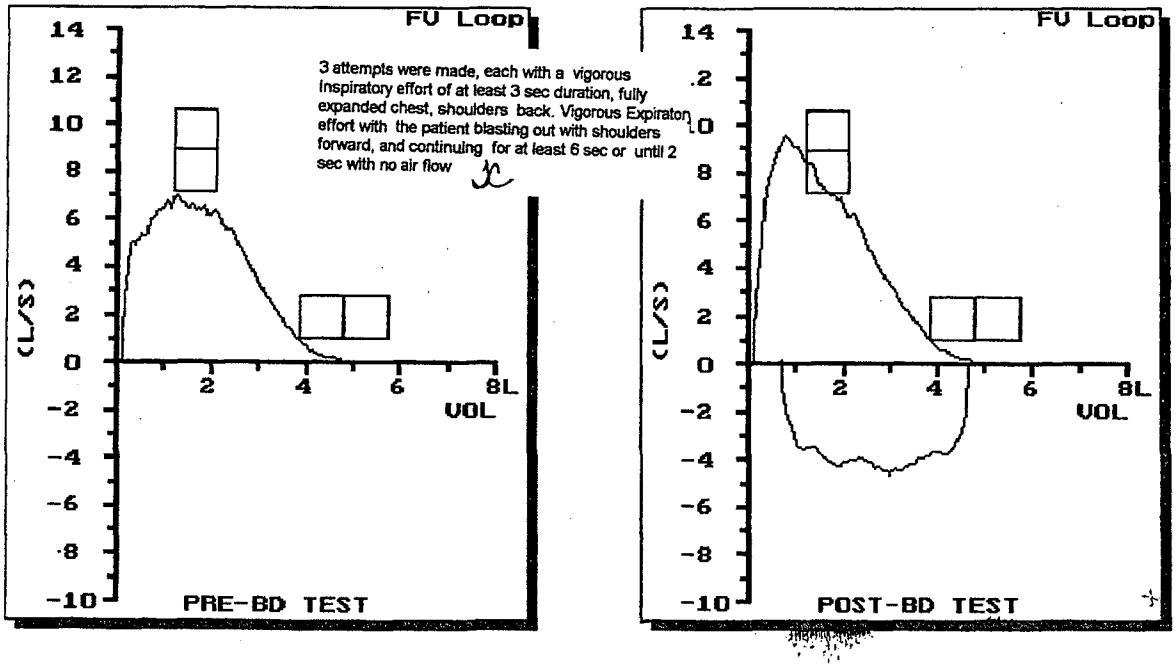
COMMENTS:
PRE-BD COMMENTS:

LAST CALIBRATED: Wed Jul 14,2004 7:53:26 am

Type	Test Date and Time	Exp.Time	Normals	Test#
Pre-BD:	Wed Jul 14,2004 10:33:01 am	7.7 secs	KNUDSON/IMTS	1
Post-BD:	Wed Jul 14,2004 10:45:34 am	6.0 secs	KNUDSON/IMTS	5

INTERPRETATION Pre: NORMAL Post: NORMAL
Dilator: albuterol Modifier: Not Clearly Improved

Expire	Pre-Medication Actual	Pre-Medication % Pred	Post-Medication Actual	Post-Medication % Pred	Pre-Post Change Actual	Pre-Post Change % Chg	Pred Value
FVC	4.72 L	99.31%	4.74 L	99.79%	0.02 L	0.48%	4.75 L
FEV 0.5	2.93 L	95.93%	3.08 L	100.90%	0.15 L	5.18%	3.05 L
FEV 1.0	3.78 L	97.77%	3.85 L	99.59%	0.07 L	1.87%	3.87 L
FEV 3.0	4.41 L	97.71%	4.48 L	99.40%	0.08 L	1.73%	4.51 L
FEV0.5/FVC	62.08%	96.60%	64.98%	101.11%	2.90%	0.99%	64.27%
FEV1.0/FVC	80.11%	98.44%	81.22%	99.80%	1.11%	0.29%	81.38%
FEV3.0/FVC	93.40%	98.39%	94.57%	99.61%	1.16%	0.26%	94.94%
PEF	6.88 L/S	79.33%	9.46 L/S	109.14%	2.58 L/S	37.57%	8.67 L/S
FEF 25-75%	3.86 L/S	97.89%	3.92 L/S	99.41%	0.06 L/S	1.55%	3.95 L/S
FEF 75-85%	0.83 L/S	78.50%	0.90 L/S	84.56%	0.06 L/S	7.71%	1.06 L/S
FEF 25	6.88 L/S	86.29%	8.26 L/S	103.61%	1.38 L/S	20.08%	7.97 L/S
FEF 50	5.40 L/S	116.87%	5.31 L/S	114.90%	-0.09 L/S	-1.69%	4.62 L/S
FEF 75	1.37 L/S	74.79%	1.51 L/S	82.30%	0.14 L/S	10.03%	1.83 L/S
[illegible] .2-1.2	5.82 L/S	79.61%	8.48 L/S	116.03%	2.66 L/S	45.75%	7.31 L/S



GUNN 004329

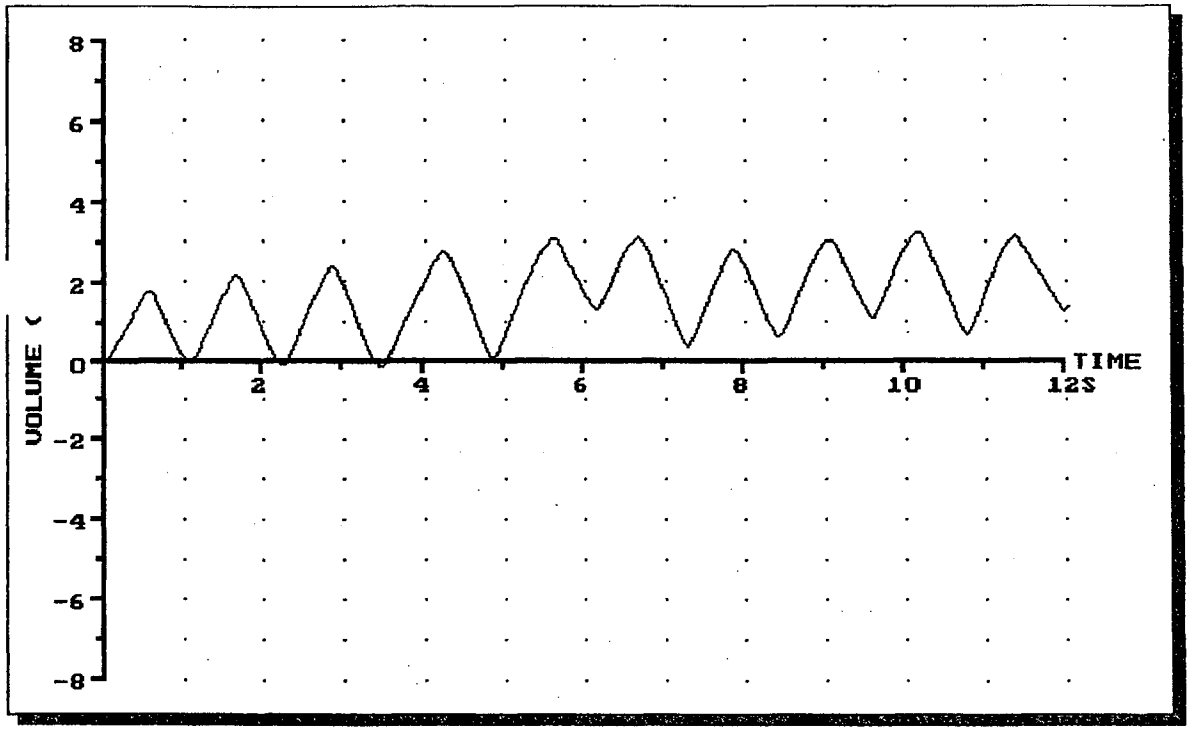
Lung and Chest Medical Associates
Multi Spiro B

ID: 77168 Casey, William
Ethnic: CAUCASIAN Height: 68.0 in. Sex: MALE Weight: 171.0 lb
Age: 45 Maximal Voluntary Ventilation Wed Jul 14,2004

TYPE	Test Date and Time	Exp.Time	Normals
Current:	Wed Jul 14,2004 10:34:08 am	12.0 secs	KNUDSON/IMTS

Result	Rate	Total
Breaths	48.25 B/M	9.65 Breaths
MVV	117.79 L/M	4.74 L

Predicted MVV = 153.34 L/M
Percent of Predicted = 76.8 %



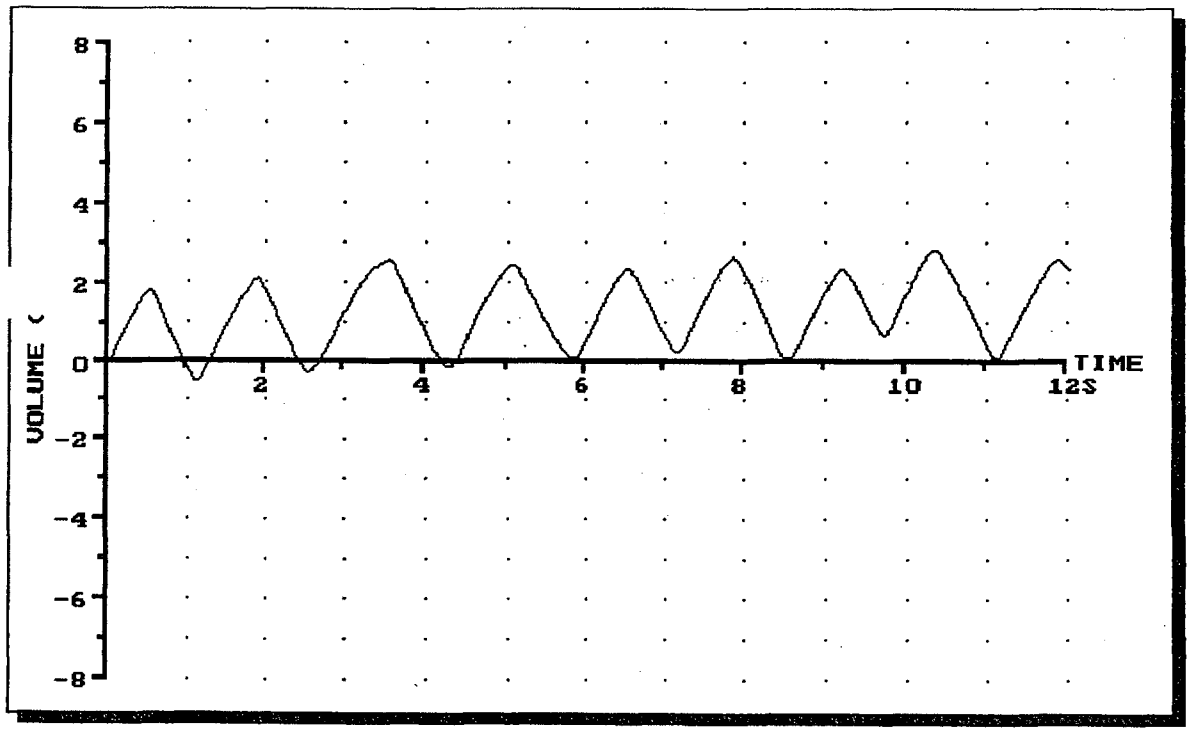
Lung and Chest Medical Associates
Multi Spiro B

ID: 77168 Casey, William
nic: CAUCASIAN Height: 68.0 in. Sex: MALE Weight: 171.0 lb
e: 45 Maximal Voluntary Ventilation Wed Jul 14,2004

TYPE	Test Date and Time	Exp.Time	Normals
Current:	Wed Jul 14,2004 10:46:34 am	12.0 secs	KNUDSON/IMTS

Result	Rate	Total
Breaths	41.53 B/M	8.31 Breaths
MVV	107.47 L/M	4.91 L

Predicted MVV = 153.34 L/M
Percent of Predicted = 70.1 %



GUNN 004331

Lung and Chest Medical Associates
MEDICAL HISTORY INFORMATION SHEET

CHART# 77168 DATE: July 14, 2004

Patient's Name William Mark Casey Age 45 Sex m

How did you hear about us? _____

Who referred you to our office? _____

Who is your family doctor? Dr Frank Gonda

I. Present Illness

1. What Health Problem has brought you to our office? not happy with current care provider - post operation for chest pain
2. How long have you had this problem? month Fatigue Dyspnea
3. Does anything you do make the problem better or worse? exertion Bleeding
4. Have you lost weight recently? no How much? _____ Were you trying to lose? _____

II. Medicines and Inhalers (MD See Blue Sheet)

1. Patient, bring all your medicines with you when you come to our office (include any inhalers and over-the-counter medicines)
2. Are you ALLERGIC to any medications or food? no Please list: _____
3. Check the space and enter date last received: PPD ___ Date _____, Tetnus ___ Date _____
   Pneumonia vaccine ___ Date _____, Flu vaccine ___ Date _____.

Michelle 3pm shift very physical job Blood type O+

III. Lung History

1. Are you a smoker? no How many packs per day? _____ How many years _____
2. If you have quit smoking, how many years did you smoke? 12 How many packs per day? _____
   How long ago did you quit? 3 weeks
3. Do you have a chronic cough? no How long? _____ Do you cough anything up? _____
   If so what color? _____
4. Have you ever coughed up blood? no
5. Do you get short of breath if you walk or climb steps? no
6. Are you short of breath while you are resting? no
7. Do you ever notice yourself wheezing? _____ What seems to make the wheezing worse?
   _____
8. Do you wake up tired? yes
9. Do you snore? yes
10. Do you have night sweats? some Fevers? _____
11. When was your last chest x-ray? June Where? Dr. Feldman
12. Potential Exposures:
    a. Does anyone else in your home smoke? No
    b. Have you ever had a skin test for TB (tuberculosis)? No When? _____
    c. What were the results of the skin test, if you know? _____
    d. Have you ever been exposed to TB? _____ When? _____

2000 Hx of 8 pack year cath → NL

LC111 – 12-23-03

GUNN 004332

e. If you have been exposed to TB, have you had a skin test since then? _____

f. Do you have indoor pets? _____ What kind? _____

g. Have you been, or are you exposed to dust or fumes? ___ What kinds?_____

h. Have you traveled out of the upstate area? _____

IV. Work History

1. What type of work do you do? production - 8 + 12 hr shifts (swing)
2. Have you done other types of work? yes Please list: paint shop - Restaurant
3. Have you ever served in the military? NO Where? _____

V. Past Medical History (Hospitalizations)

Have you ever been admitted to a hospital for an operation or illness? (Use Back of Page if necessary)

Name of Hospital	When	Reason
Mary Black	1994?	hemmorhoid surgery
Regional	2000	chest pain

VI. Family History (Use back of page if necessary)

1. Mother's Age? ___ Living? ___ Or died of _____
2. Father's Age? ___ Living? ___ Or died of Heart attack
3. Brother or Sister's Age? 44 Living? ___ Or died of cancer
4. Brother or Sister's Age? 47 Living? ✓ Or died of _____
5. Brother or Sister's Age? 42 Living? ✓ Or died of _____

VII. Social History

1. Are you married? NO Widowed? ___ Single? ___ Divorced? ✓
2. What was the highest grade you finished in school? 1 yr college
3. Do you drink alcoholic beverages (beer, wine, liquor)? yes How much? recreational
4. Have you ever used cocaine, marijuana or other street drugs? NO How long has it been since you last used? _____
5. Have you ever received a blood transfusion? ___ When? _____
6. Do you have any hobbies (raising pigeons, woodwork shop, etc)? golf

VIII. Review of Systems

1. Do you wear glasses? yes
2. Do you have trouble hearing? NO
3. Do you wear dentures? NO
4. Do you have chest pain if you are just resting? ___ walking? ___ climbing steps? ___
5. What area of your chest hurts? _____
6. Have you ever been treated for heart trouble? _____
7. Have you ever been treated for high blood pressure? NO
8. Do you have diabetes? NO
9. Do you have a problem with nausea? ___ Vomiting? ___ Diarrhea? ___ Constipation? ___ Heartburn? ___
10. Have you ever vomited bright red blood? NO

11. Have you ever had rectal bleeding? yes When? 10 yrs Ago
12. Have you ever has a "stomach x-ray"? _____ When? _____
13. Have you ever had a change in your appetite? NO More? _____ Less? _____
14. Have you ever had stomach ulcers? NO
15. Do you have any pain when you urinate? NO
16. Female patients: When was your last menstrual period? ____ Pap smear? _____
    Who is your gynecologist? _____
18. Male patients: When was your last prostate exam? Never
    Do you have trouble starting your stream when you urinate? NO
    How many times do you usually get up at night to urinate? 3 or 4
19. Do you have any numbness or tingling in your arms or legs? NO
20. Do you ever have swelling in your feet or legs? yes · feet sometimes

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING PAST OR PRESENT CONDITIONS: Have you ever had or presently have any of the following:

MEDICAL CONDITION	NO	YES	WHEN DID YOU HAVE THIS	WHAT TREATMENT ARE YOU RECEIVING
ATHRITIS		✓	current	Bextra
ASTHMA	✓			
BLADDER INFECTION	✓			
BLOOD CLOTS IN LEGS	✓			
BLOOD CLOTS IN LUNGS	✓			
CANCER	✓			
CATARACTS	✓			
CHOLESTEROL (HIGH)		✓	current	Lipitor
CIRRHOSIS OF LIVER	✓			
COLON PROBLEMS	✓			
EMPHYSEMA	✓			
GLAUCOMA	✓			
HAY FEVER	✓			
HEPATITIS (YELLOW JAUNDICE)	✓			
KIDNEY FAILURE	✓			
KIDNEY STONES	✓			
PHLEBITIS	✓			
PNEUMONIA	✓			
PROSTATE PROBLEMS	✓			
RHEUMATIC FEVER	✓			
SEIZURES	✓			
SHINGLES	✓			
SINUS INFECTION	✓			
SKIN DISEASE	✓			
STROKE	✓			

Is there anything else you feel that the doctor needs to be aware of? (Use back of this page if necessary)

Have disc problems + arthritis in lower back

LC111 – 12-23-03

CMF records

Things To Do Today:

107931 GRADY STEWART
4/14/08 CMF

108293 PATRICIA BENTON
6/12/08 CMF

www.unitedhealthcareonline.com

GUNN 004335

DOLV 4-5-02 HCA NO APPT

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: CASEY,WILLIAM UNIT #: 000146220
ORDERING PHYSICIAN: FOGARTY,CHARLES M CI#: 1480551
LOC: OPT DOB: [redacted]3/58 AN#:S0520101451
Pt. Type:OPT

Exam
50041 XR G I SERIES Date: 07/28/05 0836
74246 Ord Diag: 787.03-VOMITING ALONE

Double-contrast upper GI, 7/28/2005

Indication: Several week history of nausea and vomiting

Findings: Under fluoroscopy the patient shows normal swallowing and esophageal motility. The esophagus distends normally. Note is made only of a single small distal esophageal mucosal cleft or diverticulum, this is only a few millimeters in size. With Valsalva no hiatal hernia is seen. During assessment of the stomach several episodes of mild reflux into the distal esophagus were seen.

The stomach distends normally with no abnormal mass or impression and no mucosal irregularity. The duodenal bulb is somewhat irregular, I do not see a discrete ulcer but this could be deformed from peptic ulcer sease. Contrast does freely progress through this into the duodenum. In the third portion of the duodenum there are 2 diverticula adjacent to one another. One is relatively prominent in size, equal to that of the duodenal bulb. No retained material is seen within these and contrast freely progresses through this to the proximal small bowel.

Impression: Small mucosal cleft or diverticulum noted in the distal esophagus. This is probably a normal variant although could represent focal change of mild esophagitis. A few episodes a very mild GE reflux were seen during this study.

2. Duodenal bulb somewhat deformed although no discrete ulcers seen. This could be change from peptic ulcer disease but there is no evidence of stricturing, contrast freely progresses into the proximal small bowel on this study.

2. 2 duodenal diverticula in the third portion of the duodenum, one of these is a giant diverticulum equal in size the duodenal bulb. They

FINAL Page 1

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: CASEY,WILLIAM
ORDERING PHYSICIAN: FOGARTY,CHARLES M
LOC: OPT
Pt. Type:OPT

UNIT #: 000146220
CI#: 1480551
DOB: [redacted]/58
AN#:S0520101451

Checkin-Exam Code Summary
1480551-50041

otherwise appear unremarkable on this exam and are not likely of clinical significance.

Read By: William T JoyceMD
Released By: William T JoyceMD

n

FINAL

GUNN 004337

THE WARD LAW FIRM, P.A.

ATTORNEYS AT LAW
POST OFFICE BOX 3188
SPARTANBURG, SOUTH CAROLINA 29304
(864) 582-4365

JAMES W. HUDGENS
GENE ADAMS
H. SPENCER KING
EDWARD R. COLE
CATHY HOEFER MCCABE
ROBERT E. DAVIS*
JASON M. IMHOFF

*ALSO MEMBER NORTH CAROLINA BAR

RUFUS M. WARD (1908-1988)
L. PAUL BARNES (1931-1986)

233 SOUTH PINE STREET
SPARTANBURG, S.C. 29302

FAX. NO. (864) 583-8961
E-mail: sking@wardfirm.com

Direct No. 864-591-2364

June 16, 2006

Lung and Chest Medical Associates
Medical Records Custodian
2030 North Church Place
Spartanburg, SC 29303

Re: William Mark Casey v. Gregory J. Feldman, MD, Joseph A. Boscia, III, MD, Upstate Lung and Critical Care Specialists, PC, and Devendra Shantha, MD
CA No.: 2006-CP42-1728
Our File No.: 26-0266

Dear Records Custodian:

These **medical records and billing records** are being sought based on a medical malpractice lawsuit filed by William Mark Casey. A copy of this letter and subpoena are being sent to her attorney. Accordingly, I am providing notice under state and federal law that I am seeking the production of the information contained in the subpoena. The subpoena contains instructions for responding to it. Unless Plaintiff or her attorneys raise an objection within ten (10) days of the receipt of this subpoena , you should produce the records as specified in the subpoena.

We will, or course, pay reasonable costs for production of these documents.

I am

Very truly yours,

Donna C. Hill

Donna C. Hill, C.L.A.
Paralegal to H. Spencer King

/dch

Enclosure

cc: Chuck Thompson, Esquire w/enclosure
William U. Gunn, Esquire w/enclosure

ongoing request
MK
8/9/06

GUNN 004338

STATE OF SOUTH CAROLINA
ISSUED BY THE C MON PLEAS COURT IN THE COU OF SPARTANBURG

William Mark Casey,
Plaintiff,
v.

C.A. No. 2006-CP-42-1728

Gregory J. Feldman, MD,
Joseph A. Boscia, III, MD, Upstate Lung and
Critical Care Specialists, PC, and
Devendra Shantha, MD,
Defendants.

TO: **Medical Records Custodian, Lung and Chest Medical Associates, 2030 North Church Place, Spartanburg, SC 29303**

☐ YOU ARE COMMANDED to appear in the above named court at the place, date, and time specified below to testify in the above case.

Place of Testimony -	**Courtroom:**
	Date and Time:

☐ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

Place of Deposition:	Date and Time:

[X] YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects your possession, custody or control at the place, date and time below:

A complete copy of your records of treatment at any time **pertaining to William Mark Casey, SSN: [redacted], DOB: [redacted]-58.**

A complete copy of your billing records for treatment at any time **pertaining to William Mark Casey, SSN: [redacted] DOB: [redacted]-58.**

IN LIEU OF PERSONALLY APPEARING, THESE RECORDS MAY BE MAILED TO DONNA C. HILL,C.L.A., THE WARD LAW FIRM, P.A., PO BOX 3188, SPARTANBURG, SC 29304.

Place:**233 South Pine Street, Spartanburg, SC 29302**	Date and Time: **3:00 pm on July 31, 2006**

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

Premises	Date and Time

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS SUIT IS HEREBY DIRECTED PURSUANT TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, AND SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED SHALL TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION.

ISSUING OFFICER'S NAME, ADDRESS AND PHONE NUMBER H. Spencer King, Esq., The Ward Law Firm, P.A., 233 South Pine Street PO Box 3188, Spartanburg, SC 29304-3188 (864/582-4365)	

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1) AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF ATTORNEY FOR PLAINTIFF OR DEFENDANT) DATE: June 16, 2006

Attorney for Defendants Gregory J. Feldman, MD, Joseph A. Boscia, MD, and Upstate Lung and Critical Care Specialists, PC

CA FORM 254 (7/93) (See Rule 45, South Carolina Rules of Civil Procedure, Parts (c) & (d) on Reverse

CMP
77168
7/7/06

WILLIAM M CASEY 380

ID:MIH052484753663

OV $20/$45

ROUTINE $20

Important: Pre-authorization required for all hospital inpatient admissions or we may reduce benefits. Providers submit via SouthCarolinaBlues.com or call 1-800-334-7287.

[redacted]

For Online Service: Log into My Insurance Manager on SouthCarolinaBlues.com.
Mental Health & Substance Abuse Precertification/Claims: call ComPsych at 1-800-537-5221

Providers: Report emergency admissions within 24 hours. Submit claims to your local plan.

Members: Personnel Service Center: 1-877-436-7869
BlueCross Customer Service: 1-888-773-3658
PPO Network Provider Information: 1-800-810-2583
First Advice Nurse Line: 1-888-521-2583 (anytime)
File all claims to: BlueCross BlueShield of South Carolina, Piedmont Service Center, P.O. Box 6000, Greenville, S.C. 29606-6000.

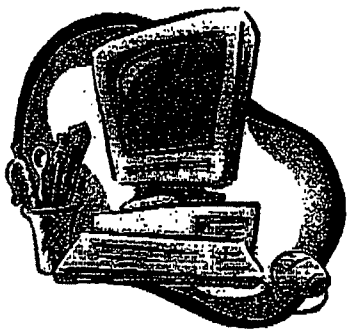
BlueCross BlueShield of South Carolina, an Independent Licensee of the Blue Cross and Blue Shield Association, provides administrative claims services only and does not assume any financial risk or obligation with respect to claims. GL

GUNN 004340

Joseph G. Grace III, Ph.D.
Licensed Counseling Psychologist
853 N. Church Street, Suite 510
Spartanburg, South Carolina 29303
(864) 560-1512

FAX TRANSMITTAL
No. of Pages incl. Cover Sheet: 17

2/9/06 WH



To: Maria @ W. Smith's Office Fax: 542-9043 RE: Wm. Mark Casey DOB: [redacted]-58	From: Sylvia for Dr. Grace Date: 2-7-06 Phone: (864) 560-1512 Fax: (864) 560-1510

Aetna report forms dated 2/3/06 & 7/19/05; 10/19/04

REMARKS: ☐ Urgent ☐ For Your Review ☐ Reply ASAP ☐ Please Comment

Grace Report 6/17/05; 9/16/04

PIEDMONT PSYCHIATRIC SERVICES

WOODRUFF ROAD PROFESSIONAL PARK
2094 WOODRUFF ROAD
GREENVILLE, SC 29607

FAX-(864)676-9432 PHONE -(864)676-9211

FACSIMILE TRANSMITTAL SHEET

TO: Joseph Grace PhD	FROM: Beth Gray - Medical Records-ext. 126
ATTENTION:	DATE: 01-31-2006
FAX NUMBER: 560-1510	TOTAL NO. OF PAGES INCLUDING COVER: # 2
RE: Casey, William D.O.B- [redacted]-1958	PATIENT ACCOUNT NUMBER: # 26562

Notes/Comments:
01-31-2006 - Office Visit - Dr. Smith

GUNN 004342

Casey, William M. [redacted]/1958
Office/Outpatient Visit
Visit Date: Tue, Jan 31, 2006 11:34 am
Provider: Jeffrey Smith, MD, M.D. (Supervisor: Jeffrey Smith, MD, M.D.)
Location: Piedmont Psychiatric Services

Electronically signed by provider on 01/31/2006 Printed on 01/31/2006 at 11:39 am.

SUBJECTIVE:

HPI:

"I think this combination is working well." Overall, depression and anxiety are better. Pt. pleased. No s.i. No medication s.e.

OBJECTIVE:

Exams:

Affect is bright and fairly relaxed. No s.i. Sensorium is clear.

ASSESSMENT:

296.22 Major depression, single episode, moderate

PLAN:

Cont. Mirtazapine 45 mg one qhs.

Cont. Adderall XR 20 mg two qam.

Cont. Ambien 10 mg one qhs.

Ret. in 3 mos.

cc: Joseph Grace PhD

Major depression, single episode, moderate

Orders:
90862 Pharmacologic management with no more than minimal medical psychotherapy

Aetna Life Insurance Company
Telephone: 877-465-0424
Fax: 866-888-2308

Aetna

Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Employee Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (MM/DD/YYYY)
CASEY, WILLIAM MARK	[redacted]	[redacted] 57

Gender	Job Title	Control Number
☑ Male ☐ Female	MICHELIN TIRE ASSEMBLY LINE	607472

Current Diagnosis	Medications:
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER FOLLOWING ORGANIC BRAIN DAMAGE (310.9) MAJOR DEPRESSIVE DISORDER (296.23)	MIRTAZAPINE 45 MG. Q.H.S. ADDERALL XR 40 MG. Q A.M. AMBIEN 10 MG. Q. H.S.

Indicate the percent of the day the following activities can be performed:

(Occasional 1-33% or .5-2.5 hrs. Frequent 34-66% or 2.6-5.0 hrs. Continuous 67-100% or 5.1-8 hrs. or Never)

	O	F	C	N		O	F	C	N
Climbing - (DEFERRED TO FAMILY PHYSICIAN AND PULMONOLOGIST)	☐	☐	☐	☐	Hand Grasping __R__L	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	Firm Hand Grasping __R__L	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	Fine Manipulation __R__L	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	Gross Manipulation __R__L	☐	☐	☐	☐
Pulling	☐	☐	☐	☐	Repetitive Motion __R__L	☐	☐	☐	☐
Pushing	☐	☐	☐	☐	Sitting __R__L	☐	☐	☐	☐
Reaching above shoulder	☐	☐	☐	☐	Standing __R__L	☐	☐	☐	☐
Forward reaching	☐	☐	☐	☐	Stooping __R__L	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	Walking __R__L	☐	☐	☐	☐
Bending	☐	☐	☐	☐	Other _____	☐	☐	☐	☐
Twisting	☐	☐	☐	☐					

Maximum weight patient is capable of lifting:

	O	F	C	N
1 - 5 lbs. (DEFERRED)	☐	☐	☐	☐
6 - 10 lbs.	☐	☐	☐	☐
11 - 20 lbs.	☐	☐	☐	☐
21 - 35 lbs.	☐	☐	☐	☐
36 - 50 lbs.	☐	☐	☐	☐
51 - 75 lbs.	☐	☐	☐	☐
75 - 100 lbs.	☐	☐	☐	☐
100 lbs. +	☐	☐	☐	☐

Approved Head and Neck Movements:

	Yes	No
Static Position	☐	☐
Frequent Flexing	☐	☐
Frequent Rotation	☐	☐

Can the Patient operate:

	Yes	No
A Motor Vehicle	☐	☐
Hazardous Machine	☐	☐
Power Tools	☐	☐

Limitations to:
Speaking _____ hrs. (DEFERRED)
Vision (explain) _____
Depth Perception _____
Hearing (explain) _____

Exposure Limitations:

	Yes	No		Yes	No
Heat	☐	☐	Dust	☐	☐
Cold	☐	☐	Fumes	☐	☐
Dampness	☐	☐	Chemicals	☐	☐
Noise	☐	☐	Radiation	☐	☐

Total # of hours patient capable of working per day: 12 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ ✓

Duration of restrictions: TOTAL Care Complete: Yes ☐ No ☑ Next Appointment: 2-9-06

Additional Comments:
PT SLOWED IN THOUGHT AND ACTION, POOR SHORT TERM & LONG TERM RECALL, POOR CONCENTRATION, UNABLE TO MULTI-TASK, POOR GROSS MOTOR AND FINE MOTOR COORDINATION, MENTAL BLOCKING, ANHEDONIA, LETHARGY, INERTIA, EASILY FATIGUED, DEPRESSIVE AFFECT, PANIC EPISODES, AGGITATED, & PARANOID IDEATION, VERY LOW FRUSTRATION TOLERANCE & INABILITY TO COPE W STRESS OF LIFE.

Physician's Signature _____ Date (MM/DD/YYYY) 2-3-06

MI DT 80-002 ME
GC-1500-1 (5-03)

n-POD

Aetna

Attending Physician Statement

Complete and sign the form using BLUE or BLACK ink.

1. **Patient Instructions** – The Physician will complete Sections 2 through 9.
The Patient will complete Section 1.
The Patient should also fill in their name at the top of Pages 2 and 3

The *Patient* is responsible for completing this section, and for ensuring that their Attending Physician completes the remainder of this statement. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. If you have any questions, please call (877) 465-0424.

(a) Control Number 607472

(b) CASEY, WILLIAM M. [redacted] [redacted]-58 5'8" 170
Patient Name (Last, First, Middle Initial) Social Security Number Birth Date (MM/DD/YYYY) Height Weight(lb)

(c) Patient Gender ☑ Male ☐ Female

(d) 240 LIGHTWOOD FARM RD, WOODRUFF, SC, 29388
Patient Home Address – Required (Current No., St., Town, State, Zip – no PO boxes) ☐ Check if New

(e) Mailing Address, if different from Home address (SAME)

(f) Patient Employer Name/City/State PREVIOUSLY MICHELIN IN SPARTANBURG, S.C.

(g) Patient Telephone Number (864) 486-9131 ☐ Check if New

(h) Job Title/Occupation PREVIOUSLY TIRE LINE ASSEMBLY

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium
☑ Long Term / Permanent Total Disability

2. **Physician Instructions**

The *Attending Physician* should complete the items below, based upon a recent examination. Attach additional documentation as needed. If you have any questions, please call (877) 465-0424.

Please complete form in its entirety and fax to (866) 888-2308. Pages 2 and 3 MUST be completed before faxing.

3. **Impairing Diagnosis & Treatment**

(a) Primary Diagnosis UNSPECIFIED NEUROPSYCHOTIC MENTAL DIS- Primary ICD Code 310.9
Secondary Diagnosis ~~OBSTR. FOLLOWING~~ ORGANIC BRAIN DAMAGE Secondary ICD Code 294.28
Secondary DX 1 Other Diagnoses MAJOR DEPRESSIVE DISORDER (296.23) (310.9) Other ICD Codes —

(b) Height 5'5" Weight 170 Date Measured (MM/DD/YYYY) 8-4-04

(c) If Pregnancy related, delivery or expected date N/A MM ____ DD ____ YYYY ____ Delivery
Type: ☐ Vaginal ☐ Cesarean

(d) Primary Procedure N/A Primary CPT Code N/A
Secondary Procedure N/A Secondary CPT Code N/A
Other Procedures — Other CPT Codes —

(e) Medication(s)/Dose/Frequency MIRTAZAPINE 45 MG. @ H.S.
ADDERALL XR 40 MG. @ AM., AMBIEN 10 MG. @ H.S.
Impairment from medication effects —

(f) Is patient still under your care for this condition? ☑ Yes ☐ No, date service terminated ____ (MM/DD/YYYY)

(g) Treatment summary COGNITIVE & SUPPORTIVE PSYCHOTHERAPY, COGNITIVE & PERSONALITY TESTING, SUPPLEMENTED BY PSYCHOTROPIC MEDS.

(h) Office visit dates: First 8-4-04 (MM/DD/YYYY) Last 1-26-06 (MM/DD/YYYY) Next 2-9-06 (MM/DD/YYYY) Frequency of appointments BIWEEKLY

(i) Was patient recently hospitalized? ☑ No ☐ Yes Date hospitalized: Admit ____ (MM/DD/YYYY) Discharge ____ (MM/DD/YYYY)

(j) Hospital Name/City/State N/A

AP DT 01-001 ME
GC-1486-1 (10-04) R-POD

GUNN 004345

Patient Name (Last, First Middle Initial) Required
CASEY, WILLIAM MARK

4. History

(a) Symptoms: COGNITIVE DYSFUNCTION (↓S.T. & L.T. RECALL, SLOWING, POOR CONCENTRATION) POOR FINE & GROSS MOTOR COORDINATION, DEPRESSIVE SYMPTOMS, AGGITATION, & FRUSTRATION TOLERANCE, LETHARGY, EASILY FATIGUED;
(b) Date symptoms first appeared or accident happened: 5-2004 MM ____ DD ____ YYYY ____
(c) Has patient ever had same or similar condition? ☑ No ☐ Yes, state when and describe.

(e) Is condition due to injury or sickness arising out of patient's employment? ☑ No ☐ Yes ☑ Unknown
(f) Other Treating Physicians POSSIBLY COMPLICATIONS OF SINCE HEINITIALLY PRESENTED WITH CHEST PAINS,
Name WILSON SMITH, M.D. Specialty PULMONOLOGY City SPARTANBURG State S.C.
Name JEFFREY SMITH, MD Specialty PSYCHIATRY City GREENVILLE State S.C.

5. Abilities/Limitations

(a) **Patient is: Place remarks in item (d) below, if applicable.**
- Competent to endorse checks and direct the use of proceeds thereof ☑ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others ☐ Yes ☑ No ☐ Other/describe in (d)
- Able to give supervision ☐ Yes ☑ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting ☐ Yes ☑ No ☐ Other/describe in (d)
- Able to do? **Select one: Place remarks in item (d) below, if applicable.**
  - ☐ **Heavy work** activity. No limitations of functional capacity.
  - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly
  - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently
  - ☐ **Sedentary work** activity – moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time
  - ☑ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity
  - ☐ **Other.** Place remarks in item (d) below.

(b) **What medical restrictions/limitations are you placing on patient?** *(Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)* CAN DO HOUSE WORK FOR ABOUT 1 HOUR BUT BECOMES QUITE FATIGUED. EMOTIONAL AND PHYSICAL STRESS ARE OVERWHELMING, UNABLE TO WORK IN GAINFUL EMPLOYMENT IN ANY CAPACITY AT PRESENT TIME,
- Number of Hours patient is capable of working in a day: ☐ 12 ☑ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☑ 1 Hour/Day (N/A)
- Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week (N/A)
- Date you prescribed restriction on work activities ... Month 5 Day 04 Year 04
- How long are these restrictions/limitations in effect? APPEARS TO BE PERMANENT RESTRICTIONS ☐ No Longer
  Days ____ Weeks ____ Months ____
- Estimated return to work date? UNREALISTIC (MM/DD/YYYY) modified duty UNREALISTIC (MM/DD/YYYY) full duty

(c) **Objective findings that substantiate impairment** *(current laboratory, physical and/or mental status examination, and other testing)*
VERY SIGNIFICANT COGNITIVE IMPAIRMENT AND SEVERE EMOTIONAL
(d) ~~Other/Comments~~ PSYCHIATRIC DISORDERS

6. Current Status HAS NEITHER IMPROVED SIG/NOR REGRESSED,

(a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☑ Not Applicable
(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?
☐ No ☑ Yes, please explain INCAPABLE OF BENEFITTING FROM VOC. REHAB. SERVICES.
(c) In your opinion, is your patient motivated to return to work? SOMEWHAT BUT INCAPABLE

AP DT 01-001 ME
GC-1488-1 (10-04)

Patient Name (Last, First Middle Initial) Required

7. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kentucky, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

8. Physician Certification

Attending Physician's Name (Print)	Degree	Specialty
JOSEPH G. GRACE, III	Ph.D.	LICENSED PSYCHOLOGIST
Address (No. Street, City, State, Zip Code)	Telephone Number	Fax Number
953 N. CHURCH ST. SUITE 510 SPARTANBURG, S.C. 29303	(864) 560-1512	(864) 560-1565

9. Physician Signature

Signature	Date (MM/DD/YYYY)
[signature]	2-3-06

AP DT 01-001 ME
GC-1486-1 (10-04)

GUNN 004347

Joseph G. Grace III, Ph.D.
Licensed Counseling Psychologist
853 N. Church Street, Suite 510
Spartanburg, South Carolina 29303
(864) 560-1512

INTELLECTUAL ASSESSMENT

NAME:	William Mark Casey
AGE:	45
DATE OF BIRTH:	[redacted]58
SS #:	[redacted]
EDUCATION:	Completed a year of college
OCCUPATION:	Disabled (Formerly a production worker with Michelin Tire Co.)
MARITAL STATUS:	Separated

COMPONENTS OF THE ASSESSMENT:

Spartanburg County School District #6 cumulative academic records of Mark Casey (10/17/66 – 06/08/77)
Wechsler Adult Intelligence Scale – 3rd Edition (WAIS-III) (06/02/05)

REVIEW OF MARK CASEY'S ACADEMIC RECORDS:

Mark Casey was administered three intelligence tests (readiness level ability testing) in the 2nd, 4th, and 6th grades. In the 2nd grade Mr. Casey earned an IQ score of 107 (67th percentile), in the 4th grade he earned an IQ score 115 (84th percentile), and in the 6th grade he earned an IQ score of 113 (81st percentile). Further, his achievement test scores from 2nd grade (1966) through 10th grade (1975) range from highs of 99th percentile to a low of 17th percentile with the vast majority of scores being above the 65th percentile. Also, Mr. Casey's Dorman Senior High School transcript reflects a well-rounded student who was a versatile athlete.

BEHAVIORAL OBSERVATIONS OF MARK CASEY FROM RECENT IQ TESTING:

Mr. Casey was administered the WAIS-III on 06/02/05. He appeared to make a conscientious effort throughout the thirteen test sections, but became frustrated and even dejected on Subtests in which he performed below his own expectations. Also, Mr. Casey exhibited lapses in concentration and memory, particularly on Subtests requiring abstract reasoning.

ANALYSIS OF TEST DATA:

Mark Casey earned a Full Scale IQ score of 97 (42nd percentile) on the Wechsler Adult Intelligence Scale – 3rd Edition. He earned a Verbal IQ score of 100 (50th percentile) and a Performance IQ score of 91 (27th percentile). These scores fall within the lower half of the "average" range of intellectual functioning (90 – 109). His Working Memory Index score of 106 (66th percentile) is his highest, while his Processing Speed Index score of 73 (4th percentile) is his lowest. Mr. Casey earned a Verbal Comprehension Index score of 100 (50th percentile) and a Perceptual Organization Index score of 99 (47th percentile). His Subtest scaled scores are as follows:

Verbal Subtests		Performance Subtests	
Vocabulary	11	Picture Completion	10
Similarities	10	Digital Symbol – Coding	4
Arithmetic	10	Block Design	9
Digit Span	11	Matrix Reasoning	11
Information	9	Picture Arrangement	10
Comprehension	10	Symbol Search	6
Letter–Number Sequencing	12		

The mean score for all Wechsler Subtests is 10 with a normal range of 8-12. Thus, Mr. Casey's scores on the two Processing Speed Index Subtests of Digit Symbol – Coding (4) and Symbol Search (6) are far below the normal range. These two Subtests are measures of visual perception analysis (ability to ascribe meaning to symbols, identify and discriminate between symbols); short-term visual memory; and visual-motor dexterity, speed and accuracy.

SUMMARY:

A review of Mr. Mark Casey's school records reveal that he was administered three IQ tests between the ages of about 7 and 12 years old. The average of these three ability measures is about 112 which placed him at the 79th percentile intellectually. Also, the vast majority of his achievement test scores between the 2nd and 11th grades are at or above the 65th percentile. However, Mr. Casey obtained a Full Scale IQ score of 97 (42nd percentile) on intellectual testing administered in June 2005. Further, he earned very deficient scores on Subtests involving processing speed (visual perception analysis; short-term visual memory; and visual-motor dexterity, speed and accuracy). IQ/intellectual

ability scores by test design remain unchanged over the course of one's lifetime except in the event of neurological disease or brain injury. Since there is a significant discrepancy between Mr. Casey's early intellectual ability measures and current IQ test results, the only reasonable conclusion is that he has experienced a neurological event which has diminished his ability to process information and perform in a number of areas as effectively as he once did.

Joseph G. Grace, III, Ph.D.
Licensed Counseling Psychologist
S. C. License # 278
June 17, 2005

GUNN 004350

September 16, 2004

Frank E. Gonda, MD
2212 Old Furnace Rd.
Spartanburg, SC 29316
Fax #: 578-7098

Re: William Mark Casey
D.O.B. [redacted]/58
SS# [redacted]

Dear Frank,

I have been following Mark Casey on a weekly basis and saw him most recently on September 16, 2004. He reportedly has been taking Zoloft, 100 mg per day for about eight weeks now as you prescribed. He estimated that he has gained about 50% benefit from Zoloft, but for about the past four weeks he seems to have plateaued and there appears to be no subjective or objective improvements. Thus, the following depressive symptoms persist: initial and terminal sleep disturbances, depressive affect most days with atypical cynicism, irritability with low frustration tolerance, anxiety and restlessness, atypical somatic symptoms, excessive worry, easily fatigued, and an inability to deal with normal life stresses.

On August 9, 2004, I administered to Mark the MMPI-II. The validity scales indicate that his test results are valid and the clinical picture is probably unchanged since that test administration. The clinical scales of his MMPI-II indicate that he is moderately depressed, moderately anxiety, but in good reality contact. He is prone to develop ulcers and other GI disturbances under stress. Also, he is prone to sudden anxiety and panic episodes. Test results confirm that he is overwhelmed with problems, is guilt-ridden, and has feeling of inadequacy and unworthiness. He tends to be quite despondent and is slowed in thought and action. Mark is also inclined to experience obsessional thoughts which trigger compulsive behaviors. His personality profile also indicates that he is angry and resentful, rigid and stubborn. He tends to be suspicious and inclined to question the motives of others. However, when not overwhelmed and depressed, he is likely to be much more adaptable, dependable and responsible. In addition, when not in an emotional crisis, he is probably realistic and practical, and is viewed by others as sociable, friendly and enthusiastic.

FILE COPY

Mark has a twenty-plus year history with Michelin and reportedly has been a very productive employee. He indicated, however, that he has been out of work since May 28th and several very recent phone calls from Michelin supervisors indicate that his job may be in jeopardy. Thus, it seems only reasonable that we accelerate his treatment in an effort to expedite his return to work. The simplest solution seems to be to increase his Zoloft to 150 mg per day. Another possibility would be to augment the therapeutic benefit of Zoloft with a second anti-depressant such as Cymbalta. Cymbalta would probably be a good choice since it would be combining the serotonergic benefits of Zoloft with the nordarenergic benefits of Cymbalta. Also, the addition of BuSpar could be helpful in the treatment of Mark's numerous anxiety symptoms.

If you are not comfortable, Frank, with a more complex psychotropic regimen, then either you or I can refer him to one of the Greenville psychiatrists with the recommendation that he be seen at their earliest opening. Michelin is not really satisfied with Mark being out on a three and one-half month leave under the care of a family physician and psychologist for a psychiatric disorder. However, since it could take two to three weeks for Mark to be seen by a psychiatrist, please consider a medication increase/change in the meantime.

Please advise (560-1512).

Sincerely yours,

Jay Grace, Ph.D.
Licensed Counseling Psychologist

Aetna

Attending Physician Behavioral Health Statement

Complete and sign the form using BLUE or BLACK ink.

1. Patient Instructions – The Physician will complete Sections 2 through 9.
The Patient will complete Section 1.
The Patient should also fill in their name at the top of Pages 2 and 3.

The *Patient* is responsible for completing this section, and for ensuring that their Attending Physician completes the remainder of this statement. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. If you have any questions, please call (877) 465-0424.

(a) Control Number N/A - LICENSED PSYCHOLOGIST

(b) WILLIAM MARK CASEY | [redacted] | [redacted] 58 | 5'8" | 160 LBS
Patient Name (Last, First, Middle Initial) | Social Security Number | Birth Date (MM/DD/YYYY) | Height | Weight(lb)

(c) Patient Gender ☑ Male ☐ Female

(d) [redacted]
Patient Home Address – Required (Current No., St., Town, State, Zip – no PO boxes) ☐ Check If New

(e) Mailing Address, if different from Home address [redacted] SPARTANBURG, S.C. 29388

(f) Patient Employer Name/City/State TERMINATED BY MICHELIN IN SPARTANBURG, S.C.

(g) Patient Telephone Number [redacted] ☐ Check If New

(h) Job Title/Occupation TERMINATED

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium
☑ Long Term / Permanent Total Disability

2. Physician Instructions

The *Attending Physician* should complete the items below, based upon a recent examination. Attach additional documentation as needed. If you have any questions, please call (877) 465-0424.

Please complete form in its entirety and fax to (866) 888-2308. Pages 2 and 3 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

DSM IV-TR MULTIAXIAL DIAGNOSIS: (please indicate the primary impairing diagnosis at this time with an*)

AXIS I	Primary Diagnosis	296.23	Secondary Diagnosis:	300.21	ICD-9 codes 296.23, 300.21
AXIS II	Primary Diagnosis	—	Secondary Diagnosis:		ICD-9 codes
AXIS III	Primary Diagnosis	294.11	Secondary Diagnosis:		ICD-9 codes 294.113
Axis IV	Primary Diagnosis	OCCUPATIONAL	Secondary Diagnosis:	ECONOMIC & SOCIAL	

Axis V (GAF) CURRENT 50 High last year 50 Goal for return to work NOT PRESENTLY FEASIBLE.
(Please support GAF with objective findings in the symptom assessment section below)

SYMPTOM ASSESSMENT

(a) Subjective symptoms and complaints: LETHARGY, INSOMNIA, EASILY FATIGUED, DEPRESSIVE AFFECT, PANIC EPISODES, POOR GROSS MOTOR & FINE MOTOR COORDINATION, ANHEDONIA, MEMORY LAPSES AND FORGETFULNESS, AND NAUSEA & VOMITING X 1 WK.

(b) Objective findings(Include mental status findings, testing results, rating scales, etc) SAME AS SUBJECTIVE SYMPTOMS + A 10 TO 18 POINT ↓ IN I.Q.

(c) Describe interpersonal stressors that impact ability to function PANIC DISORDER & AGORAPHOBIA & SOCIAL WITHDRAWAL

(d) Describe work stressors that impact ability to function POOR COORDINATION AND POOR MEMORY FUNCTION.

TREATMENT

(a) Medication(s) / Dose / Frequency: CYMBALTA 60MG BID, CONCERTA (?DOSEAGE) PLUS OTHER MEDS PRESCRIBED BY JEFFREY SMITH, MD, PSYCHIATRIST, GREENVILLE, SC. AND CHARLES FOREST, MD, PULMONOLOGIST, SPARTANBURG, S.C.

(b) Impairment from medication effects NAUSEA AND VOMITING

Compliant with meds? (SAME)

(c) Recent hospitalization? (where, when) SEE MED. RECORDS OF FRANK GONDA, MD & CHARLES FOREST, MD.

(d) Office visit dates: First 8-4-04 Last 7-19-05 Next 7-26-05 Frequency of appointments BI-WEEKLY

(e) Compliant with tx? YES Tx Goals HELP HIM GAIN EMOTIONAL STABILITY WHILE MD. EFFORTS ARE BEING MADE TO HELP HIM OBTAIN MAXIMUM PHYSICAL (ORGANIC) IMPROVEMENT.

AP DT 01-002 ME
GC-1493-1 (10-04) R-P00

GUNN 004353

Patient Name (Last, First Middle Initial) Required
CASEY, WILLIAM MARK

4. History

(a) Has patient ever had same or similar condition? ☑ No ☐ Yes, state when and describe
(b) Is condition due to injury or illness arising out of patient's employment? ☑ No ☐ Yes ☐ Unknown
(c) Name / Specialty / City / State of other Treating Physicians or Therapists
Name FRANK GONDA, M.D. Specialty FAM. MED. City SPARTANBURG State S.C.
Name JEFFREY SMITH, M.D. Specialty PSYCHIATRY City GREENVILLE State S.C.
Name CHARLES FOGARTY, M.D. Specialty PULMONARY City SPARTANBURG State S.C.

5. Abilities/Limitations

(a) Is this person capable of signing checks and directing the proceeds? POSSIBLY NOT
(b) Please check the appropriate response of the employee's ability to perform these job functions now.

	Limitations	Limited	Marked	Unable To Perform
Follow work rules	☐	☑	☐	☐
Able to work with others	☐	☐	☑	☐
Able to give supervision to others	☐	☐	☐	☑
Able to work cooperatively with others in group settings	☐	☐	☑	☐
Able to maintain persistence to task	☐	☐	☐	☑
Able to maintain attention and concentration	☐	☐	☑	☐
Able to work alone or in physical isolation from others	☐	☐	☑	☐
Able to interact with supervisors	☐	☑	☐	☐
Able to interact with public/customers	☐	☐	☑	☐
Able to use judgement and make decisions	☐	☐	☑	☐
Able to attain set standards and limits	☐	☐	☐	☑
Able to direct, control or plan activities of others	☐	☐	☐	☑

(c) Objective findings that substantiate impairment *(current laboratory, physical and/or mental status examination, and other testing)*:
SEE "SYMPTOM ASSESSMENT" SECTION OF THIS FORM

(d) What psychological/medical restrictions/limitations are you placing on this patient? *(Activities of Daily Living, Driving, etc)*
UNABLE TO PERFORM IN ANY JOB CAPACITY AT PRESENT TIME.

- Number of Hours patient is capable of working in a day: N/A ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day
- Number of Days per week patient is able to work: N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week
- Date you prescribed restriction on work activities Month 8-4-04 Day _____ Year _____
- How long are these restrictions/limitations in effect? POSSIBLY WILL NEVER RECOVER ☑ No Longer ☐ Duration
  Days _____ Weeks _____ Months _____
- Estimated return to work date? UNABLE TO DETERMINE (MM/DD/YYYY) modified duty POSSIBLY NEVER (MM/DD/YYYY) full duty

(e) Other Comments _____

6. Current Status

(a) Patient is/has ☐ Improved ☐ Unchanged ☑ Regressed
(b) Is there a medical contra-indication for patient to participate in Vocational Rehabilitation (job retraining) programs?
☐ No ☑ Yes, please explain NOT PHYSICALLY NOR EMOTIONALLY CAPABLE CAPABLE OF MEETING V.R. EVALUATION DEMANDS AT PRESENT TIME
(c) In your opinion, is your patient motivated to return to work? YES BUT REALIZES HE IS INCAPABLE OF SUCH.

AP DT 01-002 ME
GC-1483-1 (10-04)

GUNN 004354

Patient Name *(Last, First Middle Initial)* Required

7. Regulation Notice

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Attention California Residents: For your protection, California law requires notice of the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kentucky, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

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Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

8. Physician Certification

Attending Physician's Name *(Print)*	Degree	Specialty
JOSEPH G. GRACE III	P.h.D.	PSYCHOLOGY
Address *(No. Street, City, State, Zip Code)*	Telephone Number	Fax Number
853 N. CHURCH ST. SUITE 510 SPARTANBURG, S.C. 29303	(864) 560-1512	(864) 560-1565

9. Physician Signature

Signature	Date *(MM/DD/YYYY)*
Joseph G. Grace III PhD	7-19-05

AP DT 01-002 ME
GC-1493-1 (10-04)

GUNN 004355

02/07/06

Aetna: Attending Physician Behavioral Health Statement

Complete and sign the form using BLUE or BLACK ink.

1. Patient Instructions – The Physician will complete Sections 2 through 9.
The Patient will complete Section 1. The Patient should also fill in their name at the top of Page 2.

The *Patient* is responsible for completing this section, and for ensuring that their Attending Physician completes the remainder of this statement. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. If you have any questions, please call (877) 465-0424.

(a) Control Number 607472

(b) CASEY, WILLIAM MARK | [redacted] | [redacted]-58 | 5'8" | 170
Patient Name (Last, First, Middle Initial) | Social Security Number | Birth Date (MM/DD/YYYY) | Height | Weight(lb)

(c) Patient Gender ☑ Male ☐ Female

(d) [redacted], WOODRUFF, S.C. 29388
Patient Home Address – Required (Current No., St., Town, State, Zip – no PO boxes) ☐ Check if New

(e) Mailing Address, if different from Home address (SAME)

(f) Patient Employer Name/City/State MICHELIN TIRE, SPARTANBURG, S.C.

(g) Patient Telephone Number (864) 486-9131 ☐ Check if New

(h) Job Title/Occupation PRODUCTION (ASSEMBLY LINE WORKER)

(i) Type of Claim: ☑ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium ☐ Long Term / Permanent Total Disability

2. Physician Instructions

The *Attending Physician* should complete the items below, based upon a recent examination. Attach additional documentation as needed. If you have any questions, please call (877) 465-0424.

Please complete form in its entirety and fax to (866) 888-2308. Page 2 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

DSM IV-TR MULTIAXIAL DIAGNOSIS: (please indicate the primary impairing diagnosis at this time with an*)

AXIS I	Primary Diagnosis 296.23	Secondary Diagnosis: 309.81	ICD-9 codes 300.02
AXIS II	Primary Diagnosis (NONE)	Secondary Diagnosis: —	ICD-9 codes —
AXIS III	Primary Diagnosis (DEFERRED)	Secondary Diagnosis: —	ICD-9 codes —
Axis IV	Primary Diagnosis OCCUPATIONAL PROBS.	Secondary Diagnosis: HEALTH PROBS, SUPPORT GROUP PROBS.	

Axis V (GAF) CURRENT 55 High last year 90 Goal for return to work 80

(Please support GAF with objective findings in the symptom assessment section below)

SYMPTOM ASSESSMENT

(a) Subjective symptoms and complaints: INITIAL AND TERMINAL SLEEP DISTURBANCES, DEPRESSIVE AFFECT C ATYPICAL CYNICISM, IRRITABILITY & LOW FRUSTRATION TOLERANCE, ANXIETY AND RESTLESS-NESS, ATYPICAL SOMATIC COMPLAINTS, EXCESSIVE WORRY, EASILY FATIGUED, AND INABILITY TO COPE NORMAL LIFE STRESS.

(b) Objective findings(include mental-status findings, testing results, rating scales, etc) BORDERLINE MENTAL STATUS EXAM, AND MMPI-II INDICATING MODERATE BAN. AND DEPRESSIVE TENDENCIES TO DEVELOP G.I. DISTURBANCES, PANIC EPISODES, SLOWED IN THOUGHT & ACTION,

(c) Describe interpersonal stressors that impact ability to function OBSESSIONAL THOUGHTS AND COMPULSIVE BEHAVIORS.

(d) Describe work stressors that impact ability to function STRESS OF MEETING PRODUCTION, PHYSICALLY DEMANDING FOR NUMBER OF HOURS AND LIFTING HEAVY TIRES CONTINUALLY

TREATMENT

(a) Medication(s) / Dose / Frequency: ZOLOFT 150MG QD, AND SOMA 1.5,

(b) Impairment from medication effects SEDATION
Compliant with meds? YES

(c) Recent hospitalization? (where, when) RESPIRATORY ARREST AND COMA PRIOR TO PSYCH SYMPTOMS.

(d) Office visit dates: First 8-4-04 Last ____ Next ____ Frequency of appointments WEEKLY

(e) Compliant with tx? YES Tx Goals VERY

4. History

(a) Has patient ever had same or similar condition? ☑ No ☐ Yes, state when and describe

(b) Is condition due to injury or illness arising out of patient's employment? ☑ No ☐ Yes ☐ Unknown

(c) Name / Specialty / City / State of other Treating Physicians or Therapists (NOT DIRECTLY)
Name WILSON SMITH, M.D. Specialty PULMONOLOGY City SPARTANBURG State S.C.
Name FRANK GONDA, M.D. Specialty FAM. PRACT. City " State "
Name JEFFREY SMITH, M.D. Specialty PSYCHIATRY City GREENVILLE State S.C.

AP DT 01-002 ME
GC-1483-1 (6-03)

GUNN 004356

Patient Name (Last, First Middle Initial) Required
~~Elizabeth~~ CASEY, WILLIAM MARK

5. Abilities/Limitations

(a) Is this person capable of signing checks and directing the proceeds? _____

(b) Please check the appropriate response of the employee's ability to perform these job functions now.

	Unlimited Limitations	Limited	Marked	Unable To Perform
Follow work rules	☑	☐	☐	☐
Able to work with others	☑	☐	☐	☐
Able to give supervision to others	☐	☑	☐	☐
Able to work cooperatively with others in group settings	☐	☑	☐	☐
Able to maintain persistence to task	☐	☐	☑	☐
Able to maintain attention and concentration	☐	☐	☑	☐
Able to work alone or in physical isolation from others	☐	☑	☐	☐
Able to interact with supervisors	☑	☐	☐	☐
Able to interact with public/customers	☑	☐	☐	☐
Able to use judgement and make decisions	☐	☐	☑	☐
Able to attain set standards and limits	☐	☐	☐	☑
Able to direct, control or plan activities of others	☐	☐	☑	☐

(c) Objective findings that substantiate impairment (current laboratory, physical and/or mental status examination, and other testing):
SEE "SYMPTOM ASSESSMENT" SECTION

(d) What psychological/medical restrictions/limitations are you placing on this patient? (Activities of Daily Living, Driving, etc)
LIMITED RECREATION ACTIVITIES AND VERY LIMITED VOCATIONAL ACTIVITIES

- Number of Hours patient is capable of working in a day: ☐12 ☐10 ☐8 ☐6 ☐4 ☐2 ☐1 Hour/Day NONE
- Number of Days per week patient is able to work: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 Days/Week NONE
- Date you prescribed restriction on work activities ..... Month 8 Day 4 Year 04
- How long are these restrictions/limitations in effect? SYMPTOMS ARE EXPECTED TO BE UNTIL ANXIETY AND DEPRESS IS IMPROVED ☐ No Longer Required
  ROUGH ESTIMATE Days Weeks Months
- Estimated return to work date? Nov 30, 04 (MM/DD/YYYY) modified duty 1/2 TIME (MM/DD/YYYY) full duty INITIALLY

(e) Other/ Comments _____

6. Current Status

(a) Patient is/has ..... ☑ Improved ☐ Unchanged ☐ Regressed

(b) Is there a medical contra-indication for patient to participate in Vocational Rehabilitation (job retraining) programs?
☐ No ☑ Yes, please explain WOULD BE OF NO BENEFIT TO THE PATIENT

(c) In your opinion, is your patient motivated to return to work? YES BUT RESTRICTED BY PSYCHIATRIC DISORDERS.

7. Regulation Notice

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.
California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.
Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.
Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

8. Physician Certification

Attending Physician's Name (Print)	Degree	Specialty
JOSEPH G GRACE, III	PH. D.	CLINICAL/COUNSELING PSYCHOLOGY
Address (No, Street, City, State, Zip Code)	**Telephone Number**	**Fax Number**
853 N. CHURCH ST. SUITE 510 SPARTANBURG, S.C. 29303	(864) 560-1512	(864) 560-1565

9. Physician Signature

Signature	Date (MM/DD/YYYY)
Joseph G Grace, III, PhD	10-19-04

AP DT 01-002 ME
GC-1493-1 (5-05)

GUNN 004357

MARIA, Thanks very much! MARK

re 486-9873

Aetna Life Insurance Company
Telephone: 877-465-0424
Fax: 866-888-2308

Aetna Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Employee Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (MM/DD/YYYY)
CASEY, WILLIAM MARK	[redacted]	[redacted] 58

Gender	Job Title	Control Number
☑ Male ☐ Female	MICHELIN TIRE ASSEMBLY LINE	607472

Current Diagnosis	Medications:
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER FOLLOWING ORGANIC BRAIN DAMAGE (310.9) MAJOR DEPRESSIVE DISORDER (296.23)	MIRTAZAPINE 45 MG. Q.H.S. ADDERALL XR 40 MG. Q.A.M. AMBIEN 10 MG. Q. H.S.

Indicate the percent of the day the following activities can be performed:

(Occasional 1-33% or .5-2.5 hrs. Frequent 34-66% or 2.6-5.0 hrs. Continuous 67-100% or 5.1-8 hrs. or Never)

	O	F	C	N
Climbing - (DEFERRED TO FAMILY PHYSICIAN AND PULMONOLOGIST)	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Pulling	☐	☐	☐	☐
Pushing	☐	☐	☐	☐
Reaching above shoulder	☐	☐	☐	☐
Forward reaching	☐	☐	☐	☐
Carrying	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Twisting	☐	☐	☐	☐

	O	F	C	N
Hand Grasping __R__L	☐	☐	☐	☐
Firm Hand Grasping __R__L	☐	☐	☐	☐
Fine Manipulation __R__L	☐	☐	☐	☐
Gross Manipulation __R__L	☐	☐	☐	☐
Repetitive Motion __R__L	☐	☐	☐	☐
Sitting __R__L	☐	☐	☐	☐
Standing __R__L	☐	☐	☐	☐
Stooping __R__L	☐	☐	☐	☐
Walking __R__L	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

Maximum weight patient is capable of lifting:

	O	F	C	N
1 - 5 lbs. (DEFERRED)	☐	☐	☐	☐
6 - 10 lbs.	☐	☐	☐	☐
11 - 20 lbs.	☐	☐	☐	☐
21 - 35 lbs.	☐	☐	☐	☐
36 - 50 lbs.	☐	☐	☐	☐
51 - 75 lbs.	☐	☐	☐	☐
75 - 100 lbs.	☐	☐	☐	☐
100 lbs. +	☐	☐	☐	☐

Approved Head and Neck Movements:

	Yes	No
Static Position	☐	☐
Frequent Flexing	☐	☐
Frequent Rotation	☐	☐

Can the Patient operate:

	Yes	No
A Motor Vehicle	☐	☐
Hazardous Machine	☐	☐
Power Tools	☐	☐

Limitations to:
Speaking _____ hrs. (DEFERRED)
Vision (explain) _____
Depth Perception _____
Hearing (explain) _____

Exposure Limitations:

	Yes	No		Yes	No
Heat	☐	☐	Dust	☐	☐
Cold	☐	☐	Fumes	☐	☐
Dampness	☐	☐	Chemicals	☐	☐
Noise	☐	☐	Radiation	☐	☐

Total # of hours patient capable of working per day: 12 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐
Duration of restrictions: TOTAL Care Complete: Yes ☐ No ☑ Next Appointment: 2-9-06

Additional Comments:
PT. SLOWED IN THOUGHT AND ACTION, POOR SHORT TERM & LONG TERM RECALL, POOR CONCENTRATION, UNABLE TO MULTI-TASK, POOR GROSS MOTOR AND FINE MOTOR COORDINATION, MENTAL BLOCKING, ANHEDONIA, LETHARGY, INERTIA, EASILY FATIGUED, DEPRESSIVE AFFECT, PANIC EPISODES, AGGITATED, & PARANOID IDEATION, VERY LOW FRUSTRATION TOLERANCE & INABILITY TO COPE & STRESS OF LIFE.

Physician's Signature, PhD 2-3-06 Date (MM/DD/YYYY)

MI DT 80-002 ME
GC-1500-I (5-03) R-POD

GUNN 004358

Aetna

Attending Physician Statement

Complete and sign the form using BLUE or BLACK ink.

1. Patient Instructions – The Physician will complete Sections 2 through 9.
The Patient will complete Section 1.
The Patient should also fill in their name at the top of Pages 2 and 3

The ***Patient*** is responsible for completing this section, and for ensuring that their Attending Physician completes the remainder of this statement. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. If you have any questions, please call (877) 465-0424.

(a) Control Number 607472

(b) CASEY, WILLIAM M. | [redacted] | [redacted]-58 | 5'8" | 170
Patient Name *(Last, First, Middle Initial)* | Social Security Number | Birth Date *(MM/DD/YYYY)* | Height | Weight(lb)

(c) Patient Gender ☑ Male ☐ Female

(d) [redacted], WOODRUFF, SC, 29388
Patient Home Address – Required *(Current No., St., Town, State, Zip – no PO boxes)* ☐ Check if New

(e) Mailing Address, if different from Home address (SAME)

(f) Patient Employer Name/City/State PREVIOUSLY MICHELIN IN SPARTANBURG, S.C.

(g) Patient Telephone Number (864) 486-9131 ☐ Check if New

(h) Job Title/Occupation PREVIOUSLY TIRE LINE ASSEMBLY

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium
☑ Long Term / Permanent Total Disability

2. Physician Instructions

The ***Attending Physician*** should **complete the items below,** based upon a recent examination. Attach additional documentation as needed. If you have any questions, please call (877) 465-0424.

Please complete form in its entirety and fax to (866) 888-2308. Pages 2 and 3 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

(a) Primary Diagnosis UNSPECIFIED NONPSYCHOTIC MENTAL DIS- Primary ICD Code 310.9
~~Secondary Diagnosis~~ SECONDARY DX: POST TRAUMATIC ORGANIC BRAIN DAMAGE Secondary ICD Code 294.23 (310.9)
Other Diagnoses MAJOR DEPRESSIVE DISORDER (296.33) Other ICD Codes —

(b) Height 5'5" Weight 170 Date Measured *(MM/DD/YYYY)* 8-4-04

(c) If Pregnancy related, delivery or expected date N/A MM ____ DD ____ YYYY ____ Delivery Type: ☐ Vaginal ☐ Cesarean

(d) Primary Procedure N/A Primary CPT Code N/A
Secondary Procedure N/A Secondary CPT Code N/A
Other Procedures — Other CPT Codes —

(e) Medication(s)/Dose/Frequency MIRTAZAPINE 45 MG. @ H.S.
ADDERALL XR 40 MG. @ AM., AMBIEN 10 MG. @ HS.
Impairment from medication effects ____

(f) Is patient still under your care for this condition? ☑ Yes ☐ No, date service terminated ____ *(MM/DD/YYYY)*

(g) Treatment summary COGNITIVE & SUPPORTIVE PSYCHOTHERAPY, COGNITIVE & PERSONALITY TESTING SUPPLEMENTED BY PSYCHOTROPIC MEDS.

(h) Office visit dates: First 8-4-04 *(MM/DD/YYYY)* Last 1-26-06 *(MM/DD/YYYY)* Next 2-9-06 *(MM/DD/YYYY)* Frequency of appointments BIWEEKLY

(i) Was patient recently hospitalized? ☑ No ☐ Yes Date hospitalized: Admit ____ *(MM/DD/YYYY)* Discharge ____ *(MM/DD/YYYY)*

(j) Hospital Name/City/State N/A

Patient Name (Last, First Middle Initial) Required
CASEY, WILLIAM MARK

4. History

(a) Symptoms: COGNITIVE DYSFUNCTION (↓S.T. & L.T. RECALL, SLOWING, POOR CONCENTRATION) POOR FINE & GROSS MOTOR COORDINATION, DEPRESSIVE SYMPTOMS, AGGITATION, ↓FRUSTRATION TOLERANCE, LETHARGY, EASILY FATIGUED

(b) Date symptoms first appeared or accident happened 5-2004 MM ____ DD ____ YYYY ____

(c) Has patient ever had same or similar condition? ☑ No ☐ Yes, state when and describe.

(e) Is condition due to injury or sickness arising out of patient's employment? ☑ No ☐ Yes ☑ Unknown

(f) Other Treating Physicians POSSIBLY COMPLICATIONS OF SINCE HE INITIALLY PRESENTED WITH CHEST PAINS.

Name WILSON SMITH, M.D. Specialty PULMONOLOGY City SPARTANBURG State S.C.

Name JEFFREY SMITH, MD Specialty PSYCHIATRY City GREENVILLE State S.C.

5. Abilities/Limitations

(a) **Patient is: Place remarks in item (d) below, if applicable.**

- Competent to endorse checks and direct the use of proceeds thereof ☑ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others ☐ Yes ☑ No ☐ Other/describe in (d)
- Able to give supervision ☐ Yes ☑ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting ☐ Yes ☑ No ☐ Other/describe in (d)
- Able to do? **Select one: Place remarks in item (d) below, if applicable.**
  - ☐ **Heavy work** activity. No limitations of functional capacity.
  - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly
  - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently
  - ☐ **Sedentary work** activity – moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time
  - ☑ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity
  - ☐ **Other.** Place remarks in item (d) below.

(b) **What medical restrictions/limitations are you placing on patient?** ***(Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)*** CAN DO HOUSE WORK FOR ABOUT 0 AN' HOUR BUT BECOMES QUITE FATIGUED. EMOTIONAL AND PHYSICAL STRESS ARE OVERWHELMING. UNABLE TO WORK IN GAINFUL EMPLOYMENT IN ANY CAPACITY AT PRESENT TIME.

- Number of Hours patient is capable of working in a day: ☐ 12 ☑ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☑ 1 Hour/Day (N/A)
- Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week (N/A)
- Date you prescribed restriction on work activities ..... Month 5 Day 04 Year 04
- How long are these restrictions/limitations in effect? APPEAR TO BE PERMANENT RESTRICTIONS ☐ No Longer
  Days Weeks Months
- Estimated return to work date? UNREALISTIC (MM/DD/YYYY) modified duty UNREALISTIC (MM/DD/YYYY) full duty

(c) **Objective findings that substantiate impairment** *(current laboratory, physical and/or mental status examination, and other testing)*
VERY SIGNIFICANT COGNITIVE IMPAIRMENT AND SEVERE EMOTIONAL

(d) ~~Other/Comments~~ PSYCHIATRIC DISORDERS

6. Current Status HAS NEITHER IMPROVED SIGNIFICANTLY REGRESSED,

(a) Patient has ..... ☐ Improved ☐ Stabilized ☐ Regressed ☑ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?
☐ No ☑ Yes, please explain INCAPABLE OF BENEFITTING FROM VOC. REHAB. SERVICES

(c) In your opinion, is your patient motivated to return to work? SOMEWHAT BUT INCAPABLE

AP DT 01-001 ME
GC-1486-1 (10-04)

GUNN 004360

Patient Name (Last, First Middle Initial) Required

7. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kentucky, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

8. Physician Certification

Attending Physician's Name (Print)	Degree	Specialty
JOSEPH G. GRACE, III	Ph.D.	LICENSED PSYCHOLOGIST
Address (No. Street, City, State, Zip Code)	Telephone Number	Fax Number
953 N. CHURCH ST. SUITE 510 SPARTANBURG, S.C. 29303	(864) 560-1512	(864) 560-1565

9. Physician Signature

Signature	Date (MM/DD/YYYY)
	2-3-06

AP DT 01-001 ME
GC-1486-1 (10-04)

GUNN 004361