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**THE STATE OF SOUTH CAROLINA
In The Court of Appeals**

Oct 15 2021

SC Court of Appeals

**APPEAL FROM
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO: 1206236**

Appellate Case No. 2019-001936

Jennie Cox,.....Appellant,

v.

**Palmetto State Transportation, Employer, and
Cherokee Insurance Company, Carrier,.....Respondents,**

RECORD ON APPEAL

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The undersigned certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

The undersigned further certifies that a copy of the Record on Appeal was served on **George Gallagher** of Columbia South on October 15, 2021 by means of electronic mail at ggallagher@speed-seta.com and/or regular US Mail at PO Box 1169, Columbia, South Carolina 29211

October 15, 2021

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SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206236

**JENNIE COX,
Employee
Claimant,**

vs.

**PALMETTO STATE
TRANSPORTATION,
Employer,**

**CHEROKEE INSURANCE COMPANY,

Insurance Company,

Defendants.**

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ORDER

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HEARING: Held in Anderson, South Carolina on February 2, 2017

APPEARANCES: Claimant represented by Juliette B. Mims, Esquire, of Greer, South Carolina and Adrienne Turner, of Columbia, South Carolina

Defendants represented by Robert E. Horner, Esquire, of Columbia, South Carolina

PURPOSE OF HEARING: To determine issues set forth in Forms 50 and 51, including, Claimant's degree of disability. Whether or not Claimant was rendered totally disabled and whether or not Claimant is entitled to lifetime medicals.

AWARD: The Honorable Aisha Taylor, Commissioner

FILED:

APA SUBMISSIONS

Submissions on behalf of Claimant:

1. Grady Hospital
2. American Medical Response of Georgia
3. Greenville Memorial
4. James Fowler, M.D. of GHS Plastic Surgery & Aesthetics
5. GHS Center for Health & Occupational Services
6. Innervision MRI & Imaging
7. Proaxis Therapy
8. Jennifer T. Ellis, M.D. of Hillcrest Family Practice
9. Donald L. Ridgell, DMD of Upstate Prosthodontics, LLC
10. Larry W. Cobb, DMD
11. William A. Cofer, DMD
12. Walter Grady, D.O
13. Robert E. Brabham, Ph.D.
26. Life Center Health
27. CORA Rehabilitation Center

Submissions by Defendant:

14. Occupational Health
15. Piedmont Oral Surgery
16. Piedmont Oral Surgery questionnaire
17. Center for Health & Occupational Services
18. Impairment rating
19. Hillcrest Family Practice
20. Claimant's 2015 tax returns
21. Letter to Claimant's attorney regarding work
22. Liberty Bell Agency check log & ltr from CA
23. Duvall Group Investigation report
24. Photos
25. Deposition transcript of Claimant
26. Wage Records (submitted at hearing)

STIPULATIONS

This case came before the undersigned Commissioner in Anderson, South Carolina on February 2, 2017. At the hearing the Claimant was represented by Juliette B. Mims and Adrienne Turner; Palmetto State Transportation and its carrier, Cherokee Insurance Company, was represented by Robert E. Horner with Speed, Seta, Martin, Trivett & Stubley.

The parties stipulated as follows:

1. All parties are subject to, and bound by, the terms and conditions of the South Carolina Workers' Compensation Act ("Act").

2. Notice of the hearing was timely and properly served upon all necessary and proper parties, and the file and its contents, along with the Commissioner's notes, are made part of the record without objection.
3. There were no objections to the submission of APAs and/or exhibits.
4. The Claimant's average weekly wage is \$1,327.69, yielding a compensation rate of \$725.47.
5. That the Workers' Compensation Commission has jurisdiction over this matter and venue in Anderson County is proper as stipulated by all parties;
6. Claimant seeks benefits under the South Carolina Workers' Compensation Act based upon accidental injuries occurring on May 31, 2012, which occurred while in the course and scope of the Claimant's employment with the Defendant employer. The injury and date of injury are stipulated to and not disputed.

STATEMENT OF CASE

It is undisputed that on May 31, 2012 Claimant sustained compensable injuries by accident arising out of and in the course of her employment with Palmetto State Transportation as a CDL truck driver. The accident occurred while she was on a delivery in Georgia, when she was removing freight; a machine fell on her, causing her to fall to the ground face first knocking her unconscious. At the time of the accident, she injured her head, teeth, mandible, left shoulder, neck and facial nerves. As a result of the injuries Claimant has sustained, she has been treating for depression due to chronic pain and severe weight loss.

It is the Claimant's position that she has been rendered totally and permanently disabled as a result of the injuries in question and that she is entitled to lifetime medical care.

Palmetto State Transportation and its carrier admit that Claimant did in fact sustain injuries as a result of the above referenced accident, and that she has reached maximum medical improvement, but assert that she is entitled only to permanent partial benefits and continued medical care for her physical injuries as prescribed by Dr. Ridgell and Dr. Cobb.

The following issues are for determination by this Commissioner:

1. Has the Claimant sustained total and permanent disability due to her injuries?
2. To what extent is the Claimant entitled to additional medical care?
3. Is the Claimant entitled to further compensation?

EVIDENCE OF CASE

The Claimant testified that she is 64 years old, divorced and has two adult daughters.¹ She graduated from Woodmont High School in 1970 and attended TEC, but did not graduate. She obtained her Truck Driver's Class "A" license in 1985, and has worked in that capacity thereafter. At the time of the accident, Claimant had worked for Employer for eleven (11) years, and worked for US Food Service for six (6) years prior to that. Claimant testified that she had no prior physical injuries and was in good health at the time of her injuries. She testified that she did suffer from pre-existing depression related to the death of her grandson who was killed at age 16 in a car accident.

On May 31, 2012, Claimant was on a delivery in Georgia, when she was removing freight from her truck; a machine fell on her, causing her to fall to the ground face first knocking her unconscious. She was rushed to Grady Memorial in Georgia and then brought by EMS to Greenville Memorial Hospital with injuries to her head, face, mouth and neck, left shoulder, chest, low back and problems breathing. On June 1, 2012, James Fowler, M.D. performed extensive surgical intervention to address Claimant's injuries. Records indicated he performed a bilateral subcondylar mandible fracture, left body comminuted mandible fracture, avulsed maxillary and mandibular teeth, maxillomandibular fixation with screws, open reduction and internal fixation left body mandible fracture and dental tooth extraction.

Claimant was subsequently seen by Stacey Newsom, M.D. at the Center for Health and Occupational Services for chest wall pain and left shoulder pain. Dr. Newsome indicated chest wall contusions and left shoulder contusion with weakness and possible rotator cuff injury. Dr. Newsome instructed Claimant to continue with Lortab for pain, deep breathing exercises and imposed work restrictions limiting Claimant to sedentary work with a five (5) pound lifting restriction and prohibited her from operating commercial motor vehicle.

Claimant had a follow-up with Dr. Fowler on June 11, 2012, after which Dr. Fowler opined that Claimant was to remain in a "levered and wired occlusion for one more week." On July 5, 2012, Claimant underwent surgery to remove the IMG screws.

On July 6, 2012, Claimant underwent an MRI of the left shoulder at Innervision MRI &

¹ Facts included herein are derived from Claimant's live testimony at the hearing, Claimant's deposition testimony, which was submitted without objection, and medical histories derived from submitted APAs.

Imaging with an impression of “degenerative changes and mild tendinopathy in the suprae and infraspinitus tendons.” On July 17, 2012, Claimant returned to Innervision for an x-ray of the chest with an impression of COPD without acute findings. Claimant then returned to Dr. Newsome on July 17, 2012 to review the findings of the MRI and x-ray. Dr. Newsome’s diagnosis was chest wall contusions resolving and left shoulder contusion improving. Claimant was to continue the same restrictions with the additional restrictions ordered by Dr. Fowler.

On July 24, 2012, Claimant began treating with Larry W. Cobb, D.M.D at Piedmont Oral Surgery to discuss surgical oral restoration. Dr. Cobb noted Claimant had multiple jaw and teeth fractures and determined he would allow them to heal for an additional three months before attempting restorative procedures. Dr. Cobb also ordered a CT for September and sought preauthorization for implants and restoration.

Claimant again saw Dr. Newsome on August 7, 2012, at which point Dr. Newsome noted left shoulder weakness and tendinosis and chest wall contusion. She recommended physical therapy for strengthening prior to return to full duty. Dr. Newsome stated Claimant could return to work with restrictions of no lifting, pushing or pulling more than 15 pounds occasionally and no operating commercial motor vehicle. Claimant started physical therapy with Proaxis Therapy on August 22, 2012 for her left shoulder pain.

On August 28, 2012, Claimant went to her family doctor, Jennifer T. Ellis, M.D., for a follow-up. Dr. Ellis noted that her depression and insomnia had been getting worse since her last visit and Claimant was also experiencing loss of appetite and loss of interest in pleasurable activities since her work related injury.

On September 4, 2012 Dr. Cobb examined Claimant and stated she was healing well and scheduled a CT. The CT scan on October 3, 2012 also showed she was healing well. Dr. Cobb referred her to Donald L. Ridgell, DM.D. for his evaluation. Claimant saw Dr. Ridgell on October 4, 2012, wherein Dr. Ridgell examined Claimant and agreed with Dr. Cobb that a full mouth extraction of Claimant’s natural teeth with implant replacement was the best solution. Dr. Ridgell further noted that he would continue to work along-side Dr. Cobb for the maintenance and upkeep of the implants.

On October 30, 2012 Dr. Cobb opined that Claimant had “a full work up including a physical examination CBCT evaluation to determine the best treatment necessary to restore her teeth for maximum function. She has a very complicated case secondary to her normal petite size and small jaw. This has been further compromised by the very significant jaw injuries

multiple bone fractures and loss of teeth. Her remaining teeth are terminal due to the lack of bone support. These will all have to be removed. She has very minimal maxillary bone and will lose more when her teeth are removed. She will require extensive bone grafting before any definitive treatment can be achieved. Either one or both bone plates will need to be removed from the mandible before any treatment can be implemented there as well.” Dr. Cobb set out the treatment in 5 stages with an estimated cost of \$34, 215.00, not including the prosthetic work to be done by Dr. Ridgell.

On November 5, 2012, Claimant saw Dr. Fowler for a follow up examination. Dr. Fowler noted that Claimant had been seen by a prosthodontist and was scheduled for dental restoration. He specifically noted that Claimant’s nutrition has been affected in that she had to work to get enough nutrition in and was eating pureed food. Dr. Fowler recommended a softer food diet and that Claimant maintain her nutrition as needed with calorie supplements including Ensure or Carnation Instant Breakfast.

Claimant was discharged from Proaxis on November 6, 2012, after completing 20 visits, to an independent home exercise program. Following her discharge from physical therapy, she returned to Dr. Newsome on November 9, 2012. Dr. Newsome opined that her left shoulder injury was at MMI with an impairment rating of the left shoulder of 2% and stated Claimant could return to work on November 9, 2012 without restrictions with regard to her left shoulder.

On January 31, 2013, Claimant began her restoration with Dr. Cobb as follows:

- a) 01/13/13 bilateral sinus graft, removal of superior bone plate and surgical removal of teeth numbers 4, 6, 11, 21, 22, 26, 27, 28, 29;
- b) 04/29/13 surgical implant placement of teeth numbers 20, 23, 25, 27, 30; and
- c) 07/17/13 surgical implant placement of teeth number 3, 5, 6, 11, 12, 14.

During the process of her oral reconstructive surgery, Dr. Cobb referred Claimant to a nutritionist. He stated that she is “very malnourished. The success of our treatment depends on her ability to heal. I believe that all of our treatment may be in jeopardy if her overall nutrition does not improve.”

On July 15, 2013, Claimant returned to Dr. Ellis for a follow-up. Dr. Ellis stated Claimant is doing “about the same.” “She is currently experiencing fatigue, weight loss of 25 pounds over the past year and loss of appetite. Claimant states she gets hungry and tries to eat but it hurts.” Dr. Ellis refilled her anxiety and insomnia medications of Alprazolam Oral 0.5 mg and Restoril Oral Capsule 30 mg.

Upon her healing from the restoration surgeries, Claimant returned to work on August 12, 2013. Claimant testified that although she did her absolute best to perform her work duties in the same manner as before the accident, she continued to have difficulties and was never able to perform her duties as well as before she was injured. Significantly, despite her commendable attempt to return to work, Claimant continued to experience pain, inability to maintain proper nutrition except through the use of nutritional supplements, and suffered from weaknesses, fatigue and inability to concentrate.

On October 6, 2014, Claimant returned to the Center for Health & Occupational Services for reevaluation of her left shoulder. Claimant was seen by Brian Svazas, M.D. and advised him that she was having some difficulties in the left shoulder with it being sore after long truck runs. Claimant also discussed difficulties with the left ear with intermittent hearing diminution. Dr. Svazas advised that he believed the complaints she had in the left scapular border were likely related to her work injury to the shoulder. He advised that physical therapy could help clear up some of the soft tissue areas. Dr. Svazas found her at MMI with a 6% left shoulder rating and opined that "she may need some ongoing therapy to this shoulder going forward."

Dr. Ridgell opined on April 9, 2015 that Claimant will need future medical care by way of "maintenance procedures annually- more expensive than natural teeth, replace or refurbish appliances every 6-8 years and oral surgeon visit in 5 years for radiograph/CT scan." Dr. Ridgell continues to see Claimant every 6 months.

Claimant last saw Dr. Cobb on April 27, 2015 where he released her to MMI with the following impairment ratings: 15%- diet limited to soft or semi solid foods, 85% of normal function, 4% interincisal range of Motion- 30mm, 3% lateral excursion range of motion 5-6mm, 2% facial disorder- scar, 1% nerve disorder- permanent numbness of lower lip and chin on left side, for a 25% whole person. He also stated that she will need prosthetic maintenance and replacement.

Claimant continued to have pain in her jaw and returned to Dr. Fowler on June 8, 2015 and again on June 15, 2015 with draining sinus to the left jaw in the region of a previous ORIF and plate and screw placement for a compound fracture of an atrophic mandible. Claimant went out of work again on June 20, 2015 due to these issues and on July 5, 2015 Dr. Fowler performed surgery for removal of the indwelling device of the mandibular bone along with removal of plate and screws, bone biopsy and bone grafting.

Dr. Fowler released her to return to work, which Claimant did in August 2015. Claimant

had a follow-up appointment with Dr. Fowler on October 12, 2015, wherein Dr. Fowler stated “she has residual numbness from the left mental nerve that may be permanent.”

In October 2015, Claimant went from running team driving to single driving.

Throughout these surgeries for her mouth, Claimant continued to see Dr. Ellis for routine follow ups and prescription refills for her depression that continued to get worse. At her appointment on March 3, 2016, Dr. Ellis noted that since Claimant has gone to single driving, it was physically and mentally wearing her out. Dr. Ellis further noted it was still uncomfortable for her to eat as her- “teeth not lined up” and that Claimant had lost a significant amount of weight as a result. Dr. Ellis took her out of work until she could gain some weight. Claimant went to her dentist, William A Cofer, D.M.D. on April 14, 2016 to get his opinion as to the pain she continues to have chewing and eating her food. Dr. Cofer opined “I believe the reason she is having difficulties chewing and eating is due to the numbness on the left side of her lower jaw. She has had a loss of sensation since her accident.....Unfortunately; it is unlikely that she will regain any meaningful sensation due her accident.” Over the next several months, Claimant was able to show good weight improvement and return to work on June 1, 2016. However, Claimant testified she did not experience a corresponding return at her pre-accident strength. In fact, Claimant indicated her lack of strength, consistent fatigue and inability to maintain concentration rendered truck driving an unsafe occupation for her to continue. She testified credibly and without challenge from the Employer that she had conveyed her concerns to her supervisor and he indicated that the company would not be comfortable accepting the liability implications stemming from her symptoms. Claimant did not receive temporary total benefits for this period of time she was out.

Claimant ran nonstop runs for a few weeks with constant pain over her entire body. On June 14, 2016 she notified the Employer that she was in too much pain, could not work and needed additional treatment.

While awaiting authorization for additional treatment from the Employer, Claimant’s attorney sent her for an Independent Medical Evaluation with Walter Grady, DO on July 21, 2016. Upon physical examination of the Claimant and review of her prior extensive medical treatment history, Dr. Grady gave Claimant an impairment rating of 17% to the left upper extremity, 28% to left shoulder impairment and 10% whole person.

Claimant’s attorney also scheduled a physiological and vocational evaluation with Robert E. Brabham, Ph.D. on August 8, 2016. Dr. Brabham has opined that “she would be unable to

effectively perform the essential duties in any gainful work activity.”

Claimant sought treatment at the Wellness Center on her own on August 17, 2016, as she was in pain and Employer had not approve physical therapy as requested. She was making progress at the Wellness Center and her primary care doctor, Dr. Ellis, opined that she should continue there. Employer eventually authorized work hardening at CORA Rehabilitation. Claimant completed treatment three (3) times a week for several hours for a total of 20 visits between October 24, 2016 and December 19, 2016 at CORA Rehabilitation. Notably, CORA’s December 19, 2016 Functional Capacity Test results indicated Claimant is not able to perform several of the minimal material handling requirements for a truck driver.

Claimant testified that she loved her job and wanted to continue working, however, due to the pain, weakness, fatigue and anxiety she experiences is not able to perform the job. As well, Claimant also remains unable to conduct her day-to-day living activities in the same manner as before her injuries.

FINDING OF FACT

1. I find that the parties of this proceeding are subject to and bound by the terms of the Title 42 of the South Carolina Code of Laws, Annotated, dealing with South Carolina Workers’ Compensation Law with Palmetto State Transportation and Cherokee Insurance Company, employer and carrier.
2. After observing the demeanor of Claimant while she testified at the hearing, the medical records, and the other exhibits in evidence, I find that the testimony of Claimant to be fully credible regarding her work injury and its effect on her current quality of life, including her inability to work.
3. I find that the Claimant sustained admitted compensable injuries by accident arising out of in the course of her employment on Mary 31, 2012, injuries to her teeth, mandible, left shoulder, neck, facial nerve and scarring to her chin.
4. I find that based upon the medical opinions of Dr. Ellison and Dr. Brabham and testimony submitted, that Claimant had preexisting depression and her injuries caused an aggravation and/or exacerbation of the preexisting condition and is therefore compensable under the Act.
5. I find that at the time of the accident, Claimant was an employee of the Palmetto State Transportation as a truck driver.

6. I find that the applicable average weekly wage of the Claimant is One Thousand Three Hundred Twenty Seven and 69/100 (\$1,327.69) Dollars, corresponding to a compensation rate of is Seven Hundred Twenty-Five and 47/100 (\$725.47) Dollars, which was stipulated by Claimant's counsel and defense counsel at the hearing.
7. I find that the Claimant has been unable to work since June 2016 and is permanently and totally disabled pursuant to S.C. Code Ann. Section 42-9-10 as a result of her combined injuries. This finding is based on the preponderance of the evidence as a whole including the medical evidence, the credible testimony of the Claimant, and the vocational assessment of Robert Brabham, Ph.D., Claimant's age, education and work history also weighed into this decision.
8. I find that the Claimant is entitled to a lump-sum payment of the commuted value of Five Hundred (500) weeks of benefits less any amounts previously paid by Defendants in the form of temporary compensation.
9. I find that Claimant is entitled to lifetime medical treatment for her work injuries pursuant to S.C. Code Ann. Section 42-15-60 including lifetime repair, replacement and/or removal of any retained hardware. Defendants are responsible for lifetime causally related medical expenses. This includes but is not necessarily limited to: her teeth, mandible, left shoulder, neck, facial nerve and depression. The depression was aggravated by her accident.
10. The Claimant is entitled to a lump-sum payment and that the settlement proceeds of Three Hundred Thousand Nine Hundred Thirty Eight and 67/100 (\$300,938.67) Dollars shall be allocated as follows:
 - (a) One Hundred Thousand Three Hundred Two and 85/100 (\$100,302.85) Dollars for attorney's fee and Three Thousand Eight Hundred Fifty Eight and 45/100 (\$3,858.45) Dollars for related litigation expenses and costs to Juliette B. Mims;
 - (b) One Hundred Ninety Six Thousand Seven Hundred Seventy Seven and 37/100 (\$196,777.37) Dollars to the Claimant in compromise settlement of disputed future lost earnings for a period of 20.90 years or 1,086.8 weeks, the life expectancy of the Claimant (DOB; 08/14/1952) at the rate of One Hundred Eighty One and 06/00 (\$181.06) Dollars per week, pursuant to §19-1-150 of the South Carolina Code of Law, as amended.

See *Utica-Mohawk vs. Orr*, 227 S.C. 226, 87 S.E.2d 589 (1955); *Sciarotta vs. Bowen*, 837 F.2d 135 (3rd Cir. 1988); *James v. Anne's Inc.*, 688 S.E.2d 562 (S.C. 2010); See also on remand: *Sciarotta vs. Secretary of H.H.S.*, 735 F. Supp. 148 (D.N.J. 1989).

CONCLUSIONS OF LAW

It is the conclusion of the Hearing Commissioner that the following and other sections of the South Carolina Code of Laws, 1976, as amended, apply in this case:

1. Section 42-1-130 defines "employee"; Section 42-1-120 defines disability; Section 42-1-360 defines "exempt businesses"; Section 42-9-10 defines "amount of compensation for total disability"; Section 42-1-100 defines "compensation"; Section 42-1-160 defines "injury" and "personal injury"; Section 42-15-60 governs medical care; and Commission Rules 67-601 through 67-615 set forth the contested case procedures.

Accordingly, as provided in the South Carolina Code of Laws, 1976, as amended, it is the determination of this Commissioner:

1. That under Section 42-1-60, the Carrier is authorized under Section 42-5-20 to insure.
2. That under Section 42-1-130, the Claimant was a covered employee at the time in question.
3. That under Section 42-1-140, the Defendant was a covered employer under the Act.
4. That under Section 42-9-30, the Claimant sustained injuries by accident arising out of and in the course of her employment resulting in an accidental injury.
5. That under Section 42-9-10, the Claimant is deemed permanently disabled.
6. That under Section 42-15-60, the Claimant is entitled to lifetime medical treatment for her work injuries.

ORDER

IT IS THEREFORE ORDERED ADJUDGED AND DECREED that Claimant is permanently and totally disabled and is entitled to Total Disability Compensation in the amount of 500 weeks. The insurance carrier previously paid 48 weeks of temporary total benefits through

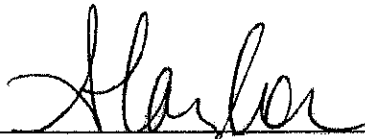
August 21, 2015; leaving 452 weeks to commute. The claimant is hereby awarded and shall be paid the commuted value of the remaining 452 weeks which equals Three Hundred Thousand Nine Hundred Thirty Eight and 67/100 (\$300,938.67) Dollars.

IT IS FURTHER ORDERED that the Employer is responsible for lifetime causally related medical expenses as outlined in the Findings hereinabove. This includes but is not necessarily limited to: her teeth, mandible, left shoulder, neck, facial nerve and depression. The depression was aggravated by her accident.

IT IS FURTHER ORDERED that Cherokee Insurance Company is and shall be the responsible carrier and shall provide coverage for the Employer with reference to this claim.

AND IT IS SO ORDERED.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION



Commissioner Aisha Taylor

CERTIFICATE OF SERVICE

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

May 23, 2017

By: Renee Smith, Administrative Assistant to Commissioner Taylor

permanently and totally disabled from a compensable injury that occurred on May 31 , 2012. For the reasons set forth below, we reverse and remand.

STATEMENT OF THE CASE

This claim arose out of an admitted injury to the Claimant, employed as tractor trailer driver for Defendant, Palmetto Transportation Company. On May 30, 2012, the claimant suffered compensable injuries after a machine fell on her causing injuries to her face and shoulder. Her injuries to her face included the removal of her remaining teeth and dental implant replacements, surgery to her upper and lower mandibles, and physical therapy for her shoulder.

The case went to a hearing on the Claimant's Form 50 on the issue of permanency. Per her Form 58, Claimant alleged, "head, neck, cognitive brain and traumatic brain dysfunction, jaw, teeth, soft tissue, nerves, left shoulder, chest, mid back and low back problems, breathing problems, depression and severe weight loss." Claimant alleged she was permanently and totally disabled due to fatigue which she contended was caused by malnutrition caused by injuries to her jaw and teeth. Defendants admitted that Claimant had suffered the loss of teeth, suffered an impairment to her jaw per the authorized treating physician's Form 14B, and suffered a 6% impairment to her shoulder.

In determining that Claimant was permanently and totally disabled, the Hearing Commissioner relied on the medical opinions of Dr. Ellis, the claimant's family physician, and Dr. Brabham, a psychiatrist who performed a one-time physiological and vocational evaluation of Claimant. The Hearing Commissioner determined that Claimant was entitled to lump-sum payment of the commuted value of five hundred weeks of benefits less any amount previously paid by Defendants in the form of temporary compensation. The Hearing Commissioner also found that pursuant to S.C. Code Ann. § 42-15-60, Claimant was entitled to lifetime benefits for

causally related medical expenses including, but not limited to lifetime repair, replacement and/or removal of any retained hardware and causally related medical treatment for her teeth, mandible, left shoulder, neck, facial nerve, and depression.

Defendants timely filed the Form 30, Request for Appeal, respectfully submitting the following errors of law:

1. That the Hearing Commissioner committed an error of law when she found the Claimant was permanently and totally disabled without requiring the Claimant to establish, by medical evidence stated to a reasonable degree of medical certainty, that Claimant's alleged fatigue, or any other alleged debilitating condition, in March 2016 was related to her work-related accident that occurred in May 2012.

2. That the Hearing Commissioner erred as a matter of law when she found that the testimony of Dr. Brabham supported the Claimant's position that she was permanently and totally disabled, as Dr. Brabham is not a medical doctor who was qualified to establish, to a reasonable degree of medical certainty, that Claimant's alleged fatigue in 2016 was causally related to her work-related injury suffered in May 2012.

3. That the Hearing Commissioner erred in finding the Claimant permanently and totally disabled because the Claimant failed to establish to a reasonable degree of medical certainty that any alleged symptoms she was having in March 2016 for which she took herself out of work were related to malnutrition which was related to her work-related injury.

4. That the Hearing Commissioner erred as a matter of law when she found that the report of Dr. Brabham supported the Claimant's position that she was permanently and totally disabled, as Dr. Brabham's report failed to meet the required standard for medically complex cases.

5. That the Hearing Commissioner erred as a matter of law in relying upon Dr. Brabham's report to support the conclusion that the Claimant was permanently and totally disabled, as Dr. Brabham's report contained erroneous information regarding the Claimant's ability to work—namely, Dr. Brabham reported that after her work related accident, the Claimant attempted to work for one week but was unable to continue when, in fact, the Claimant worked from November 2012 until March 2016 when she took herself out of work.

6. That the Hearing Commissioner erred as a matter of law in relying upon the records of Dr. Ellis to support the Claimant's position that she was permanently and totally disabled, as Dr. Ellis never establish in any form that the Claimant was permanently and totally disabled, as in fact, Dr. Ellis returned the Claimant to work after writing her a work excuse for several weeks, stating that there was no basis for the Claimant not to return to work.

7. That the Hearing Commissioner erred as a matter of law in relying upon Dr. Ellis in finding that the Claimant was permanently and totally disabled, as Dr. Ellis never causally related, to a reasonable degree of medical certainty, any of Claimant's medical conditions to her work-related accident, and to the contrary, stated that the Claimant's absence from work was not related to her work-related injury.

8. That the Hearing Commissioner erred in finding the Claimant permanently and totally disabled because the Claimant failed to establish to a reasonable degree of medical certainty that any alleged symptoms she was having in March 2016 for which she took herself out of work were related to malnutrition which was related to her work-related injury.

9. That the Hearing Commissioner erred as a matter of law when she found that Dr. Ellis' records supported the position that the Claimant was permanently and totally disabled,

as Dr. Ellis found no reason for Claimant to be out of work and wrote the Claimant back to work.

10. That the Hearing Commissioner erred as a matter of law in finding that the Claimant's weight loss/current weight alone would be sufficient to establish that the Claimant suffered malnourishment or fatigue resulting from the accident, when Claimant weighed less in 2013, 2014, and 2015, when she worked for three years as a CDL driver following her accident, and moreover, the Hearing Commissioner went beyond her qualifications and arrived at a medical conclusion that she was not qualified to make regarding the issue of the Claimant's weight when no other medical doctor testified that the Claimant suffered from malnourishment or fatigue that resulted in a permanent and total disability.

11. That the Hearing Commissioner erred as a matter of law in finding the Claimant permanently and totally disabled when Dr. Stacy Newsom opined that the Claimant could return to work on November 9, 2012, without restrictions, and Claimant did return to work without restrictions.

12. That the Hearing Commissioner erred as a matter of law in finding the Claimant permanently and totally disabled when the Claimant's dietary restrictions in 2016 were identical to the restrictions she had in 2012 and 2013 when she was released by her treating physicians to return to work and Claimant never had an alteration in those restrictions.

13. That the Hearing Commissioner erred as a matter of law in finding the Claimant permanently and totally disabled when Dr. Brian Svazas opined that the Claimant had suffered a 6% impairment to her shoulder and could attend physical therapy if desired,

though Claimant declined further physical therapy, but was otherwise able to return to work without restrictions.

14. That the Hearing Commissioner erred in finding that the Claimant was permanently and totally disabled because factually, there is no support for such a conclusion, and to the extent there are any facts, such facts fail to rise to the level of established beyond the preponderance of the evidence that the Claimant is permanently and totally disabled.

15. That the Hearing Commissioner erred in finding that there were sufficient facts to find the Claimant permanently and totally disabled, as such facts are not supported by the greater weight of the evidence;

16. That the Hearing Commissioner erred in finding that Dr. Brabham was credible in his opinions, as Dr. Brabham's report was factually erroneous in multiple regards and were not established by the evidence, including but not limited to the fact that Dr. Brabham stated that "to her credit, Ms. Cox tried to return to work, and actually drove a one week run. However, she was exhausted while doing so, and since that time, she has been unable to return to any gainful employment whatsoever, because of her on-the-job injuries on May 31, 2012." Dr. Brabham erroneously believe that Claimant had not worked in almost four years. Dr. Brabham's opinions were also erroneous in the following particulars: (1) that Claimant had lost 20 pounds since the accident; (2) in relying upon the Claimant's opinion for medical causation, nothing that in Claimant's opinion her weight loss was due to ongoing dental issues; (3) that Claimant had major problems falling asleep when, in fact, Claimant had been on insomnia medication for years, and before the accident; (4) he stated that due to her injury, she was unable to handle any type of work that would require her to maintain the same position for more than 30 minutes which was wholly erroneous in light of the fact the

Claimant drove tractor trailer trucks for 11 hours (or in 11 hour shifts) in 2013, 2014, 2015, and two months into 2016 without ever once calling in sick or declining to take a run.

17. That the Hearing Commissioner erred in relying upon Dr. Brabham's report to the extent he opined that she took Xanax because of the accident and that her injury was the cause of her current problems because Dr. Brabham only stated that "it was reasonable to conclude" the accident was the cause, which does not meet the most probably, to a reasonable degree of medical certainty standard which is required in this case and all medically complex cases.

18. That the Hearing Commissioner erred in finding the Claimant permanently and totally disabled, with such a conclusion unsupported by the facts, against the greater weight of the evidence, not supported by a preponderance of the evidence and such a conclusion constituted an abuse of discretion.

19. That the Hearing Commissioner erred in finding the Claimant permanently and totally disabled and failed to consider such facts which established otherwise the following facts, and the Hearing Commissioner erred in finding the Claimant credible, based upon the following facts which establish Claimant was not credible:

a. That the Claimant returned to work driving long distance, over-the-road trucking jobs from November 2012 until March 2016, when she voluntarily took herself out of work;

b. That at the time she took herself out of work, Claimant reported that she "hurt all over" and stopped showing up for work.

c. That prior to taking herself out of work in March 2016, Claimant never once turned down an assignment to drive, never took vacation or sick leave, and accepted

every driving offer given to her (her employment was not forced dispatch and Claimant was free to accept or turn down any job she wanted).

d. That in 2013, the Claimant earned \$57,602.75 in her employment as an OTR driver with Palmetto State Transport.

e. That in 2014, the Claimant earned \$75,464.77 in her employment as an OTR driver with Palmetto State Transport.

f. That in 2015, the Claimant earned \$63,693.25 in her employment as an OTR driver with Palmetto State Transport.

g. That the Claimant's dietary restrictions never changed from 2012 until 2016;

f. That Claimant did not receive or seek any additional physical therapy to her shoulder and still had the 6% rating to her shoulder from Dr. Svazas;

h. That although the Claimant lost the approximate 9-11 natural teeth she had at the time of the accident, the Claimant's lost teeth were replaced with dental implants, which allowed her to eat 85% solid good and 15% semi-solid food;

i. that the Claimant took herself out of work in March 2016 and was not taken out of work by Dr. Ellis, though Dr. Ellis later approved several weeks out of work after the fact, though Dr. Ellis later stated that she could not medically continue to write the Claimant out of work beyond May 2016;

j. that the Claimant did not lose 25 pounds as alleged, and in fact, at various times, weighed near the same after the accident as she did before the accident, and by December 2016, weighed more than she did at any time before her accident;

k. that the Claimant had a longstanding history of depression that was recorded long before this accident, and in fact, she admitted that her depression was related to the death of her grandson and not this accident, and at no time in the nearly give years between her accident and the Hearing did the Claimant ever request, seek, or receive any therapy related to her depression;

l. that to the extent Claimant had some depression, she was placed on an anti-depression by Dr. Ellis and within a matter of two months felt much better;

m. That the Claimant was already on anxiety and insomnia medications before this accident and that there is no evidence or medical testimony that the accident was the cause of her continuing to receive these prescriptions over the four years she continued to work;

n. That in October 2015, the Claimant went being a team driver on a dedicated route to being a single driver running various routes, but despite this change, the Claimant still did not turn down an assignment or try to work any reduced hours prior to her voluntarily ceasing her employment in March 2016;

o. That although Dr. Cofer opined that the Claimant had numbness in her jaw because of the accident, this numbness had been present since the accident and formed the basis of Dr. Cobb giving her a 2% impairment to the facial nerve, and thus was not a new finding or recent development that impacted her ability to work and there was no medical testimony causally related any of Claimant's alleged malnourishment or fatigue or "body aches" to her facial nerve;

p. That the Claimant returned to work on June 1, 2016, but walked off the job two weeks later, without a doctor's excuse and was not written out of work for this absence and to this day, has never been written out of work by a medical doctor;

q. That Dr. Ellis never opined that the Claimant was permanently and totally disabled;

r. That in completing her disability paperwork, Dr. Ellis specifically stated that the Claimant's ongoing medical problems were not related to her work-related injury;

s. That the Claimant's testimony that her employer was "not comfortable accepting the liability implications stemming from her symptoms" is not credible due to the fact that her Employer continued to offer her employment through her absence, did not terminate her from her employment, and in October 2016, specifically offered Claimant a job driving as a team driver after Claimant represented that driving as a single driver was part of her concerns, but despite this, Claimant did not return to work;

t. That although Claimant stated she worked two weeks in June 2016 "with constant pain over her entire body," not doctor found that these alleged pains were causally related to her accident in May 2012, and the records of Dr. Ellis do not reflect any such pains ever being documented;

u. And other facts as shown by the record and will be briefed at the appropriate time.

20. That the Hearing Commissioner erred in finding that the Employer "authorized work hardening" when the Employer, as a benevolent employer, arranged for work hardening based upon Claimant's assurances that she could return to work if allowed to participate in or complete a "full body" program.

21. That the Hearing Commissioner erred in finding the Claimant was unable to return to work due to pain, weakness, fatigue, and anxiety, when there was no medical evidence causally related an inability to return to work to such alleged medical conditions.

22. That the Hearing Commissioner erred in Finding of Fact #4, as neither Dr. Ellis nor Dr. Brabham testified that the Claimant suffered an aggravation or exacerbation of a pre-existing condition that was, to a reasonable degree of medical certainty, causally related to her accident in May 2012.

23. That the Hearing Commissioner erred in Finding of Fact #7, as there was no medical evidence to establish that the Claimant was permanently and totally disabled because of her accident in May 2012, no medical evidence Claimant was permanently disabled, and no medical evidence stated to a reasonable degree of medical certainty, thus constituting an error of law.

24. That the Hearing Commissioner erred in Finding of Fact #7 in finding that Dr. Brabham and/or the Claimant was credible, for the reasons set forth herein.

25. That the Hearing Commissioner erred in Finding of Fact #8 in finding that the Claimant was entitled to a lump sum, as the Hearing Commissioner failed to take into account the standard for awarding lump sum benefits as required by *Thompson v. Steel Erectors*, 369 S.C. 606 (Ct. App. 2006); moreover, the Hearing Commissioner erred in finding the Claimant was entitled to a lump sum, as the award in such a manner deprives the Defendants of their ability to establish that the Claimant underwent a change of condition for the better, depriving them of a statutory right.

26. That the Hearing Commissioner erred in Finding of Fact #9 in finding that the Claimant had suffered an aggravation of depression, as there was no medical evidence from a

qualified medical doctor, stated to a reasonable degree of medical certainty, establishing that the Claimant suffered an aggravation of depression causally related to her work-related accident of May 2012, and in finding the Claimant was entitled to future medical care for depression when Claimant had never asked for, sought, or received depression related to her accident. Moreover, there is no evidence that the Claimant's pre-existing depression was quiescent but rather was an ongoing issue and therefore such condition could not be compensable under South Carolina law and *Gordon v. E.I. Du Pont De Nemours Co.*, 228 S.C. 67, 76 (S.C. 1955), or at a minimum, expert testimony was required to establish causation.

27. That the Hearing Commissioner erred in Conclusion of Law #5, as said finding is not supported by the evidence and erroneous as a matter of law and fact for the grounds set forth herein.

28. That the Hearing Commissioner erred in Conclusion of Law #6, as said finding is not supported by the evidence and erroneous as a matter of law and fact for the grounds set forth herein.

29. That the Hearing Commissioner erred in failing to find that the Claimant suffered complete loss of earning capacity from her May 2012 injury, as is required to establish permanent and total disability; to the extent such a finding can be inferred, it is against the preponderance of the medical and lay evidence presented.

30. That the Hearing Commissioner erred in failing to find that the Claimant had an inability to perform services other than those so limited in quality, dependability, and quantity that a reasonable market for them did not exist, as is required to establish permanent

and total disability; to the extent such a finding can be inferred, it is against the preponderance of the medical and lay evidence presented.

31. That the Hearing Commissioner failed to properly place the burden of proof on the Claimant as is required under the Act, as the Claimant failed to show that she had made reasonable efforts to obtain employment and had failed because of an injury produced handicap.

32. Even assuming Claimant established that she was unable to be an OTR driver, the same of which is denied, the Claimant failed to establish by a preponderance of the evidence that she was unable to work in other suitable employment, as the medical and lay evidence establish she was capable of working.

EVIDENCE OF THE CASE

On May 31, 2012, the Claimant, while working in the course and scope of her employment as a tractor trailer driver for Palmetto State Transport, suffered injuries after a machine fell on her, knocking her to the ground. Because of the accident, the Claimant suffered injuries to her face and shoulder. Her injuries to her face included the removal of her remaining teeth (over time), surgery to her upper and lower mandibles, and the implantation of dental implants/dentures.

As to her left shoulder, Claimant was seen by Dr. Stacy Newsom. Claimant underwent an MRI of the shoulder which showed no physical injury and was deemed to be nonsurgical. Claimant started physical therapy with Proaxis Therapy on August 22, 2012, for her left shoulder pain.

On July 24, 2012, Claimant began treating with Dr. Larry W. Cobb at Piedmont Oral Surgery. Dr. Cobb determined that she needed an additional three months before attempting

restorative procedures. Dr. Cobb subsequently associated Dr. Ridgell with regard to the dental implants of the Claimant. It was later determined that she would need removal of her remaining natural teeth, bone grafting, and either one or both mandible plates had to be removed.

By November 9, 2012, the Claimant had completed physical therapy on her shoulder and was released to return to work by Dr. Newsom. (APA p. 285) The Claimant and her Employer both agreed that Claimant's position as a driver with Palmetto State did not require her to lift over 35 pounds because Palmetto State is a "no touch" freight hauler, i.e., the drivers do not have to load/unload the freight. With this understanding, Dr. Newsom released the Claimant to return to work at Palmetto State without restrictions. (APA p. 285). Dr. Newsom also found that Claimant had a 2% impairment to her left shoulder. (Id.)

On January 31, 2013, Claimant had her remaining 9 teeth removed. On April 29, 2013, the Claimant had 5 dental implants inserted. On July 7, 2013, Claimant had 6 dental implants. During this period, the Claimant continued to work as an over-the-road truck driver, except for when she was recovering for 4 to 6 weeks following each procedure. Both before and after the accident, the Claimant was driving as a team driver, and running a dedicated route from Greenville, South Carolina to Brownsville, Texas. While driving as a team driver, Claimant would still drive 10 hours straight before having her team driver relieve her, just as she would if she had been a solo driver. (H.T. 35-37).

On October 6, 2014, Claimant was seen by Dr. Brian Svazas for her shoulder. (APA p. 295). She complained that she had trouble reaching behind her and when driving her zero-clearance mower. (Id.) She stated that her range of motion and strength in the left arm were doing quite well. (Id.) She noted some soreness when driving long runs when she uses her left arm to steer and her right arm to flip switches. (Id.) She did not sleep on the left side but

otherwise had no difficulties with her left arm. (Id.) On exam, she could put her arm through full ranges of motion. She had no weakness in the arm. (Id.) She was pain free on supraspinatus and infraspinatus testing with no weakness with either maneuver. (Id.) She reported that the pain was alleviated with Tylenol. (Id.)

Dr. Svazas found that “the patient is functioning at 100%, as she has returned to her truck driver position and is thriving in this career.” (APA p. 296). He recommended physical therapy for her, which the claimant declined. (Id.) Dr. Svazas conclude by stating that she was fit for full duty as a truck driver that she was at MMI, he increased her rating to 6%. He completed a Form 14B on her finding that she could return to work without restrictions. (APA p. 300).

The Claimant continued to work full time as a driver for Palmetto State. Palmetto State is not a “forced dispatch” company—the Claimant was not required to take every run or job that was offered to her. (H.T. 55-57). She was free to turn down any runs she desired and work as much, or as little, as she wanted. (H.T. 55-57). She admitted it was rare she would be forced to move any freight. (H.T. p. 49). Despite this, she testified that she not only continued to work, but also took every run offered to her from 2012 until 2016. (H.T. 55-57).

On April 27, 2015, Dr. Cobb found the Claimant to be at MMI with the following impairment ratings: 4% interincisal range of Motion- 30mm, 3% lateral excursion range of motion 5-6mm, 2% facial disorder for a scar, 1% to the facial nerve. Her diet was to consist of 85% normal foods and 15% soft or semi-solid foods. (APA p. 301-302).

On July 5, 2015 Dr. Fowler performed surgery for removal of some of the hardware in her jaw. In August 2015, Dr. Fowler released her to return to work without restrictions.

Dr. Ridgell completed a Form 14B on the Claimant on April 9, 2015, and noted that she could return to work without restrictions. (APA p. 299).

In October 2015, Claimant went from “team driving” to single driving because the route she had run as a team driver was lost by Palmetto State and was no longer available. (H.T. 16:17-25; 35:16-23). Notwithstanding the preceding statements, on approximately March 3, 2016, the Claimant reported that she had “pain all over” and was unable to work. Claimant confirmed that she had suffered no new injury that caused her to suffer “pain all over.” Claimant later alleged that her pain came from fatigue which originated from malnourishment which came from her inability to eat the prescribed diet of 85% of a normal food and 15% semi-soft foods. She alleged her fatigue was all the result of her injury and loss of weight.

At the Hearing, the Claimant testified that she had lost a significant amount of weight and loss of energy due to the accident. (H.T. 23:1-21;24:10-21). She also claimed to suffer from fatigue and weight loss that was preventing her from being able to perform her job duties. (H.T. 33:11-24). Claimant acknowledged being treated for depression prior to this incident. (H.T. 27:23 – 28:5). On cross examination, the Claimant admitted her weight was not significantly lower than it had been prior to the accident and that she had gained weight during her physical therapy in 2016. (H.T. 33:25-34:25; 39:6 – 19; 40:17 – 24; 45:3 – 23; 46: 4 – 12).

Claimant acknowledged that she was released to full duty without restrictions in November 2012, and then periodically thereafter by various physicians associated with her care. (H.T. 35:4-9). Claimant acknowledged that upon her return to work, she returned to being a tandem driver and that she drove 10 hours per day per D.O.T. regulations, and that as a solo driver, her driving hours were the same. (H.T. 36:14 – 37:5) She also acknowledged that in the years after the accident, she earned nearly the same or slightly more money than prior to the accident. (H.T. 38:1 – 4; 16 – 25;39:1-4). Claimant also admitted that despite doing the same work she was doing prior to the accident, and being offered similar work through Palmetto

Transport, Claimant took herself out of work and refused to return. (H.T. 41:8 – 22; 48:12 – 17). Prior to taking herself out of work in 2016, Claimant never turned down a run and even did extra runs, despite the fact she could turn down any run she wanted. (H.T. 55:1 – 13; 56:1-3).

In 2013, the Claimant earned \$57,602.75, which was near her average income for a full year. (APA p. 372-375). In 2014, the Claimant earned \$75,464.77, above her normal average. (APA p. 372-375). In 2015, the Claimant earned \$63,693.25 with Palmetto State, which was in the normal range of what she had made over the course of her employment. (APA p. 326-339).

STANDARD OF REVIEW

The Full Commission is the ultimate fact finder in Workers' Compensation cases and is not bound by the Single Commissioner's findings of fact. See Ross v. American Red Cross, 298 S.C. 490, 381 S.E.2d 728 (1989); see also Hoxit v. Michelin Tire Corp., 304 S.C. 461, 405 S.E.2d 407 (1991) (Full Commission is fact finder).

The Full Commission is empowered to make its own findings of fact and to reach its own conclusions of law consistent or inconsistent with those of the Single Commissioner. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2d 162 (1992); see also Brayboy v. Clark Heating Co., 306 S.C. 56, 409 S.E.2d 767 (1991) (Full Commission may review award of Single Commissioner and make its own findings of fact and conclusions of law). The final determination of witness credibility and the weight to be accorded evidence is reserved to the Full Commission. Ross, 298 S.C. at 492, 381 S.E.2d at 730; Rogers v. Kunja Knitting Mills, Inc., 312 S.C. 377, 440 S.E.2d 401 (Ct. App. 1994).

Where there are conflicts in the evidence over a factual issue, the findings of the Full Commission shall be conclusive. Rogers, 312 S.C. at 380, 440 S.E.2d at 403; see also Stokes v. First Natl Bank, 306 S.C. 46, 410 S.E.2d 248 (1991) (regardless of a conflict in the evidence,

either of different witnesses or of the same witness, a finding of fact by the Commission is conclusive).

LAW/ANALYSIS

The Defendants argue that the Claimant failed to prove that she was permanently and totally disabled and that permanency in this case should have been awarded to the Claimant pursuant to South Carolina Code Section 42-9-30. We agree.

South Carolina Code Section 42-9-10 provides for permanent and total disability “when the incapacity for work resulting from an injury is total.” A claim can be pursued for permanent and total disability under this section when a claimant has suffered injury to more than one body under South Carolina Code section 42-9-30. When proceeding under Section 42-9-10, however, a claimant must establish his disability, as it is not presumed as it is under Section 42-9-30. See Brown v. Owen Steel Co., 316 S.C. 278, 280, 450 S.E.2d 57, 58 (Ct. App. 1994). “Disability” means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment. S.C. Code Ann. § 42-1-120.

The extent of disability is a question of fact to be proved as any other fact is proved. In Wynn v. Peoples Natural Gas Co. of S. C., 238 S.C. 1, 11–12, 118 S.E.2d 812, 817–18 (1961), our Supreme Court stated:

Disability in compensation cases is to be measured by loss of earning capacity. Total disability does not require complete helplessness.... The generally accepted test of total disability is inability to perform services other than those that are “so limited in quality, dependability, or quantity that a reasonably stable market for them does not exist.”

Wynn v. Peoples Natural Gas Co. of S. C., 238 S.C. at 11–12, 118 S.E.2d at 817–18 (1961). An award cannot rest on surmise, conjecture or speculation; it must be founded on evidence of

sufficient substance to afford a reasonable basis for it. Id. citing Revers v. V. P. Loftis Co., 214 S.C. 162, 51 S.E.2d 510.

If a claimant is attempting to establish causation of a medically complex condition, expert medical testimony is generally required. Brown v. La France Indus., 286 S.C. 319, 333 S.E.2d 348 (Ct. App. 1985); McLeod v. Piggly Wiggly Carolina Co., 280 S.C. 466, 313 S.E.2d 38 (Ct. App. 1984) (noting that depression was a medically complex issue). While the lack of medical causation may be overcome in some cases with competent evidence, The Appellate Panel is given discretion to weigh and consider all the evidence, both lay and expert, when deciding whether causation has been established. Ballenger v. S. Worsted Corp., 209 S.C. 463, 467, 40 S.E.2d 681, 685 (1946). McLeod provides the Appellate Panel with the ability to ascertain the proficiency of an expert and to decide whether a “higher degree of expertise” is needed regarding an award. Id. at 280 S.C. at 471, 313 S.E.2d at 41 (holding the award should be remanded for redetermination when an alleged defect and injury sustained by the claimant concerned a complicated area of the body requiring a higher degree of expertise than provided to the Appellate Panel).

As noted by the Supreme Court in Wynn v. Peoples Natural Gas Co. of S. C., 118 S.E.2d 812, 238 S.C. 1 (1961), “reliance on lay testimony and administrative expertise is not justified when the medical question is no longer an uncomplicated one and carries the fact-finders into realms which are properly within the province of medical experts.... The increasing tendency to accept awards unsupported by medical testimony should not be allowed to obscure the necessity of establishing medical causation by expert testimony in all but the simple and routine cases.” Id. citing Larson's Workmen's Compensation Law, Section 79.54. Moreover, the Court in Wynn

further rejected the exact same proposition advanced here: that a claimant's own statement that she is unable to work is sufficient to support an award of permanent and total disability. Id.

The underlying Order bases permanent and total disability on the Claimant's weight in 2016, her testimony she was fatigued and unable to work, and reliance upon Dr. Ellis and Dr. Brabham. Our review of the record, however, does not supporting a finding of permanent and total disability, factually or causally.

Claimant's allegations in this case were that she had become malnourished, that her malnourishment caused her to suffer fatigue, and that her fatigue rendered her to be permanently and totally disabled, while Defendants argued that Claimant (a) failed to present sufficient evidence to establish these facts and (b) provided no medical evidence to support her claim.

A review of the record reveals that the Claimant provided no medical testimony or evidence to support her allegations of malnourishment, resulting in fatigue, rendering her permanently and totally disabled. None of the authorized treating physicians placed any restrictions on Claimant's ability to work, let alone opined that the Claimant was totally and permanently disabled. To the contrary, the authorized treating physicians all opined that the Claimant could return to work full duty following her accident: (1) On November 9, 2012, Dr. Stacy Newsom stated she could return to work without restriction and gave her a 2% rating to the shoulder (APA p. 285); (2) Dr. Cobb rated the Claimant in April 2015 and stated that she could return to work without restriction. (APA p. 302); (3) Dr. Svazas increased her impairment rating to the left shoulder to 6%, but found "that she is fit for full duty as a truck driver"; (4) Dr. Ridgell noted on his Form 14B that the Claimant could return to work without restrictions in April 2015. (APA p. 299).

In addition, Claimant did not complain to any of these physicians that she was suffering malnourishment or fatigue or ever registered a complaint that she was unable to work. While certainly the Claimant reported some issues with numbness of her facial nerve and some loss of function that impacted her diet, these issues were present from the outset when Claimant returned to work from 2012 until 2016. Moreover, these issues are reflected in the impairment ratings she received from her authorized treating physicians.

The Hearing Commissioner's Order relied upon the records of Dr. Ellis to support the decision that claimant was permanently and totally disabled. Dr. Ellis' records show, however, that she was written back to work by Dr. Ellis. Dr. Ellis never opined that the Claimant was permanently and totally disabled or opined on issues of causation other than to state her issues were not causally-related to her accident, or at best, were multi-factorial.

On March 3, 2016, the Claimant reported to Dr. Ellis that she was becoming mentally and physically fatigued. This was the first report of fatigue reported by the Claimant to any doctor. Dr. Ellis continued to see the Claimant in March 2016, April 2016, and May 2016. On April 22, 2016, Dr. Ellis noted that she believed the Claimant's weight loss and fatigue was "multifactorial." However, Dr. Ellis never identified the factors she felt were contributing to the Claimant's current status. Dr. Ellis did not opine to a reasonable degree of medical certainty that the Claimant's current condition (1) was causally related to her injury or (2) that Claimant was unable to return to work.

By May 9, 2016, Claimant reported that her energy level was improving. Dr. Ellis stated that she was "unable to continue to recommend [Claimant] out of [work] without clear deadline. [A]grees would be reasonable to return to work if maintains currents (sic) level of weight." Thus, as of May 9, 2016, Dr. Ellis opined that the Claimant had no restrictions that prevented her

from returning to work. On May 23, 2016, it was noted that the Claimant weighed 109.6 pounds and Dr. Ellis wrote her back to work. Claimant did not return to see Dr. Ellis after this visit returning her to work.

Dr. Ellis also completed disability paperwork for Claimant. (APA p. 322). Dr. Ellis wrote that the Claimant's primary condition was fatigue and weakness and a secondary condition of weight loss. (Id.) Dr. Ellis indicated that she expected significant improvement in the Claimant's medical condition in 1-2 months with a return to work date of May 30, 2016. (Id.) Dr. Ellis further indicated that the Claimant had no permanent restrictions preventing her from returning to work. (Id.) Finally, Dr. Ellis wrote that the Claimant's condition was not due to an accident. (Id.)

Based upon our review of the record, we find that Dr. Ellis' records do not support a finding of permanent and total disability, and to the contrary, support the fact that the Claimant was cleared to work without restrictions in May 2016. Dr. Ellis' records further support that rather than Claimant being permanently and totally disabled, the condition from which she was suffering, even if it was causally related, was short-term and did not result in total disability.

The Hearing Commissioner also relied upon Dr. Brabham's report to support a finding of permanent and total disability, which the Defendants contend was erroneous. We agree.

Dr. Brabham's report documenting his understanding of the Claimant's work history following the accident is clearly erroneous. In reciting her post-accident work history, Dr. Brabham states "[t]o her credit, Ms. Cox tried to return to work, and actually drove a one-week 'run.' However, she was 'exhausted' while doing so, and since that time, she has been unable to return to any gainful employment whatsoever, as a result of her on-the-job injuries on 5-31-12." (APA p. 274). Nowhere else in his report does Dr. Brabham recite any facts or information that

would lead us to believe that he was aware she worked full-time from January 2013 through March 3, 2016 and earning those amounts that were around or above her normal income. This lack of knowledge of the Claimant's work history undermines Dr. Brabham's report and its conclusions and do not provide a basis for determining that the Claimant is permanently and totally disabled. Alternatively, Dr. Brabham's report is outcome determinative.

Additionally, Dr. Brabham is not a medical doctor who was qualified to establish to a reasonable degree of medical certainty that Claimant's alleged fatigue that developed in 2016 was causally related to her work-related injury suffered in May 2012, or that any alleged fatigue would have rendered her permanently and totally disabled. Although Dr. Brabham cites portions of medical notes from the Claimant's authorized treating physicians and her treatment history, he does not cite any medical records from Claimant's authorized treating physicians that indicate the claimant has restrictions, let alone was unable to work. All the treating physicians in this case indicate that the Claimant could return to work without restrictions; accordingly, Dr. Brabham's conclusion that she is permanently and totally disabled is not supported by the opinions of the treating physicians.

Finally, we note that Dr. Brabham's conclusions about the Claimant's inability to perform activity because she is "unable to sustain much activity, due to pain" and that she must recline 2-3 hours of her day, to be in conflict with the record in this case. Claimant's medical records do not support any such complaints, let alone to be so great as to render her unable to work. Dr. Ellis' records reveal no such complaints of pain. There is no evidence the Claimant sought out any treatment for complaints of pain. The Claimant was not prescribed medicine for pain. Claimant testified what shoulder pain she may have was alleviated by Tylenol and/or SalonPas patches, and in 2014, Claimant rejected an offer to return to physical therapy on her

shoulder per Dr. Svazas. Moreover, Dr. Brabham's report is inconsistent with Claimant's testimony that from 2013 to 2016, she drove 10-hour runs across country in 2014, 2015, and 2016, from Greenville, South Carolina to Brownsville, Texas. She drove this route nonstop, but for gas and food, starting her first run on a Monday and ending on a Wednesday and making a second run on Thursday and ending on a Saturday. (Cox 8/23/16 depo., p. 17).

Based upon a review of the record, the briefs, and the oral arguments of this matter, the Appellate Panel **REVERSES AND REMANDS** the Decision and Order of the Hearing Commissioner dated May 23, 2017. The Findings of Fact and Conclusions of Law set forth herein, and below, shall become, and hereby are, the law of the case.

FINDINGS OF FACT:

1. The Claimant did sustain compensable injuries to her teeth, mandible, left shoulder, and facial nerve, as well as scarring to her chin.
2. The Claimant received medical care under with Dr. Cobb, Dr. Ridgell, Dr. Fowler, Dr. Cofer, Dr. Newsom, and Dr. Svazas for her injuries.
3. Upon being released by each of the authorized treating physicians, the Claimant was released to work full duty with no restrictions on her ability to perform her duties as an over-the-road truck driver.
4. Following her accident, the Claimant returned to work in November 2012 and shortly thereafter resumed her normal job as an OTR truck driver.
5. Claimant continued to work full-time as an OTR in 2013, 2014, 2015, save for those periods of time when she was undergoing further care.

6. In March 2016, Claimant took herself out of work, stating she was tired and unable to work due to fatigue secondary to malnourishment that was alleged to have resulted from her injuries.
7. Claimant saw her family physician, Dr. Ellis, in March 2016 for her complaints.
8. While Dr. Ellis treated the Claimant for weight loss and reported fatigue, by May 9, 2016, Dr. Ellis reported that the Claimant could return to work as a OTR truck driver. Dr. Ellis reiterated that opinion on May 23, 2016.
9. Dr. Ellis further completed a disability application for the Claimant, which stated that the Claimant's weight loss and reported fatigue were temporary in nature, lasted one to two months, and were not related to her accident.
10. At no point did Dr. Ellis opine as to the causation of Claimant's complaints; nor did Dr. Ellis opine that these complaints resulted in any permanent disability or even restrictions on Claimant's ability to work.
11. Dr. Cobb, Dr. Ridgell, Dr. Fowler, Dr. Cofer, Dr. Newsom, and Dr. Svazas, the authorized treating physicians, all released the Claimant to return to work full duty over the course of their treatment of the Claimant.
12. Claimant admits that she took every run offered to her between 2012 and 2016 and did not turn down any jobs until March 2016.
13. Claimant admitted, and her records, revealed that her weight throughout her recovery period fluctuated and that by May 2016, Dr. Ellis opined, and the Claimant agreed, that her weight was sufficient for her to return to work.

14. Claimant admitted that she was offered a tandem job by her employer, which she believed would allow her to return to work, but she declined to take her employer up on that offer to drive as a team driver and declined to return to work.
15. The Claimant provided no medical evidence to support her contention that she suffered from malnourishment or fatigue causally related to her 2012 injury.
16. The Claimant provided no medical evidence establishing that she was on restrictions or was permanently and totally disabled secondary to malnourishment.

CONCLUSIONS OF LAW

1. That under S.C. Code Ann. § 42-3-20 and § 42-3-180 (1985), the Commission has jurisdiction over the parties to hear the issues in dispute.
2. That under S.C. Code Ann. § 42-1-130, the Claimant is a covered employee.
3. That under S.C. Code Ann. § 42-1-140, Palmetto Transportation Company is a covered employer.
4. That under S.C. Code Ann. § 42-1-150, there was an employer/employee relationship between the parties at the time in question.
5. That the burden of establishing total and permanent disability, or any benefit, is on the Claimant. Lee v. Bondex, Inc., 406 S.C. 97, 749 S.E.2d 155 (Ct. App. 2013).
6. That under S.C. Code Ann. § 42-9-10, Claimant failed to meet her burden of proving permanent and total disability and is not entitled to permanent and total disability award under S.C. Code Ann. § 42-9-10.
7. That as Claimant failed to prove that she was permanently and totally disabled, the Claimant is not entitled to a lump sum award of permanent and total disability. S.C. Code Ann. § 42-9-10.

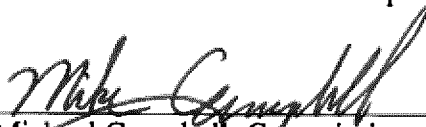
8. That the Claimant failed to establish by medical evidence, stated to a reasonable degree of medical certainty, that she suffered malnourishment resulting in fatigue or any alleged causal relationship to her May 30, 2012 accident. Brown v. La France Indus., 286 S.C. 319, 333 S.E.2d 348 (Ct. App. 1985); McLeod v. Piggly Wiggly Carolina Co., 280 S.C. 466, 313 S.E.2d 38 (Ct. App. 1984).
9. That the Claimant is not permanently and totally disabled as a result of her May 30, 2012, accident. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2d 162 (1992) (the Full Commission is empowered to make its own findings of fact and to reach its own conclusions of law consistent or inconsistent with those of the Single Commissioner); Brayboy v. Clark Heating Co., 306 S.C. 56, 409 S.E.2d 767 (1991) (Full Commission may review award of Single Commissioner and make its own findings of fact and conclusions of law).
10. That the Claimant is entitled to treatment for her work injuries pursuant to S.C. Code Ann. § 42-15-60 including lifetime repair, replacement and/or removal of any retained hardware.
11. That the Claimant shall be awarded compensation pursuant to S.C. Code Ann. § 42-9-30 and S.C. Reg. 67-1101 for any disability suffered as a result of her May 31, 2012 injury, as shall be determined by a Hearing Commissioner on remand.
12. This matter shall not be remanded to the Hearing Commissioner who heard this matter initially on February 2, 2017, but to another Commissioner.
13. The Claimant is not permanently and totally disabled.

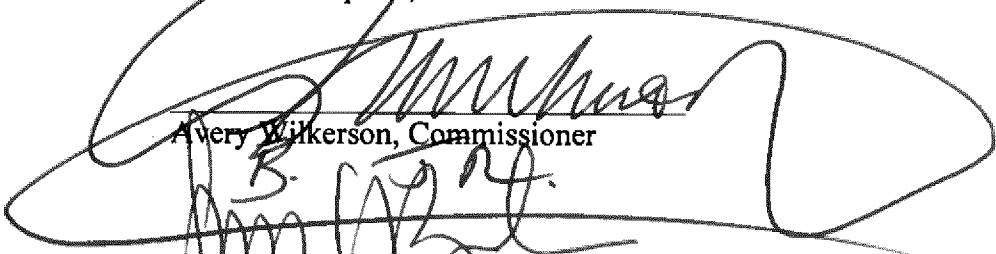
ORDER

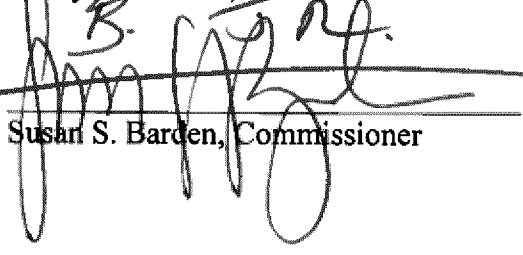
IT IS, THEREFORE, ORDERED that the Order of the Hearing Commissioner filed in the above-captioned matter on May 23, 2017, is hereby Reversed as to all Findings of Fact and Conclusions of Law related to the finding of permanent and total disability. Pursuant to this Order, a Hearing Commissioner should determine Claimant's permanency award for her compensable injuries sustained because of her May 31, 2012 injury, pursuant to this Order.

AND IT IS SO ORDERED.

South Carolina Workers' Compensation Commission


Michael Campbell, Commissioner


Avery Wilkerson, Commissioner


Susan S. Barden, Commissioner

CERTIFICATE OF SERVICE

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

By Eugenia on May 21, 2018

DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NUMBER 1206236

Jennie Cox, EMPLOYEE,

versus

Palmetto State Transportation, EMPLOYER

and

Cherokee Insurance Company, CARRIER

HEARING: Held on Tuesday, February 12, 2019 in Spartanburg, South Carolina

APPEARANCES: Claimant represented by Juliette B. Mims of The Mims Law Firm, 100 E. Poinsett Street, Greer, South Carolina 29651.

Defendants represented by George D. Gallagher of Speed, Seta, Martin, Trivett & Stublely, LLC, P.O. Box 11669, Columbia, SC 29211.

PURPOSE OF HEARING: Remand on issues as set forth by Full Commission Order.

DECISION AND ORDER BY: The Honorable T. Scott Beck

FILED: May 21, 2019

STIPULATIONS

Counsel for the parties stipulated to the following at the Hearing:

- 1) Jennie Cox (“Claimant”) sustained compensable facial, dental, and shoulder injuries arising out of and in the course of her employment as a truck driver for Palmetto State Transportation (“Palmetto”) on May 31, 2012. Palmetto’s carrier, Cherokee Insurance Company (“Cherokee”) accepted compensability of the claim and provided medical and compensation benefits in accordance with the Act. Therefore, the South Carolina Worker’s Compensation Commission (“Commission”) has jurisdiction to adjudicate all disputed issues presented in this claim.
- 2) The purpose of the current Hearing is to determine all issues pursuant to the Full Commission Appellate Panel’s (“Panel”) Order dated May 21, 2018. Specifically, the Panel REVERSED the Order of Commissioner Aisha Taylor awarding Claimant permanent and total disability under S.C. Code §42-9-10 and REMANDED the case to a jurisdictional commissioner for entry of an award of permanent partial disability benefits (“PPD”) for specifically enumerated scheduled members pursuant to S.C. Code §42-9-30 and WCC Regulation 67-1101.
- 3) Counsel for the parties received timely and proper Notice of the Hearing.
- 4) There is no objection to venue in Spartanburg County, South Carolina.
- 5) Claimant’s average weekly wage (“AWW”) and applicable compensation rate are \$1327.69 and \$725.47, respectively.
- 6) Defendants stipulate to remain financially responsible for causally related maintenance and replacement of all prosthetic devices and retained hardware Claimant possesses because of her injuries, including dental implants and the prosthetic devices to repair her broken jaw for the remainder of her lifetime per S.C. Code §42-15-60 (C), as well as physical therapy for the left shoulder, if necessary, per S.C. Code §42-15-60 (B).

APA SUBMISSIONS

Pursuant to the S.C. Administrative Procedures Act (“APA”) and WCC Regulation 67-612, the following medical records and other documentary evidence were admitted into the Record without objection for purposes of this Hearing:¹

-
1. ¹ Defendants objected to Claimant’s proposed submission of evidence generated after the original Hearing, specifically, an addendum from the Claimant’s vocational expert and medical records from providers with dates of service after the original Hearing. Defendants contend the undersigned Commissioner must render an award per the Panel’s remand instructions based on the existing Record at the time of the Panel’s decision. The objection was sustained. Robert Brabham’s report dated 7/16/2018 and records from Claimant’s primary care provider, Dr. Ellis, generated after the original Hearing were

<u>Provider</u>	<u>Dates</u>	<u>Pages</u>
Robert E. Brabham, Ph.D.	7/16/18	385-386
Jennifer T. Ellis, MD	5/9/16-8/2/18	408-447
Occupational Health	11/9/12-3/10/16	448-451
Piedmont Oral Surgery	1/31/13-4/30/15	452-459
Piedmont Oral Surgery Questionnaire	2/23/16	460
Center for Health & Occupational Services	10/6/14-6/29/15	461-464
Impairment Ratings-Form 14Bs	4/9/15-4/30/15	465-468
<u>Exhibits:</u>		
Full WCC Appellate Order	5/21/18	469-496
The Honorable Aisha Taylor, Commissioner	5/23/17	497-508

STATEMENT OF THE CASE

Pursuant to the Panel’s Order, the only issue before the undersigned is entry of a PPD award for the enumerated scheduled members. Specifically, the Panel sates, in pertinent part, on page 24 of its Order that it “**REVERSES AND REMANDS** the Decision and Order of the Hearing Commissioner dated May 23, 2017. The Findings of Fact and Conclusions of Law set forth herein, shall become, and hereby are, the law of the case.” The Panel further states in its Finding of Fact # 1 that “Claimant did sustain compensable injuries to her teeth, mandible, left shoulder, and facial nerve, as well as scarring to her chin.” Finally, the Panel ordered that a “Hearing Commissioner should determine Claimant’s permanency award for her compensable injuries sustained because of her May 31, 2012 injury pursuant to this Order.”

Despite this mandate, Claimant seeks additional relief not addressed by the Panel’s Order, specifically, an order for psychological evaluation and treatment. Defendants counter the Panel clearly

specifically excluded. However, Claimant’s counsel was granted leave to proffer additional evidence that was not part of the original Record. The undersigned Commissioner only considered relevant portions of the original Record necessary to comply with the Panel’s instructions that were resubmitted by the parties as APA Submissions for purposes of this Hearing.

reversed ALL the original Hearing Commissioner's findings, orders, and award, including her finding of a compensable psychological overlay injury. The Panel, as the ultimate fact finder, then found that the scope of Claimant's compensable injuries is limited to those enumerated in its Find of Fact # 1- teeth, mandible, left shoulder, facial nerve, and scarring to her chin. Therefore, Defendants urge that the undersigned has no authority to order further psychological evaluation/treatment. In reply, Claimant argues that the Panel did not make a specific finding denying compensability of Claimant's psychological injury; therefore, that issue remains unresolved and enables the undersigned to grant their requested relief.

EVIDENCE OF THE CASE

For the undersigned's convenience and to expedite a timely adjudication of the current action, the parties have agreed to resubmit only portions from the original Record relevant to the determination of issues in accordance with the Panel's remand instructions. The original Record contains voluminous medical records and materials that were relevant to the issues already decided by the Panel but not to the issues on remand. The Commission's file is also incorporated into the Record of this case and for the current action.

A. Claimant's Testimony

Claimant testified at the Hearing. She is currently 65 years old. She graduated from High School and attended a truck driving school to obtain her CDL. She has worked primarily as a truck driver since 1985. She worked for Palmetto based out of Greenville, SC for approximately 10 years. She previously worked briefly in the textile industry.

Claimant briefly described her accident, injuries, and subsequent course of treatment. Regarding the accident, Claimant explained she was unloading freight from her trailer at a facility in Georgia when a machine fell on top of her, knocked her to the floor of the loading dock where she struck her jaw and mouth, and pinned her underneath. Her primary injuries were a broken jaw and several missing teeth. She later was treated for shoulder pain. She was transported via EMS to an Emergency Room in Atlanta. After her condition was stabilized, she was transferred to the hospital in Greenville. She underwent surgery to repair a broken jaw and her mouth was wired shut for several weeks. She still has a prosthetic device/appliance in her jaw. She had a prominent laceration on her chin that required stitches.

Claimant acknowledged that she had several missing teeth prior to this accident but cannot recall the exact amount. Claimant thinks she lost 13 total teeth as a direct result of her accident- teeth either knocked out in the original accident and/or teeth later extracted to repair her jaw and treat her other dental injuries. Claimant recounted numerous residual issues related to her jaw and dental injuries, including the

following: difficulty with speech, difficulty chewing, and weight loss due to inability to eat all solid foods. The undersigned personally observed minor visible scarring on Claimant's chin.

Regarding her left shoulder injury, Claimant confirmed she did not undergo surgery and was only treated conservatively. She describes frequent residual pain, difficulty sleeping, limited overhead range of motion, and difficulty lifting. Claimant ultimately returned to work at full duty in November 2012. She last worked for Palmetto in 2016.

B. Medical Evidence

Following emergency treatment of her broken jaw, Claimant was treated in follow up by numerous medical providers with multiple specialties, including a plastic surgeon (Dr. Fowler); an oral surgeon (Dr. Cobb), a prosthodontist (Dr. Ridgell); and occupational medicine (Dr. Newsome and Dr. Svazas). Claimant has maxillary and mandibular appliances in her jaw that may require replacement or revision. (Defense APA p. 450). Regarding her shoulder, Dr. Newsome noted on 11/9/2012 that "she states she has had a lot of improvement. She is not having any pain and not requiring any pain medications. She states she is continuing her physical therapy exercises at home and feels able to return to work." (APA p. 448). On physical exam, Dr. Newsom found the following: full range of motion of bilateral upper extremities, mild weakness with external rotation of the left shoulder, internal rotation and supraspinatus testing within normal limits, and excellent grip strength. She was released to return to work without restriction.

Dr. Svazas saw Claimant for a reevaluation on 10/6/2014 (APA pp. 461-462). Claimant's subjective complaints and physical exam noted by Dr. Svazas essentially mirror Dr. Newsom's findings. Dr. Newsom states "I do find that the patient is functioning at 100%, as she has returned to her truck driver position and is thriving in this career."

After being released at maximum medical improvement ("MMI") by the authorized treating providers, Claimant was assigned the following impairment ratings: 2% to the left shoulder per Dr. Newsom dated 11/9/2012; 6% to the shoulder per Dr. Svazas dated 4/8/2015; 7% to the mandible per Dr. Cobb dated 4/30/2015; 2% facial nerve disorder per Dr. Cobb dated 4/30/2015; and 11 lost teeth as documented by Dr. Cobb at various times throughout his treatment notes. Claimant was also referred by his counsel for an orthopedic IME with Dr. Grady on July 25, 2016. Dr. Grady assigned a 28% rating to the left shoulder.

FINDINGS OF FACT

After hearing Claimant's testimony, review of all records relevant to the issues presented on remand, and consideration of able arguments from counsel for the parties, the undersigned hereby makes the following findings of fact in accordance with Panel's instructions:

- 1) The remand order specifically instructs me to determine permanency on the following compensable body parts specifically delineated in the Panel's order: teeth, mandible, left shoulder, facial nerve, and scarring to the chin.
- 2) Because I am constrained by the Panel's specific instructions to only enter an award for PPD to the enumerated body parts, I cannot order Defendants to provide Claimant with further psychological evaluation and treatment.
- 3) The Panel has at least implicitly found Claimant to be at MMI via their finding that an award of permanency is ripe for determination; therefore, I cannot order additional medical or psychological treatment to purportedly attain MMI. Again, Claimant has already been adjudicated to have reached MMI by the Panel and I cannot overrule the Panel since Full Commission is the ultimate fact finder in workers compensation matters under the applicable standard of review.
- 4) Likewise, I cannot order additional psychological evaluation or treatment as post-MMI palliative care per S.C. Code §42-15-60 (B) at this juncture when a) the Panel's Order does not empower me to do so; and b) the issue of whether the Panel intended to deny compensability of the alleged psychological claim in its 5/12/2018 Order requires further clarification.
- 5) Defendants have stipulated to responsibility for causally related replacement and maintenance of Claimant's dental implants and prosthetic appliances in her jaw for her lifetime and physical therapy for the left shoulder, if necessary.
- 6) Claimant could not pinpoint the number of teeth she lost secondary to this accident, and conceded she was missing teeth prior to her injury. The objective medical records confirm that Claimant had the following teeth extracted and/or replaced with implants following the accident: tooth #'s 3, 5, 6, 11, 12, 14, 20, 23, 25, 27 and 30. Claimant is therefore entitled to 22 weeks of compensation for these 11 lost teeth (2 weeks per tooth per Regulation 67-1101). An award for additional lost teeth would be based purely on speculation.
- 7) The undersigned observed a very faint scar in two locations on Claimant's chin for which she is awarded 1 week of compensation.
- 8) Regarding an award of compensation for injury to Claimant's facial nerve, WCC Regulation 67-1101 states such award shall be made in accordance with the AMA Guides to the Evaluation of Permanent Impairment. ("Guides"). The applicable sections of the Guides 13.4e and table 13-12.

Dr. Cobb assigned a 1% rating to the facial nerve, which corresponds to a Class I Impairment under the Guides. Claimant is hereby awarded 2 weeks of compensation for the facial nerve injury.

- 9) Claimant was assigned a 7% rating to the mandible by Dr. Cobb. Pursuant to WCC R. 67-1101 the minimum number of weeks of compensation due for a permanent mandibular injury is 25 weeks. Claimant's residual problems with chewing is clear evidence of a permanent injury. As such, she is hereby awarded 25 weeks of PPD benefits for her jaw injury.
- 10) Regarding PPD compensation for the left shoulder injury, the undersigned finds that Claimant has sustained a 15% specific loss of use the left shoulder and is therefore entitled to 45 weeks of compensation. The undersigned gives more weight to the opinions and ratings of Dr. Svazas than the rating from Dr. Grady.
- 11) Any Appeal to the Full Commission from this Decision and Order should be heard by the same Panel in order to clarify issues regarding the alleged psychological condition and any other issues not addressed in the remand instructions. All other issues, if any, not specifically addressed herein are only addressable by the Panel.

CONCLUSIONS OF LAW

The issues presented in the current action before the undersigned are governed by the following provisions of applicable law:

- 1) Under the South Carolina Workers Compensation Act the Full Commission Appellate Panel is the ultimate finder of fact and arbiter of the claim and is not bound by a single commissioner's findings of fact and conclusions of law. *See Ross v. American Red Cross*, 298 S.C. 490, 381 S.E.2d 728 (SC 1989). The Panel is empowered to make its own findings and conclusions consistent or inconsistent with those of the single commissioner. *McGuffin v. Schlumberger-Sangamo*, 307 S.C. 184, 414 S.E.2d 162 (SC 1992).
- 2) Upon review of a single commissioner's Order and award, the panel may "reconsider the evidence, receive further evidence, rehear the parties or their representatives and, if proper, amend the award." S.C. Code §42-17-50. Inherent in the Panel's jurisdiction to "amend the award" is the authority to delegate the matter to a single commissioner for further findings if it so chooses. *See S.C. Code §42-17-40* ("The commission or any of its members shall hear the parties at issue ... and shall determine the dispute in a summary manner.") However, the single commissioner is obviously bound by the duties delegated to him or her by the Panel, and the single commissioner may not rule on issues beyond the scope of the Panel's remand instructions.

- 3) MMI is the point at which, in the commission's opinion, no further medical treatment will tend to lessen the degree of claimant's impairment. O'Banner v. Westinghouse, 319 S.C. 24, 459 S.E.2d 324 (Ct. App. 1995). Once a claimant has been adjudged to have reached MMI, entitlement to permanent disability compensation is ripe for determination. See Curiel v. Environmental Management Systems, 655 S.E.2d 482 (Ct. App. 2007).
- 4) S.C. Code § 42-9-30 (14) governs the award of PPD compensation for loss of use of the shoulder up to a maximum of 300 weeks.
- 5) S.C. Code § 42-9-30 (23) governs proper and equitable compensation for visible scarring and disfigurement to members exposed in the workplace up to a maximum of 50 weeks.
- 6) WCC Regulation 67-1101 governs compensation for loss of other scheduled members and body parts not specifically enumerated in § 42-9-30, including the mandible, facial nerve, and teeth.
- 7) S.C. Code § 42-15-60 provides for maintenance and replacement of prosthetic devices and ongoing/future medical treatment.

ORDER AND AWARD

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that in accordance with the Panel's remand instructions, Claimant is entitled to the following weeks of permanent partial disability compensation at the stipulated compensation rate of \$725.47:

- a) 45 weeks of compensation (\$32,646.15) for 15% loss of use of the shoulder;
- b) 25 weeks of compensation (\$18,136.75) for injury to the mandible;
- c) 22 weeks of compensation (\$15,960.34) for loss of 11 teeth;
- d) 2 weeks of compensation (\$1450.94) for injury to the facial nerve; AND
- e) 1 week of compensation (\$725.47) for scarring/disfigurement to the chin.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Defendants shall tender this award of compensation to Claimant in a non-commuted lump sum per WCC Regulation 67-1605.

IT IS FINALLY ORDERED, ADJUDGED AND DECREED that Defendants shall be financially responsible for causally related maintenance and replacement, if necessary, of Claimant's prosthetic devices secondary to the accident and injuries referenced herein, specifically, the 11 dental implants and appliances in her jaw for her lifetime per S.C. Code §42-15-60 (C) , and physical therapy for the left shoulder, if necessary, per S.C. Code §42-15-60 (B).

IT IS SO ORDERED!



T. Scott Beck, Commissioner

CERTIFICATE OF SERVICE

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

May 21, 2019

By: Shawnee DeBruhl, Administrative Assistant to Commissioner Beck

Jennie Cox,
Employee,
vs.
Palmetto State Transportation,
Employer,
and
Cherokee Insurance Company,
Carrier,
Defendants

FULL COMMISSION APPELLATE
PANEL ORDER

August 19, 2019, in Columbia, South Carolina.

Claimant represented by Juliette B. Mims, Esquire and Henry J. Mims, Esquire of the Mims Law Firm and Adrienne Turner, Esquire of Columbia, South Carolina.

PANEL:

Commissioner Susan S. Barden, Chair
Commissioner Avery B. Wilkerson
Commissioner R. Michael Campbell

October 18, 2019

STATEMENT OF THE CASE

Jennie Cox ("Claimant") sustained compensable facial, dental, and shoulder injuries arising out of and in the course of her employment as a truck driver for Palmetto State Transportation ("Palmetto") on May 31, 2012. Specifically, Claimant was unloading freight from her trailer at a facility in Georgia when a machine fell on top of her, knocked her to the floor of the loading dock where she struck her jaw and mouth, and pinned her underneath. Her primary injuries were a broken jaw and several missing teeth for which she received emergency treatment and extensive follow up treatment with multiple dental and facial reconstruction specialists. She later developed shoulder pain, which was treated conservatively. Palmetto's carrier, Cherokee Insurance Company ("Cherokee") accepted compensability of the claim and provided medical and compensation benefits in accordance with the Act. Claimant was paid approximately 48 weeks of temporary total disability benefits (TTD) before ultimately returning to full duty work as a truck driver. She remained gainfully employed until June of 2016 when she resigned her employment, citing inability to continue working due to chronic pain, fatigue, and malnourishment.

This matter initially came before Commissioner Aisha Taylor for Hearing on February 2, 2017 pursuant to Forms 50 and 51. Claimant alleged entitlement to permanent and total disability benefits (PTD) under S.C. Code §42-9-10 secondary to her work injuries. Defendants disputed her PTD claim but acknowledged her entitlement to scheduled disability compensation under §42-9-30 and WCC R. 67-1101. By Order dated May 23, 2017 Commissioner Taylor found, *inter alia*, that Claimant's accident and injuries aggravated her preexisting depression and awarded her PTD. Defendants appealed Commissioner Taylor's findings and PTD award to the Full Commission Appellate Panel ("Panel"), citing numerous factual and legal errors.

By Order dated May 21, 2018 the Panel reversed Commissioner Taylor's entire Order and remanded the case to a jurisdictional commissioner for entry of an award of permanent partial disability benefits ("PPD") for specifically enumerated scheduled members pursuant to S.C. Code §42-9-30 and WCC Regulation 67-1101. Specifically, the Panel stated, in pertinent part, on page 24 of its Order that it "REVERSES AND REMANDS the Decision and Order of the Hearing Commissioner dated May 23, 2017. The Findings of Fact and Conclusions of Law set forth herein, shall become, and hereby are, the law of the case." The Panel further states in its Finding of Fact # 1 that "Claimant did sustain compensable injuries to her teeth, mandible, left shoulder, and facial

nerve, as well as scarring to her chin.” Finally, the Panel ordered that a “Hearing Commissioner should determine Claimant’s permanency award for her compensable injuries sustained because of her May 31, 2012 injury pursuant to this Order.”

This matter was then heard by Commissioner Scott Beck on February 12, 2019 pursuant to the Panel’s remand instructions. Despite the Panel’s clear mandate, Claimant sought additional relief not addressed by the Panel’s Order, specifically, an order for psychological evaluation and treatment. Defendants countered that the Panel clearly reversed ALL the original Hearing Commissioner’s findings, orders, and award, including her finding of a compensable psychological overlay injury. The Panel, as the ultimate fact finder, then found that the scope of Claimant’s compensable injuries was limited to those enumerated in its Finding of Fact # 1- teeth, mandible, left shoulder, facial nerve, and scarring to her chin. In reply, Claimant argued that the Panel did not make a specific finding denying compensability of Claimant’s psychological injury; therefore, that issue remains unresolved and enabled Commissioner Beck to grant their requested relief.¹

In addition, Claimant sought to introduce additional evidence generated after the original Hearing before Commissioner Taylor, specifically, an addendum from the Claimant’s vocational expert and medical records from providers with dates of service after the original Hearing. Defendants objected to these submissions, contending that Commissioner Beck must render an award per the Panel’s remand instructions based on the existing Record at the time of the Panel’s decision. The objection was sustained. Robert Brabham’s report dated 7/16/2018 and records from Claimant’s primary care provider, Dr. Ellis, generated after the original Hearing were specifically excluded. However, Claimant’s counsel was granted leave to proffer additional evidence that was not part of the original Record.

By Order dated May 21, 2019 Commissioner Beck awarded the following PPD compensation per the Panel’s remand instructions:

- a) 45 weeks of compensation (\$32,646.15) for 15% loss of use of the shoulder;

¹ Although not specifically referenced in the Panel’s remand instructions, S.C. Code §42-15-60 (B)(2) requires the Commission to determine a claimant’s entitlement to ongoing and/or reasonably anticipated future medical treatment along with any permanency award. Per this statutory mandate, Defendants stipulated at the Remand Hearing to provide lifetime repair, replacement, and/or removal of Claimant’s mandibular appliance and dental implants, as well as physical therapy for Claimant’s shoulder, if necessary. Commissioner Beck accepted the stipulation.

- b) 25 weeks of compensation (\$18,136.75) for injury to the mandible;
- c) 22 weeks of compensation (\$15,960.34) for loss of 11 teeth;
- d) 2 weeks of compensation (\$1450.94) for injury to the facial nerve; AND
- e) 1 week of compensation (\$725.47) for scarring/disfigurement to the chin.

Commissioner Beck denied Claimant's request for further psychological evaluation/treatment on grounds that such relief was not permitted by the Panel's Order, which specifically only instructed him to enter scheduled disability awards for the specifically delineated injured body parts. Commissioner Beck also reasoned that he could not order additional psychological evaluation/treatment because the Panel found, at least implicitly, that Claimant was at MMI by determining that entry of a permanency award was ripe. Finally, Commissioner Beck stated, "[a]ny Appeal to the Full Commission from this Decision and Order should be heard by the same Panel in order to clarify issues regarding the alleged psychological condition and any other issues not addressed in the remand instructions. All other issues, if any, not specifically addressed herein are only addressable by the Panel."

Claimant appealed Commissioner Beck's Order back to the Panel. Claimant raised numerous exceptions to the Order, but her grounds for appeal can essentially be consolidated as follows: 1) Commissioner Beck erred by denying her request for further psychological evaluation/treatment; 2) Commissioner Beck erred by excluding evidence from consideration at the remand Hearing that was not part of the existing Record; AND 3) Commissioner Beck erred in limiting his permanency award according to the Panel's instructions and by not finding her permanently and totally disabled.

STANDARD OF REVIEW

It is elementary that when an appellate tribunal remands a case, the lower tribunal has only the jurisdiction and authority mandated by the higher tribunal. Prince v. Beaufort Memorial Hospital, 392 S.C. 599, 709 S.E.2d 122 (Ct. App. 2011). Therefore, matters heard and decided by the higher tribunal cannot be reheard, reconsidered, or relitigated in the lower tribunal. Ackerman v. McMillan, 324 S.C. 440, 477 S.E.2d 267 (Ct. App. 1996). Under the South Carolina Workers Compensation Act, the Full Commission Appellate Panel is the ultimate finder of fact and arbiter of the claim and is not bound by a single commissioner's findings of fact and conclusions of law. See Ross v. American Red Cross, 298 S.C. 490, 381 S.E.2d 728 (SC 1989). The Panel is

empowered to make its own findings and conclusions consistent or inconsistent with those of the single commissioner. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2d 162 (SC 1992). Finally, upon review of a single commissioner's Order and award, the panel may "reconsider the evidence, receive further evidence, rehear the parties or their representatives and, if proper, amend the award." S.C. Code §42-17-50.

FINDINGS OF FACT

This matter was reheard by the Panel at the Review Hearing on August 19, 2019. After careful consideration of able arguments by counsel for the parties and review of the evidentiary Record and applicable law, the Panel concludes that Commissioner Beck's Order is legally and factually correct as stated and his Award is supported by the preponderance of the evidence in the record. As such, the Order is hereby **AFFIRMED WITH AMENDMENTS**. Specifically, the Panel makes the following Findings of Fact independent of Commissioner Beck's findings and conclusions:

- 1) Commissioner Beck properly followed this Panel's remand instructions to determine Claimant's entitlement to PPD compensation benefits for the following compensable body parts as found in the Panel's prior order: teeth, mandible, left shoulder, facial nerve, and scarring to the chin.
- 2) Because Commissioner Beck was constrained by the Panel's specific instructions to only enter an award for PPD to the enumerated body parts, he correctly concluded that he was not authorized to order Defendants to provide Claimant with further psychological evaluation and treatment.
- 3) In response to Commissioner Beck's prayer for clarification of the Panel's intentions regarding the alleged psychological claim, the Panel reiterates that Claimant's alleged psychological injury is DENIED, which was the express intent of the Panel when it REVERSED the Decision and Order of Commissioner Taylor dated May 23, 2017. This constitutes a complete reversal of Commissioner Taylor's findings regarding the alleged psychological injury.
- 4) To further clarify our original Order, the Panel also finds that Claimant has reached maximum medical improvement (MMI) for all compensable injuries stemming from her May 31, 2012 accident.

- 5) For these reasons, Commissioner Beck correctly declined Claimant's request for further psychological evaluation and treatment.
- 6) Commissioner Beck properly excluded and rejected consideration of evidence proffered by Claimant, including an addendum from the Claimant's vocational expert and medical records from providers with dates of service after the first Hearing in this matter. The Panel did not intend for the remand Hearing before Commissioner Beck to be *de novo*. As such, Commissioner Beck was proper in only considering relevant portions of the original Record necessary to comply with the Panel's instructions that were resubmitted by the parties as APA Submissions for purposes of the remand Hearing.
- 7) Moreover, the Panel did not consider Claimant's proffered evidence on the grounds that it is irrelevant to the issues currently before the Commission in light of the Panel's prior Order. Specifically, additional vocational evidence from Claimant's expert is not relevant to the issue of PPD compensation based on medical impairment and/or loss of use of the individual compensable injuries found. Likewise, evidence from Claimant's primary care provider generated after the original Hearing is not relevant because its probative value only goes to the alleged psychological injury, which as noted earlier, was found to be not compensable by the Panel.
- 8) Defendants stipulated to responsibility for causally related replacement and maintenance of Claimant's dental implants and prosthetic appliances in her jaw for her lifetime, as well as physical therapy for the left shoulder if necessary.
- 9) Claimant could not pinpoint the number of teeth she lost secondary to this accident, and conceded she was missing teeth prior to her injury. The objective medical records confirm that Claimant had the following teeth extracted and/or replaced with implants following the accident: tooth #'s 3, 5, 6, 11, 12, 14, 20, 23, 25, 27 and 30. Claimant is therefore entitled to 22 weeks of compensation for these 11 lost teeth (2 weeks per tooth per Regulation 67-1101). An award for additional lost teeth would be based purely on speculation.
- 10) Commissioner Beck noted on the record that he observed a very faint scar in two locations on Claimant's chin for which he awarded 1 week of compensation. There is no evidence in the Record indicating this award was insufficient.

- 11) Regarding Commissioner Beck's award of compensation for injury to Claimant's facial nerve, WCC Regulation 67-1101 states such award shall be made in accordance with the AMA Guides to the Evaluation of Permanent Impairment, ("Guides"). The applicable sections of the Guides 13.4e and table 13-12. Dr. Cobb assigned a 1% rating to the facial nerve, which corresponds to a Class I Impairment under the Guides. Therefore, the award of 2 weeks of compensation for the facial nerve injury is proper and supported by evidence in the Record.
- 12) Claimant was assigned a 7% rating to the mandible by Dr. Cobb. Pursuant to WCC R. 67-1101 the minimum number of weeks of compensation due for a permanent mandibular injury is 25 weeks. Claimant's residual problems with chewing is clear evidence of a permanent injury. As such, Commissioner Beck properly awarded 25 weeks of PPD benefits for Claimant's jaw injury.
- 13) Regarding PPD compensation for the left shoulder injury, the Panel finds that Claimant has sustained a 15% specific loss of use the left shoulder and is therefore entitled to 45 weeks of compensation. The Panel gives more weight to the opinions and ratings of Dr. Svazas as the authorized treating physician than the rating from Claimant's IME provider, Dr. Grady.

CONCLUSIONS OF LAW

The issues presented in the current action before the Panel are governed by the following provisions of applicable law:

- 1) Under the South Carolina Workers Compensation Act, the Full Commission Appellate Panel is the ultimate finder of fact and arbiter of the claim and is not bound by a single commissioner's findings of fact and conclusions of law. See Ross v. American Red Cross, 298 S.C. 490, 381 S.E.2d 728 (SC 1989). The Panel is empowered to make its own findings and conclusions consistent or inconsistent with those of the single commissioner. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2d 162 (SC 1992).
- 2) Upon review of a single commissioner's Order and award, the panel may "reconsider the evidence, receive further evidence, rehear the parties or their representatives and, if proper, amend the award." S.C. Code §42-17-50. Inherent in the Panel's jurisdiction to

"amend the award" is the authority to delegate the matter to a single commissioner for further findings if it so chooses. *See* S.C. Code §42-17-40 ("The commission or any of its members shall hear the parties at issue ... and shall determine the dispute in a summary manner.") However, the single commissioner is obviously bound by the duties delegated to him or her by the Panel, and the single commissioner may not rule on issues beyond the scope of the Panel's remand instructions.

- 3) MMI is the point at which, in the commission's opinion, no further medical treatment will tend to lessen the degree of claimant's impairment. O'Banner v. Westinghouse, 319 S.C. 24, 459 S.E.2d 324 (Ct. App. 1995). Once a claimant has been adjudged to have reached MMI, entitlement to permanent disability compensation is ripe for determination. *See* Curiel v. Environmental Management Systems, 655 S.E.2d 482 (Ct. App. 2007).
- 4) S.C. Code § 42-9-30 (14) governs the award of PPD compensation for loss of use of the shoulder up to a maximum of 300 weeks.
- 5) S.C. Code § 42-9-30 (23) governs proper and equitable compensation for visible scarring and disfigurement to members exposed in the workplace up to a maximum of 50 weeks.
- 6) WCC Regulation 67-1101 governs compensation for loss of other scheduled members and body parts not specifically enumerated in § 42-9-30, including the mandible, facial nerve, and teeth.
- 7) S.C. Code § 42-15-60 provides for maintenance and replacement of prosthetic devices and ongoing/future medical treatment.

ORDER AND AWARD

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Commissioner Becks' award of PPD benefits is hereby **AFFIRMED**. Specifically, Claimant is entitled to the following weeks of permanent partial disability compensation at the stipulated compensation rate of \$725.47:

- a) 45 weeks of compensation (\$32,646.15) for 15% loss of use of the shoulder;
- b) 25 weeks of compensation (\$18,136.75) for injury to the mandible;
- c) 22 weeks of compensation (\$15,960.34) for loss of 11 teeth;
- d) 2 weeks of compensation (\$1450.94) for injury to the facial nerve; AND

e) 1 week of compensation (\$725.47) for scarring/disfigurement to the chin.

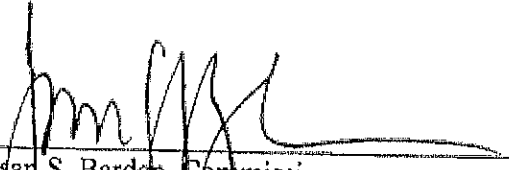
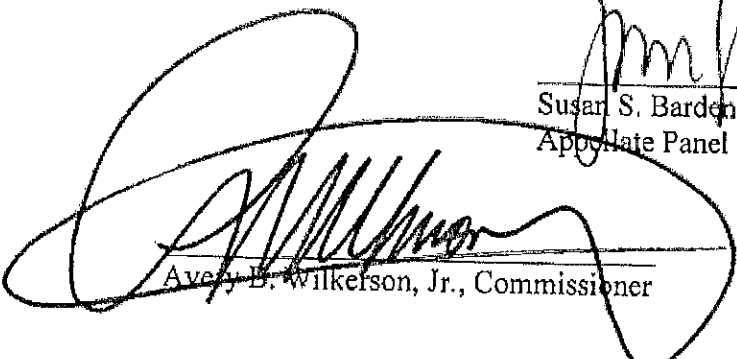
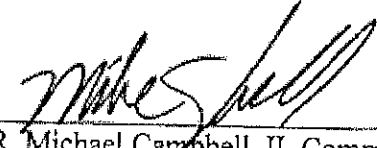
IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Defendants shall tender this award of compensation to Claimant in a non-commuted lump sum per WCC Regulation 67-1605.

IT IS FURTHER ORDERED ADJUDGED AND DECREED that Claimant's prayer for additional evaluation and treatment of her alleged psychological injury is hereby **DENIED**.

IT IS FINALLY ORDERED, ADJUDGED AND DECREED that Defendants shall be financially responsible for causally related maintenance and replacement, if necessary, of Claimant's prosthetic devices secondary to the accident and injuries referenced herein, specifically, the 11 dental implants and appliances in her jaw for her lifetime per S.C. Code §42-15-60 (C), and physical therapy for the left shoulder, if necessary, per S.C. Code §42-15-60 (B).

IT IS SO ORDERED!

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION


Susan S. Barden, Commissioner,
Appellate Panel Chair
Avery B. Wilkerson, Jr., Commissioner
R. Michael Campbell, II, Commissioner

CERTIFICATE OF SERVICE

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

By Eugenia Hollmon on October 18, 2019



Claimant's Name: Jennie Cox Employer's Name: Palmetto State Transportation
Address: 222 W. Chapman Road Address: 1050 Park West Blvd.
City: Belton State: SC Zip: 29627 City: Greenville State: SC Zip: 29611
Home Phone: (864) 243-0032 Work Phone: () - Carrier: Cherokee Insurance Company
Preparer's Name: Juliette B. Mims Preparer's Phone #: (864) 877-0463

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$1,327.69 2. AWW: \$725.47 Date of Injury: 05/31/12
3. Type of injury and body part(s): Head, neck, cognitive brain and traumatic brain dysfunction, jaw, teeth, soft tissue, nerves, left shoulder, chest, mid back, low back problems breathing, depression and severe weight loss
4. Facts in controversy: Claimant is at maximum medical improvement? To what extent is Claimant's permanent impairment? Whether Claimant is entitled to repayment of Temporary Total Disability?
5. Legal issues involved: Whether the Claimant has reached maximum medical improvement? Whether the Claimant is permanently disabled? Whether the Claimant is entitled to additional medical care? Whether Claimant is entitled to payment of Temporary Total Disability from March 3, 2016 through May 31, 2016 and June 14, 2016 to the present?
6. Unusual aspects: None
7. Witnesses (designate if expert):* Claimant
8. Exhibits: The Claimant's medical records. The Claimant reserves the right to offer additional evidence in response to any testimony or evidence by the Defendants in their Pre-Hearing Brief of APA Submissions.
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
See attached Notice of Witnesses and Medical Reports to be Introduced as Evidence on Behalf of the Claimant. Claimant reserves The right to add additional records upon receipt pursuant to Morgan v. JPS. Regulation 67-613.
10. Name, address, and specialty, if any, of the treating physician: James L. Fowler, III, M.D., GHS Plastic Surgery & Aesthetics, Greenville, SC
Larry Cobb, DMD, Piedmont Oral Surgery, PA, Greenville, SC; Jennifer T. Ellis, M.D., Hillcrest Family Practice, Simpsonville, SC; Donald L. Ridgell, DMD, Upstate Prosthodontics, Greenville, SC.
11. Impairment rating(s); body part(s); physician and date of opinion: Stacey Newsom, M.D., 2% left upper extremity on 11/09/12; Brian Svazas, M.D., 6% to left shoulder on 04/08/15; Donald Ridgell, M.D. medical opinion as to future medical care/maintenance on 04/09/15; Larry Cobb, DMD, 15%-diet limited to soft or semi solid foods- 85% of normal function, 4% interincisal range of Motion- 30mm, 3% lateral excursion range of motion 0 5-6mm, 2% facial disorder- scar, 1% nerve disorder- permanent numbness of lower lip and chin on left side, 25% whole person on 04/30/15; Walter Grady, DO, 17% left upper extremity, 28% to left shoulder impairment, 10% whole person on 07/25/16; and Robert E. Brabham, Ph.D. Psychological and Vocational Evaluation on 08/08/16.
12. I am amending my Form 50/51 in the following manner: N/A

☒ **Mediation**

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

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

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Robert E. Horner, Esquire Address Speed, Seta, Martin, Trivett & Stubley, PO Box 11669, Columbia, SC 29211 on the 5th day of December 2016, by:

☒ first class postage ☐ certified mail ☐ personal service ☒ electronic service

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

Signature: s/Juliette B. Mims Email: jbmims@themimslawfirm.com
Date of hearing: December 20, 2016 Time needed for hearing: 45 minutes

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

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206236

JENNIE COX,
Employee
Claimant,

vs.

PALMETTO STATE TRANSPORTATION,

Employer

AND

CHEROKEE INSURANCE COMPANY,

Carrier

Defendants.

**NOTICE OF WITNESS AND
WRITTEN MEDICAL REPORTS TO
BE INTRODUCED AS DIRECT
EVIDENCE ON BEHALF OF
OF CLAIMANT**

**TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
ROBERT HORNER, ESQUIRE, ATTORNEY FOR DEFENDANTS:**

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

	<u>NAME OF PROVIDER/OTHER</u>	<u>DATE(S) OF RECORD(S)</u>	<u>NUMBER OF PAGES</u>
APA #1	Grady Hospital	05/31/12	1-33
APA #2	American Medical Response of Georgia	05/31/12	34-39
APA #3	Greenville Memorial	06/01/12 & 06/02/12	40-42
APA #4	James Fowler, M.D. GHS Plastic Surgery & Aesthetics	06/01/12-10/12/15	43-70
APA #5	GHS Center for Health & Occupational Services	06/12/12-04/08/15	71-95
APA #6	Innervision MRI & Imaging	07/06/12 & 07/17/12	96-97
APA #7	Proaxis Therapy	08/21/12-11/29/12	98-181
APA #8	Jennifer T. Ellis, M.D. Hillcrest Family Practice	08/28/12-09/22/16	182-226
APA #9	Donald L. Ridgell, DMD Upstate Prosthodontics, LLC	10/04/12-10/28/15	227-235
APA #10	Larry W. Cobb, DMD Upstate Prosthodontics, LLC	10/30/12-10/27/16	236-265
APA #11	William A. Cofer, DMD	04/14/16	266
APA #12	Walter Grady, D.O	07/25/16	267-273
APA #13	Robert E. Brabham, Ph.D.	08/05/16	274-284

YOU ARE FURTHER NOTIFIED that you have the right of cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the depositions of any of the physicians whose reports submitted for the purposes of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Claimant/Employee.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Claimant/Employee: Jennie Cox

THE MIMS LAW FIRM

s/Juliette B. Mims
Juliette B. Mims
100 E. Poinsett Street
Greer, SC 29651-3404
(864)877-0463
ATTORNEY FOR CLAIMANT

Greer, South Carolina

December 5, 2016

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206236

JENNIE COX,
Employee
Claimant,

vs.

PALMETTO STATE
TRANSPORTATION,
Employer

AND

CHEROKEE INSURANCE COMPANY,
Carrier

Defendants.

APA SUBMISSIONS

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APA #12 Walter Grady, D.O.	267-273
APA #13 Robert E. Brabham, Ph.D.	274-284

APA #1
GRADY HOSPITAL
05/31/12



GRADY HOSPITAL
80 Jesse Hill Jr. Drive
Atlanta, GA 30303
ED Record

COX, JENNIE
MRN: 100071167
DOB: 8/14/1952, Sex: F
Adm: 5/31/2012, D/C: 5/31/2012

ED Arrival Information

Expected	Arrival	Acuity	Means of Arrival	Escorted By	Service	Admission Type
-	5/31/2012 15:35	Emergent	Grady Ambulance	Self	Emergency Medicine (Non- admitting)	Emergency

Chief Complaint

Fall [180198]

per EMS pt at work and piece of equipment fell on her and knocked her to the floor. c/o right rib, face, mid back pain

Diagnosis

Closed fracture of unspecified part of
ramus of mandible

ED Events

Date/Time	Event	User	Comments
05/31/12 1535	Patient arrived in ED	HARRIS, PAULINE	
05/31/12 1535	Patient expected in ED	HARRIS, PAULINE	
05/31/12 1535		HARRIS, PAULINE	
05/31/12 1535		HARRIS, PAULINE	
05/31/12 1538	Patient transferred	HEMMINGS, COLETTE	From room EDWR1 to room EDWR2
05/31/12 1544	Triage Completed	HEMMINGS, COLETTE	
05/31/12 1551	Patient roomed in ED	GRIFFIN, PEGGY	To room Trauma6
05/31/12 1554	Assign Nurse	PEDRO, OYINKANSOLA	PEDRO, O assigned as Registered Nurse
05/31/12 1603	Assign Mid-level	GARDNER, KEMBERLY	GARDNER, K assigned as Resident
05/31/12 1603	Assign Physician	GARDNER, KEMBERLY	
05/31/12 1604	Assign Attending	HUOT, CHAD	HUOT, C assigned as Attending
05/31/12 1604	Assign Physician	HUOT, CHAD	
05/31/12 1605	Lab Ordered	GARDNER, KEMBERLY	LIPASE-SERUM, URINALYSIS, COMPLETE, TYPE AND SCREEN ONLY, PT WITH INR ONLY, ETHANOL-SERUM, CHEM 8, METABOLIC PANEL, CBC, PLAT, WBC DIFF, APTT
05/31/12 1605	XR Ordered	GARDNER, KEMBERLY	XR CHEST PA OR AP, XR PELVIS LIMITED
05/31/12 1605	Imaging Exam Ordered	GARDNER, KEMBERLY	
05/31/12 1605	CT Ordered	GARDNER, KEMBERLY	CT HEAD WO CONTRAST, CT MAXILLOFACIAL WO CONTRAST
05/31/12 1605	Imaging Exam Ordered	GARDNER, KEMBERLY	
05/31/12 1606	Imaging Exam Started	BRAY, JENNIFER	
05/31/12 1606	Imaging Exam Started	BRAY, JENNIFER	
05/31/12 1618	Imaging Exam Ended	BRAY, JENNIFER	
05/31/12 1618	Imaging Exam Ended	BRAY, JENNIFER	
05/31/12 1621	CT Ordered	ELLIS, MELBA	CT BRAIN FACE WO CONTRAST
05/31/12 1621	Imaging Exam Ordered	ELLIS, MELBA	
05/31/12 1624	CT Ordered	GARDNER, KEMBERLY	CT CHEST W CONTRAST, CT CERVICAL SPINE WO CONTRAST
05/31/12 1624	Imaging Exam Ordered	GARDNER, KEMBERLY	
05/31/12 1624	Imaging Preliminary	EDI, RAD RESULTS IN	



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ED Record

COX, JENNIE
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ED Events

Date/Time	Event	User	Comments
	Result		
05/31/12 1624	XRay Preliminary Result	EDI, RAD RESULTS IN	(Preliminary result) XR CHEST PA OR AP
05/31/12 1626	CT Ordered	ELLIS, MELBA	CT BRAIN C SPINE FACE WO CONTRAST
05/31/12 1626	Imaging Exam Ordered	ELLIS, MELBA	
05/31/12 1626	Imaging Preliminary Result	EDI, RAD RESULTS IN	
05/31/12 1626	XRay Preliminary Result	EDI, RAD RESULTS IN	(Preliminary result) XR PELVIS LIMITED
05/31/12 1635	Xray Final Result	EDI, RAD RESULTS IN	(Final result) XR CHEST PA OR AP
05/31/12 1635	Xray Final Result	EDI, RAD RESULTS IN	(Final result) XR PELVIS LIMITED
05/31/12 1657	Lab Resulted	EDI, LAB IN HLSEVEN	(Final result) CHEM 8, METABOLIC PANEL
05/31/12 1657	Lab Resulted	EDI, LAB IN HLSEVEN	(Final result) LIPASE-SERUM
05/31/12 1705	Lab Resulted	EDI, LAB IN HLSEVEN	(Final result) ETHANOL-SERUM
05/31/12 1705	Lab Resulted	EDI, LAB IN HLSEVEN	(Final result) LIPASE-SERUM
05/31/12 1705	Lab Resulted	EDI, LAB IN HLSEVEN	(Final result) CHEM 8, METABOLIC PANEL
05/31/12 1706	Lab Resulted	EDI, LAB IN HLSEVEN	(Final result) CBC, PLAT, WBC DIFF
05/31/12 1711	Imaging Exam Started	ELLIS, MELBA	
05/31/12 1711	Imaging Exam Started	ELLIS, MELBA	
05/31/12 1727	Imaging Exam Ended	ELLIS, MELBA	
05/31/12 1728	Imaging Exam Ended	ELLIS, MELBA	
05/31/12 1728	Lab Resulted	EDI, LAB IN HLSEVEN	(Preliminary result) PT WITH INR ONLY
05/31/12 1731	Lab Resulted	EDI, LAB IN HLSEVEN	(Final result) PT WITH INR ONLY
05/31/12 1731	Lab Resulted	EDI, LAB IN HLSEVEN	(Final result) APTT
05/31/12 1738	Registration Completed	HARRIS, PAULINE	
05/31/12 1932	Lab Resulted	EDI, LAB IN HLSEVEN	(Final result) TYPE AND SCREEN ONLY
05/31/12 1944	Assign Nurse	PEDRO, OYINKANSOLA	FELIZ-GUILLEN, L assigned as Registered Nurse
05/31/12 1944	Remove Nurse	PEDRO, OYINKANSOLA	PEDRO, O removed as Registered Nurse
05/31/12 2220	Transfer Disposition Selected	GARDNER, KEMBERLY	ED Disposition set to Transfer to Another Facility
05/31/12 2220	Disposition Selected	GARDNER, KEMBERLY	
05/31/12 2235	Charting Complete	HUOT, CHAD	
05/31/12 2235	Physician LOS Filed	HUOT, CHAD	LOS Code 99285 filed
05/31/12 2240	Patient transferred to OTF	KALOZ, CHRISTY	
05/31/12 2240	Patient transferred	KALOZ, CHRISTY	From room Trauma6 to room OTF1
05/31/12 2308	Remove Nurse	FELIZ-GUILLEN, LOIDA	FELIZ-GUILLEN, L removed as Registered Nurse
05/31/12 2308	Patient discharged	PROFFITT, WINDY	
05/31/12 2308	Patient departed from ED	PROFFITT, WINDY	
05/31/12 2309	Team Member Removed	GARDNER, KEMBERLY	GARDNER, K removed as Resident
06/01/12 0000	ED Census	TABER, JOSHUA	
06/01/12 0902	Remove Attending	TABER, JOSHUA	HUOT, C removed as Attending
06/01/12 1138	Imaging Preliminary Result	EDI, RAD RESULTS IN	



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COX, JENNIE
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DOB: 8/14/1952, Sex: F
Adm: 5/31/2012, D/C: 5/31/2012

ED Events

Date/Time	Event	User	Comments
06/01/12 1138	CT Preliminary Result	EDI, RAD RESULTS IN	(Preliminary result) CT CHEST W CONTRAST
06/01/12 1408	CT Final Result	EDI, RAD RESULTS IN	(Final result) CT CHEST W CONTRAST
06/01/12 1808	Imaging Preliminary Result	EDI, RAD RESULTS IN	
06/01/12 1808	CT Preliminary Result	EDI, RAD RESULTS IN	(Preliminary result) CT BRAIN C SPINE FACE WO CONTRAST
06/01/12 1832	CT Final Result	EDI, RAD RESULTS IN	(Final result) CT BRAIN C SPINE FACE WO CONTRAST
06/02/12 1847		PROFFITT, WINDY	
05/31/12 1605		GARDNER, KEMBERLY	
05/31/12 1624		GARDNER, KEMBERLY	

ED Treatment Team

Provider	Role	From	To	Phone	Pager
Huot, Chad P., MD	Attending Provider	05/31/12 1604	06/01/12 0902	404-778-2624	
Pedro, Oyinkansola, RN	Registered Nurse	05/31/12 1554	05/31/12 1944		
Gardner, Kimberly R., MD	Resident	05/31/12 1603	05/31/12 2309	404-616-5800	PIC 18552
Feliz-Guillen, Loida, RN (Inactive)	Registered Nurse	05/31/12 1944	05/31/12 2308		

Discharge Orders

None

ED Notes

ED Notes by Pedro, Oyinkansola, RN at 5/31/2012 4:52 PM

Version 1 of 1

Author: Pedro, Oyinkansola, RN Service: (none) Author Type: Registered Nurse
Filed: 5/31/2012 4:54 PM Note Time: 5/31/2012 4:52 PM Status: Signed
Editor: Pedro, Oyinkansola, RN (Registered Nurse)
59 y/o female to ED s/p GLF on face. -LOC. Alert and Oriented x 4. Breathing even and non-labored. C-collar intact. Pt reports a machine fell on her back and caused her to fall on the floor face first. Bleeding in controlled. Cardiac monitor in place. Awaiting CT. Will continue to monitor.

Signed by Pedro, Oyinkansola, RN on 5/31/2012 4:54 PM

ED Notes by Feliz-Guillen, Loida at 5/31/2012 7:53 PM

Version 1 of 1

Author: Feliz-Guillen, Loida Service: (none) Author Type: Registered Nurse
Filed: 5/31/2012 7:54 PM Note Time: 5/31/2012 7:53 PM Status: Signed
Editor: Feliz-Guillen, Loida
ENT consult MD Calligas at bedside for Chin LAC repair.

Signed by Feliz-Guillen, Loida on 5/31/2012 7:54 PM

ED Notes by Feliz-Guillen, Loida at 5/31/2012 8:00 PM

Version 1 of 1

Author: Feliz-Guillen, Loida Service: (none) Author Type: Registered Nurse
Filed: 5/31/2012 8:00 PM Note Time: 5/31/2012 8:00 PM Status: Signed
Editor: Feliz-Guillen, Loida
Family at bedside.



GRADY HOSPITAL
80 Jesse Hill Jr. Drive
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ED Record

COX, JENNIE
MRN: 100071167
DOB: 8/14/1952, Sex: F
Adm: 5/31/2012, D/C: 5/31/2012

ED Notes (continued)

ED Notes by Feliz-Guillen, Loida at 5/31/2012 8:00 PM

Version 1 of 1

Signed by Feliz-Guillen, Loida on 5/31/2012 8:00 PM

ED Notes by Feliz-Guillen, Loida at 5/31/2012 7:35 PM

Version 1 of 1

Author: Feliz-Guillen, Loida

Service: (none)

Author Type: Registered Nurse

Filed: 5/31/2012 8:08 PM

Note Time: 5/31/2012 7:35 PM

Status: Signed

Editor: Feliz-Guillen, Loida

Initial contact with patient, care assumed with patient lying supine on stretcher alert and oriented with family at bedside, patient is missing some upper and lower teeth, patient await's ENT consult for dispo. Patient voices no complaints at this time. RN will continue to monitor for changes.

Signed by Feliz-Guillen, Loida on 5/31/2012 8:08 PM

ED Notes by Dorsett, Tamiko, MSW at 5/31/2012 9:36 PM

Version 1 of 1

Author: Dorsett, Tamiko, MSW

Service: (none)

Author Type: Social Worker

Filed: 5/31/2012 9:49 PM

Note Time: 5/31/2012 9:36 PM

Status: Signed

Editor: Dorsett, Tamiko, MSW (Social Worker)

Social Services was requested by Dr. Huot to assist patient and family with transportation for a transfer to Greenville, South Carolina. Social worker provided the family with a list of transportation providers. Patient's family was able to schedule transportation with AMR. Social worker informed Dr. Huot of the transportation arrangements made by patient's family. Social Services will assist further as needed.

Signed by Dorsett, Tamiko, MSW on 5/31/2012 9:49 PM

ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM

Version 1 of 1

Author: Gardner, Kimberly R., MD

Service: (none)

Author Type: Resident

Filed: 5/31/2012 10:21 PM

Note Time: 5/31/2012 4:33 PM

Status: Signed

Editor: Gardner, Kimberly R., MD (Resident)

Related Notes: Continued by Huot, Chait P., MD (Physician) filed at 5/31/2012 10:35 PM

EMERGENCY MEDICINE PROVIDER NOTE

Chief Complaint

Patient presents with

- Fall

per EMS pt at work and piece of equipment fell on her and knocked her to the floor. c/o right rib, face, mid back pain

HISTORY OF PRESENT ILLNESS

HPI Comments: 59 yo female presents after fall. Patient unloading a truck at a loading dock. States a heavy piece of equipment (~200lbs) fell and hit her in the back. Largest point of impact between shoulder blades- per patient. Patient states she was pinned beneath the equipment. Did hit her chin and teeth. Now presents complaining of mouth pain, left shoulder and scapula pain and right sided lower rib pain. Denies any abdominal pain. No LOC.

Patient is a 59 y.o. female presenting with trauma and fall. The history is provided by the patient.

Trauma

ED Notes (continued)**ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM**

Version 1 of 1

The incident occurred just prior to arrival. There has been chest pain and difficulty breathing. There has been no fever, no abdominal pain, no diarrhea, no vomiting, no headaches and no cough. There were no sick contacts. She has received no recent medical care.

Fall

The accident occurred less than 1 hour ago. The fall occurred while standing. She fell from a height of 3 to 5 ft. She landed on a hard floor. The volume of blood lost was minimal. Point of impact: chin/face. The pain is moderate. She was not ambulatory at the scene. There was entrapment after the fall. There was no drug use involved in the accident. There was no alcohol use involved in the accident. Pertinent negatives include no fever, no abdominal pain, no vomiting and no headaches. Treatment on scene includes a c-collar and a backboard. She has tried nothing for the symptoms.

PAST MEDICAL HISTORY

The information below is populated from the nursing note but has been reviewed by the provider. Discrepancies will be noted in the HPI above

History reviewed. No pertinent past medical history.

History reviewed. No pertinent past surgical history.

No family history on file.

History**Social History**

- Marital Status: N/A
- Spouse Name: N/A
- Number of Children: N/A
- Years of Education: N/A

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: None
- Alcohol Use: No
- Drug Use: No
- Sexually Active:

Other Topics**Concern**

- None

Social History Narrative

- None

SBIRT

Information below is populated from nursing, Right-click refreshes data

Tobacco: Yes

Women: Drinks: 0 (never)

Drugs: No

REVIEW OF SYSTEMS**Review of Systems**

ED Notes (continued)**ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM**

Version 1 of 1

Constitutional: Negative for fever and chills.
Respiratory: Negative for cough.
Cardiovascular: Positive for chest pain.
Gastrointestinal: Negative for vomiting, abdominal pain and diarrhea.
Musculoskeletal: Positive for back pain, joint swelling and arthralgias.
Skin: Positive for wound.
Neurological: Negative for dizziness, speech difficulty, weakness and headaches.
Psychiatric/Behavioral: Negative for confusion and agitation.
All other systems reviewed and are negative

Initial Vital Signs

Temp: 35.7 °C (96.3 °F)
Heart Rate: 85
Resp: 20
BP: 105/64 mmHg
SpO2: 98 %

PHYSICAL EXAM**Physical Exam**

vitals reviewed.

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.
No distress. Cervical collar and backboard in place.

A- intact**B- equal bilaterally****C- 2+ radial/2+DP pulses****D- pupils 3mm reactive, GCS 15****HENT:**

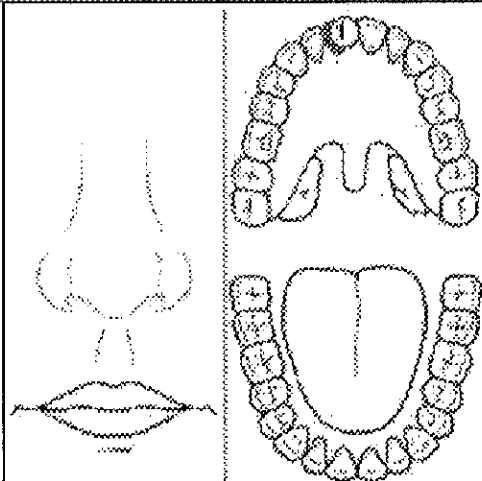
Head: Atraumatic.

Mouth/Throat: Oropharynx is clear and moist. Abnormal dentition.

ED Notes (continued)

ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM

Version 1 of 1



1: impacted tooth

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Neck supple.

Cardiovascular: Normal rate and regular rhythm.

Pulmonary/Chest: Effort normal and breath sounds normal.

Abdominal: Soft. She exhibits no distension. There is no tenderness. There is no rebound and no guarding.

Musculoskeletal: She exhibits no edema.

Neurological: She is alert and oriented to person, place, and time. She has normal strength. No cranial nerve deficit.

Skin: Skin is warm and dry. Laceration noted.

2cm laceration to chin

Procedures

Information below is documented by providers, but will be empty if no procedures were performed

Procedures

EM Work-up

MDM

Number of Diagnoses or Management Options

Diagnosis management comments: 59 yo female presents after fall secondary to heavy equipment landing on her.

- Primary survey intact
- Secondary survey significant for impacted tooth and chin lac
- FAST negative
- CXR and pelvis XR
- CT head and face
- cbc, chem, ua, lipase, pt/inr

4:49 PM

Patient without midline ttp on clearance of backboard. However patient continues to complain of left



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ED Notes (continued)

ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM

Version 1 of 1

shoulder pain- will also CT chest. EKG with old anterior Q waves. Otherwise unremarkable.

MEDICAL DECISION MAKING

NARRATIVE:

CT head negative. CT face- communitied fracture of the mandible. Primarily left symphaseal. Extends bilaterally- left angle of the mandible, bilateral ramus. Right greater wing of sphenoid. No cspine fracture. CT chest- nothing acute - emphysema. No fractures. No PTX.

7:24 PM

Patient clinically cleared from c-collar. ENT at bedside to evaluate for facial fractures and laceration repair.

10:20 PM

Patient wishes to be transferred to another facility. Accepted by trauma surgeon in Greenville, SC. Transport at bedside. Will transfer now.

DISPOSITION

Most Recent Vitals

Right-click to refresh data below for latest vital signs

Temp: 35.7 °C (96.3 °F)

Heart Rate: 73

Resp: 19

BP: 150/84 mmHg

SpO2: 99 %

Diagnosis(es):

1. Mandible fracture

Condition:

unchanged

Disposition:

Transfer to Other Facility

Provider: Kimberly R. Gardner, MD

Supervision: Initial plan discussed with Dr Huot

Gardner, Kimberly R., MD

Resident

05/31/12 2221

Huot, Chad P., MD

05/31/12 2235



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ED Notes (continued)

ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM

Version 1 of 1

Signed by Gardner, Kimberly R., MD on 5/31/2012 10:21 PM

ED Provider Notes by Huot, Chad P., MD at 5/31/2012 4:33 PM

Version 1 of 1

Author: Huot, Chad P., MD

Service: Emergency Medicine
(Non-admitting)

Author Type: Physician

Filed: 5/31/2012 10:35 PM

Note Time: 5/31/2012 4:33 PM

Status: Signed

Editor: Huot, Chad P., MD (Physician)

Related Notes: Related Note by Gardner, Kimberly R., MD (Resident) filed at 5/31/2012 10:21 PM

Chad P. Huot, MD I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note.

Huot, Chad P., MD
05/31/12 2235

Signed by Huot, Chad P., MD on 5/31/2012 10:35 PM

ED Orders

Start		Status	Ordering Provider
05/31/12 2230	fentaNYL (SUBLIMAZE) 0.05 mg/mL injection 50 mcg ONCE	Last MAR action: Given - by FELIZ-GUILLEN, LOIDA on 05/31/12 at 2220	GARDNER, KIMBERLY R.
05/31/12 2100	clindamycin (cleocin) 900 mg/50 mL D5W IVPB 900 mg ONCE	Last MAR action: Given - by FELIZ-GUILLEN, LOIDA on 05/31/12 at 2045	GARDNER, KIMBERLY R.
05/31/12 1930	lidocaine-EPINEphrine 1 %-1:100000 injection 10 mL ONCE	Last MAR action: Given - by FELIZ-GUILLEN, LOIDA on 05/31/12 at 1955	GARDNER, KIMBERLY R.
05/31/12 1900	fentaNYL (SUBLIMAZE) 0.05 mg/mL injection 50 mcg ONCE	Last MAR action: Given - by PEDRO, OYINKANSOLA on 05/31/12 at 1906	GARDNER, KIMBERLY R.
05/31/12 1800	fentaNYL (SUBLIMAZE) 0.05 mg/mL injection 50 mcg ONCE	Last MAR action: Given - by PEDRO, OYINKANSOLA on 05/31/12 at 1758	GARDNER, KIMBERLY R.
05/31/12 1630	fentaNYL (SUBLIMAZE) 0.05 mg/mL injection 50 mcg ONCE	Last MAR action: Given - by PEDRO, OYINKANSOLA on 05/31/12 at 1627	GARDNER, KIMBERLY R.
05/31/12 1630	0.9% sodium chloride (NS) IV fluid ONCE	Last MAR action: Given - by PEDRO, OYINKANSOLA on 05/31/12 at 1627	GARDNER, KIMBERLY R.



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ED Orders

Start	Status	Ordering Provider
05/31/12 1627 CT Brain C Spine Face wo Contrast 1 TIME IMAGING	Final result	GARDNER, KIMBERLY R.
05/31/12 1626 EKG 12 lead ONE TIME	Preliminary result	GARDNER, KIMBERLY R.
05/31/12 1625 CT chest with contrast 1 TIME IMAGING	Final result	GARDNER, KIMBERLY R.
05/31/12 1606 Lipase ONE TIME	Final result	GARDNER, KIMBERLY R.
05/31/12 1604 APTT ONE TIME	Final result	GARDNER, KIMBERLY R.
05/31/12 1604 CBC, Platelets, WBC Differential ONE TIME	Final result	GARDNER, KIMBERLY R.
05/31/12 1604 Chem 8, Metabolic Panel ONE TIME	Final result	GARDNER, KIMBERLY R.
05/31/12 1604 Ethanol - serum ONE TIME	Final result	GARDNER, KIMBERLY R.
05/31/12 1604 PT with INR only ONE TIME	Final result	GARDNER, KIMBERLY R.
05/31/12 1604 Type and Screen ONE TIME	Final result	GARDNER, KIMBERLY R.
05/31/12 1604 XR pelvis 1 View 1 TIME IMAGING	Final result	GARDNER, KIMBERLY R.
05/31/12 1604 XR Chest PA or AP 1 TIME IMAGING	Final result	GARDNER, KIMBERLY R.



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Lab Results (05/31/12 - 05/31/12)

Resulted: 05/31/12 1731, Result Status: Final
result

APTT [40573720]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen Collection: Blood - Venous 05/31/12 1604
Resulting Lab: GRADY MAIN LABORATORY

Component	Value	Ref Range	Flag	Comment	Lab
APTT	29.4	26.8 - 35.6 SEC	-		GRALA B

Resulted: 05/31/12 1731, Result Status: Final
result

PT with INR only [40573724] (Abnormal)

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen Collection: Blood - Venous 05/31/12 1604
Resulting Lab: GRADY MAIN LABORATORY

Component	Value	Ref Range	Flag	Comment	Lab
PROTHROMBIN TIME	10.9	11.0 - 13.4 SEC	L	-	GRALA B
INR	1.0				GRALA B

Comment:

INR IS USEFUL FOR MONITORING COUMADIN THERAPY.
THERAPEUTIC RANGES FOR THE INR VARY WITH CLINICAL STATE.

FOR PREVENTION OF EMBOLISM, PROPHYLAXIS OF VENOUS EMBOLISM,
OR TREATMENT OF DEEP VEIN THROMBOSES: INR=2.0-3.0

FOR MECHANICAL HEART VALVE OR RECURRENT SYSTEMIC
EMBOLISM: INR=2.5-3.5

Resulted: 05/31/12 1728, Result Status:
Preliminary result

PT with INR only [40573724] (Abnormal)

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen Collection: Blood - Venous 05/31/12 1604
Resulting Lab: GRADY MAIN LABORATORY

Component	Value	Ref Range	Flag	Comment	Lab
PROTHROMBIN TIME	10.9	11.0 - 13.4 SEC	L	-	GRALA B
INR	1.0				GRALA B

Comment:

INR IS USEFUL FOR MONITORING COUMADIN THERAPY.
THERAPEUTIC RANGES FOR THE INR VARY WITH CLINICAL STATE.

FOR PREVENTION OF EMBOLISM, PROPHYLAXIS OF VENOUS EMBOLISM,
OR TREATMENT OF DEEP VEIN THROMBOSES: INR=2.0-3.0

FOR MECHANICAL HEART VALVE OR RECURRENT SYSTEMIC



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Lab Results (05/31/12 - 05/31/12) (continued)

PT with INR only [40573724] (Abnormal)

EMBOLISM: INR=2.5-3.5

Resulted: 05/31/12 1728, Result Status:
Preliminary result

CBC, Platelets, WBC Differential [40573721]

Resulted: 05/31/12 1706, Result Status: Final
result

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen Collection: Blood - Venous 05/31/12 1604
Resulting Lab: GRADY MAIN LABORATORY

Component	Value	Ref Range	Flag	Comment	Lab
WBC COUNT-BLOOD	7.3	4.0 - 8.5 K/mcL	-		GRALA B
% Neutrophils-Blood	55	25 - 62 %	-		GRALA B
% Monocytes-Blood	5	2 - 11 %	-		GRALA B
% Eosinophil-Blood	2	< 9 %	-		GRALA B
% Basophil-Blood	1	< 3 %	-		GRALA B
% Lymphocytes-Blood	37	20 - 53 %	-		GRALA B
RBC COUNT-BLOOD	4.68	3.90 - 5.20 M/mcL	-		GRALA B
HEMOGLOBIN-BLOOD	15.4	11.5 - 15.5 GM/DL	-		GRALA B
HEMATOCRIT-BLOOD	43.8	35.0 - 45.0 %	-		GRALA B
RBC MCV	94	80 - 97 fL	-		GRALA B
RBC MCHC	35.2	32.0 - 36.0 %	-		GRALA B
RBC RDW	13.1	11.5 - 14.5 %	-		GRALA B
PLATELET COUNT-BLOOD	244	140 - 440 K/mcL	-		GRALA B
# Neutrophils-Blood	4.0	K/mcL	-		GRALA B
# Lymphocytes-Blood	2.7	0.5 - 4.5 K/mcL	-		GRALA B
# Monocytes-Blood	0.4	< 1.2 K/mcL	-		GRALA B
# Eosinophils-Blood	0.2	< 0.8 K/mcL	-		GRALA B
# Basophils-blood	0.1	< 0.3 K/mcL	-		GRALA B
# NEUT (Seg+Band+Meta)-Blood	4.0	1.8 - 7.3 K/mcL	-		GRALA B

Chem 8, Metabolic Panel [40573722] (Abnormal)

Resulted: 05/31/12 1705, Result Status: Final
result



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Lab Results (05/31/12 - 05/31/12) (continued)

Resulted: 05/31/12 1705, Result Status: Final
result

Chem 8, Metabolic Panel [40573722] (Abnormal)

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen Collection: Blood - Venous 05/31/12 1604
Resulting Lab: GRADY MAIN LABORATORY

Component	Value	Ref Range	Flag	Comment	Lab
UREA NITROGEN- SERUM	12	8 - 22 MG/DL	-		GRALA B
GLUCOSE, CASU AL-SERUM	87	70 - 125 MG/DL			GRALA B
Comment:	IMPAIRED GLUCOSE CONTROL: 126-199 PROVISIONAL DIAGNOSIS OF DIABETES: >= 200				
SODIUM-SERUM	137	132 - 144 MEQ/L	-		GRALA B
POTASSIUM- SERUM	4.3	3.4 - 5.1 MEQ/L	-		GRALA B
CHLORIDE- SERUM	102	101 - 111 MEQ/L	-		GRALA B
CO2 CONTENT- SERUM	24	22 - 32 MEQ/L	-		GRALA B
ANION GAP	11	1 - 13	-		GRALA B
OSMO, CALCULA TED	273	275 - 300 MOSM/L	L		GRALA B
CREATININE- SERUM	0.9	0.4 - 1.0 MG/DL	-		GRALA B
GLOMERULAR FILTRATION RATE CALC	INSUFFICIENT CLINICAL DATA TO CALCULATE ESTIMATED GFR.	>60		INSUFFICIENT CLINICAL DATA TO CALCULATE ESTIMATED GFR.	
CALCIUM, TOTAL SERUM	9.7	8.9 - 10.3 MG/DL	-		GRALA B
CALCIUM, ALBU MIN ADJUSTED	9.7	8.9 - 10.3 MG/DL	-		GRALA B
ALBUMIN, BCG- SERUM	4.7	3.5 - 5.0 GM/DL	-		GRALA B

Resulted: 05/31/12 1705, Result Status: Final
result

Ethanol - serum [40573723]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen Collection: Blood - Venous 05/31/12 1604
Resulting Lab: GRADY MAIN LABORATORY

Component	Value	Ref Range	Flag	Comment	Lab
ETHANOL- SERUM	< 10	MG/DL	-		GRALA B

Resulted: 05/31/12 1705, Result Status: Final
result

Lipase [40573729]



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Lab Results (05/31/12 - 05/31/12) (continued)

Resulted: 05/31/12 1705, Result Status: Final
result

Lipase [40573729]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen: Blood - Venous 05/31/12 1604
Collection:

Resulting Lab: GRADY MAIN LABORATORY

Component	Value	Ref Range	Flag	Comment	Lab
LIPASE-SERUM	52	16 - 62 U/L	-		GRALA B

Resulted: 05/31/12 1657, Result Status: Final
result

Chem 8, Metabolic Panel [40573722] (Abnormal)

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen: Blood - Venous 05/31/12 1604
Collection:

Resulting Lab: GRADY MAIN LABORATORY

Component	Value	Ref Range	Flag	Comment	Lab
UREA NITROGEN- SERUM	12	8 - 22 MG/DL	-		GRALA B
GLUCOSE, CASU AL-SERUM	87	70 - 125 MG/DL			GRALA B
Comment:	IMPAIRED GLUCOSE CONTROL: 126-199 PROVISIONAL DIAGNOSIS OF DIABETES: >= 200				
SODIUM-SERUM	137	132 - 144 MEQ/L	-		GRALA B
POTASSIUM- SERUM	4.3	3.4 - 5.1 MEQ/L	-		GRALA B
CHLORIDE- SERUM	102	101 - 111 MEQ/L	-		GRALA B
CO2 CONTENT- SERUM	24	22 - 32 MEQ/L	-		GRALA B
ANION GAP	11	1 - 13	-		GRALA B
OSMO, CALCULA TED	273	275 - 300 MOSM/L	L		GRALA B
CREATININE- SERUM	0.9	0.4 - 1.0 MG/DL	-		GRALA B
GLOMERULAR FILTRATION RATE CALC	INSUFFICIENT CLINICAL DATA TO CALCULATE ESTIMATED GFR.	>60		INSUFFICIENT CLINICAL DATA TO CALCULATE ESTIMATED GFR.	
CALCIUM, TOTAL SERUM	9.7	8.9 - 10.3 MG/DL	-		GRALA B
CALCIUM, ALBU MIN ADJUSTED	9.7	8.9 - 10.3 MG/DL	-		GRALA B
ALBUMIN, BCG- SERUM	4.7	3.5 - 5.0 GM/DL	-		GRALA B

Resulted: 05/31/12 1657, Result Status: Final
result

Lipase [40573729]



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Lab Results (05/31/12 - 05/31/12) (continued)

Resulted: 05/31/12 1657, Result Status: Final
result

Lipase [40573729]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen: Blood - Venous 05/31/12 1604
Collection:

Resulting Lab: GRADY MAIN LABORATORY

Component	Value	Ref Range	Flag	Comment	Lab
LIPASE-SERUM	52	16 - 62 U/L	-		GRALA B

Resulted: 05/31/12 1606, Result Status: In
process

APTT [40573720]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen: Blood - Venous 05/31/12 1604
Collection:

Resulting Lab: GRADY MAIN LABORATORY

Resulted: 05/31/12 1606, Result Status: In
process

CBC, Platelets, WBC Differential [40573721]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen: Blood - Venous 05/31/12 1604
Collection:

Resulting Lab: GRADY MAIN LABORATORY

Resulted: 05/31/12 1606, Result Status: In
process

Chem 8, Metabolic Panel [40573722]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen: Blood - Venous 05/31/12 1604
Collection:

Resulting Lab: GRADY MAIN LABORATORY

Resulted: 05/31/12 1606, Result Status: In
process

Ethanol - serum [40573723]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen: Blood - Venous 05/31/12 1604
Collection:

Resulting Lab: GRADY MAIN LABORATORY

Resulted: 05/31/12 1606, Result Status: In
process

PT with INR only [40573724]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605
Specimen: Blood - Venous 05/31/12 1604
Collection:

Resulting Lab: GRADY MAIN LABORATORY

Resulted: 05/31/12 1606, Result Status: In
process

Lipase [40573729]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605

Resulting Lab: GRADY MAIN LABORATORY



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Lab Results (05/31/12 - 05/31/12) (continued)

Resulted: 05/31/12 1606, Result Status: In process

Lipase [40573729]

Specimen Blood - Venous 05/31/12 1604
Collection

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
7 - GRALAB	GRADY MAIN LABORATORY	Andrew N Young M.D.	80 Jesse Hill Jr. Drive Atlanta GA 30303	12/07/09 1428 - 06/28/12 1113

EKG Results

EKG 12 lead (Preliminary result)

Result time: 05/31/12
16:33:14

Preliminary result

Narrative:

Heart Rate 68
QRS Interval 84 ms
QT Interval 392 ms
QTC Interval 417 ms
P Axis 84 deg
QRS Axis -58 deg
T Wave Axis 55 deg
P-R Interval 132 msec
- ABNORMAL ECG -
SINUS ARRHYTHMIA, RATE 63-80
VENTRICULAR PREMATURE COMPLEX
LEFT AXIS DEVIATION
PROBABLE ANTEROSEPTAL INFARCT, AGE INDETERM

ED Current OP Medications

None

Medications not reviewed this encounter

Medication Comments

** No Medication Comments Found **

ED Prescriptions

None

Allergies as of 5/31/2012

Reviewed on: 5/31/2012

No Known Allergies

Discharge Instructions

Cox, Jennie (MR # 100071167)

None



GRADY HOSPITAL
80 Jesse Hill Jr. Drive
Atlanta, GA 30303
ED Record

COX, JENNIE
MRN: 100071167
DOB: 8/14/1952, Sex: F
Adm: 5/31/2012, D/C: 5/31/2012

All Flowsheet Data (05/31/12 0000--05/31/12 2359)

Data

	05/31/12 2220	05/31/12 1935	05/31/12 1906	05/31/12 1806	05/31/12 1758

Vitals

BP	140/72 mmHg -LF	132/73 mmHg -OP
Pulse	88 -LF	92 -OP
Resp	25 -LF	19 -OP
SpO2	97 % -LF	95 % -OP

OTHER

I have documented the pain assessment	Yes -LF	Yes -OP	Yes -OP

	05/31/12 1627	05/31/12 1604	05/31/12 1603	05/31/12 1541	

Vitals

BP	150/84 mmHg -OP	105/64 mmHg -CH
Temp		35.7 °C (96.3 °F) -CH
Temp src		Oral -CH
Pulse	73 -OP	85 -CH
Resp	19 -OP	20 -CH
SpO2	99 % -OP	98 % -CH

Height 1.702 m (5' 7") -OP

Weight 52.164 kg (115 lb) -CH

OTHER

I have documented the pain assessment	Yes -OP

Custom Formula Data

	05/31/12 1603	05/31/12 1541			

OTHER

Percent Weight Change Since Birth 0 -CH

IBW/kg (Calculated) Male 66.1 kg -OP

Low Range Vt 6cc/kg MALE 396.6 mL -OP

Adult Moderate Range Vt 8cc/kg MA 528.8 mL -OP

Adult High Range Vt 10cc/kg MALE 661 mL -OP

IBW/kg (Calculated) FEMALE 61.6 kg -OP

Low Range Vt 6cc/kg FEMALE 369.6 mL -OP



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Adult Moderate 492.8 mL -OP

Range vt

8cc/kg

FEMALE

IBW/kg 61.6 -OP

(Calculated)

Low Range Vt 369.6 mL -OP

6cc/kg

Adult Moderate 492.8 mL -OP

Range Vt

8cc/kg

Adult High 616 mL -OP

Range Vt

10cc/kg

Relevant Labs and Vitals

Temp (in 35.7 -CH
Celsius)

Secondary Assessment

05/31/12 1649

FAST

ABD FAST Negative -OP

Secondary Assessment

Head

--
Avulsion to chin.
Impacted and missing
teeth -OP

Eyes WDL -OP

Ears WDL -OP

Mouth/Throat WDL -OP

Neck/Back

--
C-collar intact. C-
spine tenderness. -
OP

Chest WDL -OP

Cardiac WDL -OP

Abdomen WDL -OP

Pelvis/GU WDL -OP

Extremities WDL -OP

Triage Plan

05/31/12 1543

Triage Plan

Triage Level 2 -CH

ED ZONE -CH

Destination

SBIRT

05/31/12 1603

SBIRT

Tobacco Yes -OP

Women: Drinks 0 (never) -OP

Drugs No -OP

Vital Signs



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	05/31/12 1935	05/31/12 1806	05/31/12 1604	05/31/12 1603	05/31/12 1541
Vital Signs					
Temp					35.7 °C (96.3 °F) -CH
Temp src					Oral -CH
Pulse	88 -LF	92 -OP	73 -OP		85 -CH
Pulse Source	Monitor;Pulse Ox -LF				Monitor -CH
Resp	25 -LF	19 -OP	19 -OP		20 -CH
BP	140/72 mmHg -LF	132/73 mmHg -OP	150/84 mmHg -OP		105/64 mmHg -CH
MAP (mmHg)	87 -LF	87 -OP			
BP Location	Left arm -LF				Right arm -CH
Patient Position	Supine -LF				Supine -CH
SpO2	97 % -LF	95 % -OP	99 % -OP		98 % -CH
Patient Currently in Pain	Denies -LF		Yes -OP		Yes -CH
Pain Assessment Scale					
Pain Assessment Scale			Verbal Analog (0-10) -OP		Verbal Analog (0-10) -CH
Patient-Stated Pain Level			10 -OP		7 -CH
Patient's Stated Pain Goal					No pain -CH
Pain Type			Acute pain -OP		Acute pain -CH
Pain Location			Mouth -OP		Face -CH
Pain Descriptors					Aching -CH
Pain Frequency					Continuous -CH
Pain Onset					--
Multiple Pain Sites					x one hour -CH Yes -CH
Pain 2					
Pain Rating 2					7 -CH
Pain Type 2					Acute pain -CH
Pain Location 2					Back -CH
Pain Orientation 2					Mid -CH
Pain Descriptors 2					Aching -CH
Pain Frequency 2					Continuous -CH
Patient's Stated Pain Goal 2					No pain -CH
Height and Weight					
Height				1.702 m (5' 7") -OP	
Height Method				Stated -OP	
Weight					52.164 kg (115 lb) -CH
Weight Method					Stated -CH



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Primary Assessment

	05/31/12 1935	05/31/12 1649			
Airway					
Obstructed?		Patent -OP			
Breathing					
Breathing Effort		Spontaneous -OP			
Trachea		Midline -OP			
Chest Wall		WDL -OP			
Breath Sounds		Clear -OP			
Right					
Breath Sounds		Clear -OP			
Left					
Circulation					
Skin		WDL -OP			
Uncontrolled Bleeding		No -OP			
Disability					
Responsiveness		Alert -OP			
Loss of Consciousness (LOC)		No -OP			
Eye Opening	4 -LF	4 -OP			
Best Verbal Response	5 -LF	5 -OP			
Best Motor Response	6 -LF	6 -OP			
Glasgow Coma Scale Score	15 -LF	15 -OP			

Anthropometrics

	05/31/12 1603	05/31/12 1541			
Anthropometrics					
Height	1.702 m (5' 7") -OP				
Weight		52.164 kg (115 lb) -CH			
Weight Change	0 -CH				

Focused Assessment

	05/31/12 1935	05/31/12 1806	05/31/12 1649	05/31/12 1604	05/31/12 1544
Airway					
Airway (WDL)				WDL -CH	
Obstructed?		Patent -OP			
Breathing					
Breathing (WDL)				WDL -CH	
SpO2	97 % -LF	95 % -OP		99 % -OP	
Circulation					
Circulation (WDL)				WDL -CH	
Disability					



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Disability
(WDL)

WDL -CH

05/31/12 1541

Breathing

SpO2 98 % -CH

Neurological

05/31/12 1935

Neurological

Neuro (WDL) WDL -LF

Respiratory

05/31/12 1935

Respiratory

Respiratory WDL -LF
(WDL)

Cardiac/Telemetry

05/31/12 1935

Cardiac

Cardiac (WDL) WDL -LF

Cardiac Regular -LF

Regularity

Cardiac NSR -LF

Rhythm

Telemetry Yes -LF

Monitor On

Telemetry Yes -LF

Audible

Telemetry Yes -LF

Alarms Set

Arrival Documentation

05/31/12 1935

05/31/12 1806

05/31/12 1604

05/31/12 1541

05/31/12 1540

Means of Arrival

Means of

Arrival

A -CH

Prehospital Treatment

Prehospital

Treatment

Yes -CH

Prehospital Care

Backboard

Long Board -CH

Cervical Collar

Yes -CH

SpO2

97 % -LF

95 % -OP

99 % -OP

98 % -CH

Care Handoff

05/31/12 2307

Care Handoff

Report Given to
Given to other
(Comment)
pt transfered to
other hospital via
AMR transportation
-LF



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Suicide Risk

05/31/12 1603					
Suicide Risk					
Do you have any thoughts of hurting yourself or others? No -OP					

GCS

05/31/12 1935	05/31/12 1649				
Glasgow Coma Scale					
Eye Opening	4 -LF	4 -OP			
Best Verbal Response	5 -LF	5 -OP			
Best Motor Response	6 -LF	6 -OP			
Glasgow Coma Scale Score	15 -LF	15 -OP			

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

Initials	Name	Effective Dates
CH	Hemmings, Colette, RN	09/09/10 -
OP	Pedro, Oyinkansola, RN	09/24/10 -
LF	Feliz-Guillen, Loida	-

Admission Information - Patient Record Only

Arrival Date/Time:	05/31/2012 3:35 PM	Admit Date/Time:	05/31/2012 3:51 PM	IP Adm. Date/Time:	None
Admission Type:	Emergency	Point of Origin:	Self Referral	Admit Category:	None
Means of Arrival:	Grady Ambulance	Primary Service:	Emergency Medicine (Non-admitting)	Secondary Service:	N/A
Transfer Source:	None	Service Area:	Grady Health System Service Area	Unit:	Ghs Emergency
Admit Provider:	None	Attending Provider:	Huot, Chad P., MD	Referring Provider:	None

Radiology Results (06/01/12 -)

Resulted: 06/01/12 1831, Result Status: Final result

CT Brain C Spine Face wo Contrast [40573742]

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605	Resulted by:	Krishnan, Arun R., MD McDermott, Matthew C., MD
Performed:	05/31/12 1710 - 05/31/12 1726	Resulting Lab:	GRADY RADIOLOGY
Specimen Collection	05/31/12 1710		
Narrative:	Patient Name: COX, JENNIE DOB: Aug 14, 1952 SEX: F Ordering Physician: HUOT, CHAD		

HEAD CT WITHOUT IV CONTRAST

Radiology Results (06/01/12 -) (continued)Resulted: 06/01/12 1831, Result Status: Final
result**CT Brain C Spine Face wo Contrast [40573742]**CT OF THE FACIAL BONES WITHOUT IV CONTRAST
CERVICAL SPINE CT WITHOUT IV CONTRAST

INDICATION: Pain following trauma. Large object fell on top of patient. Patient is bleeding from the oropharynx and impacted tooth.

TECHNIQUE: Axial CT images from skull base to vertex without IV contrast. Multiple-row detector helical CT examination of the facial bones and mandible without IV contrast. Axial, sagittal, and coronal reconstructed images. Multiple-row detector helical CT examination of the cervical spine without IV contrast. Axial, sagittal, and coronal reconstructed images.

COMPARISON: None.

FINDINGS:**HEAD CT:**

No acute intracranial hemorrhage or abnormal extra-axial fluid collections. Focal hypodensities in the right anterior limb of the internal capsule and right thalamus are nonspecific and may represent prior lacunar infarction or dilated perivascular spaces. Mild periventricular the scattered white matter hypodensities also nonspecific, but likely represent microangiopathic white matter changes. No evidence of acute large territory infarction. Density in the larger dural venous sinuses is grossly normal. There is calcified atherosclerotic plaque of the intracranial internal carotid arteries.

No hydrocephalus.

No displaced skull base or calvarium fractures identified, but there is a suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal. There is also patchy opacification of ethmoid sinuses, mucosal thickening of frontal sinuses. Mastoid air cells are clear. There is soft tissue density in the bilateral external auditory canals, which is likely cerumen.

FACE CT:

Complex and comminuted fracture of the mandible involving the left parasymphiseal region extending vertically to involve the root of several mandibular teeth, where there are periapical abscesses about the central and lateral left mandibular incisors, with both buccal and lingual breakthrough, but no noncontrast evidence of soft tissue abscess. The fracture also involves the left body of the mandible, and the left inferior alveolar nerve canal. There are additional bilateral condylar neck and ramus fractures, both with apex lateral angulation. The temporomandibular joints are not involved bilaterally. There is a suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal. Other facial bones show no additional fractures or dislocation. No aggressive osseous lesions.

The globes are normal. The extraocular muscles, intraconal fat, and extraconal fat are within normal limits. The lacrimal glands appear normal. The orbital walls and optic canals are normal.

No lesion of the imaged skull base or calvarium is present. Air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal. There is also patchy opacification of ethmoid sinuses, mucosal thickening of

Radiology Results (06/01/12 -) (continued)

Resulted: 06/01/12 1831, Result Status: Final
result

CT Brain C Spine Face wo Contrast [40573742]

frontal sinuses. Mastoid air cells are clear.

CSPINE CT:

No evidence of acute fracture or subluxation, with likely degenerative minimal retrolisthesis of C6 on C7. The cervical spine demonstrates normal alignment. Vertebral body heights are maintained. No aggressive osseous lesions are identified.

Intervertebral disc space heights are maintained. There are mild degenerative changes of the cervical spine and anterior osteophyte at C4, posterior osteophytes at C4, C5 and C7.

No abnormality of the cranio-cervical junction.

Evaluation of the individual levels demonstrates no disc herniation, or central spinal canal stenosis. Facet and uncovertebral hypertrophy cause moderate bilateral neuroforaminal stenosis at C6-C7. No other neural foraminal narrowing.

There is abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma. The prevertebral and paraspinal soft tissues demonstrate no abnormality. Visualized lung apices show bilateral consolidations and paraseptal emphysema, but for complete intrathoracic findings please see separately dictated report for CT of the chest.

IMPRESSION:

1. No intracranial hemorrhage or abnormal extra-axial fluid collection.
2. Focal hypodensities in the right anterior limb internal capsule and right thalamus are nonspecific and may represent prior lacunar infarction or dilated perivascular spaces.
3. Mild periventricular and scattered white matter hypodensities likely represent microangiopathic white matter changes.
4. Soft tissue density in the bilateral external auditory canals, likely cerumen. Correlation with otoscopic exam is recommended.
5. Comminuted fracture of the mandible involving the left parasymphysal region extending vertically to involve the root of several mandibular teeth. Fracture line extends along the left body of the mandible and involves the inferior alveolar nerve canal.
6. Periapical abscesses about the central and lateral left mandibular incisors, with both buccal and lingual breakthrough, but no noncontrast evidence of soft tissue abscess.
7. Left mandibular ramus fracture with apex lateral angulation. TMJ uninvolved.
8. Right mandibular ramus with minimal apex lateral angulation. TMJ uninvolved.
9. Suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal.
10. No acute abnormality of the cervical spine, with degenerative changes, noted above, including facet and uncovertebral hypertrophy causing moderate bilateral neuroforaminal stenosis at C6-C7.
11. Abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma, especially given reported bleeding from oropharynx.

Visualized lung apices show bilateral consolidations and paraseptal emphysema, but for complete intrathoracic findings please see separately dictated report for CT of the chest.

---INITIAL FINDINGS AND COMMUNICATION--- ADDITIONAL HX: Status post trauma. Large object fell on top of patient. --- COMP: [] --- PRELIMINARY READ: HEAD: No acute intracranial hemorrhage or abnormal extra-axial fluid collections. Focal hypodensities



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Radiology Results (06/01/12 -) (continued)

Resulted: 06/01/12 1831, Result Status: Final result

CT Brain C Spine Face wo Contrast [40573742]

within the right anterior limb internal capsule and right thalamus are nonspecific and may represent dilated perivascular spaces or age-indeterminate lacunar infarctions. Mild periventricular and subcortical white matter hypodensity, nonspecific. No acute calvarial fractures. Soft tissue density within the bilateral external auditory canals likely represents cerumen. C-spine: No acute fracture or subluxation of the cervical spine. There is abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma, although attention on follow-up and/or direct visual inspection is recommended to exclude underlying neoplasm. After speaking with clinician, patient is bleeding from the oro pharynx and impacted tooth in this may explain the findings. Face: There is a comminuted fracture of the mandible involving the left parasymphyseal region extending vertically to involve the root of several mandibular teeth. Fracture line extends along the left angle of the mandible. There is fracture with apex lateral angulation of the left mandibular ramus proximal to the TMJ joint. There is fracture of the right mandibular ramus with minimal apex lateral angulation as well. Fracture extends through the inferior alveolar nerve canal on the left. There is an additional minimally displaced fracture of the left greater wing of the sphenoid. Scattered mucosal thickening within the bilateral frontal sinuses ethmoid air cells. Foamy debris within the left sphenoid chamber is nonspecific. No obvious skull base fracture. --- The above findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

The final report essentially agrees with the preliminary report.

AK

These images were reviewed and interpreted by Arun Krishnan, MD.

Resulted: 06/01/12 1757, Result Status: Preliminary result

CT Brain C Spine Face wo Contrast [40573742]

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605	Resulted by:	Krishnan, Arun R., MD McDermott, Matthew C., MD
Performed:	05/31/12 1710 - 05/31/12 1726	Resulting Lab:	GRADY RADIOLOGY
Specimen Collection	05/31/12 1710		
Narrative:	Patient Name: COX, JENNIE DOB: Aug 14, 1952 SEX: F Ordering Physician: HUOT, CHAD		

HEAD CT WITHOUT IV CONTRAST
CT OF THE FACIAL BONES WITHOUT IV CONTRAST
CERVICAL SPINE CT WITHOUT IV CONTRAST

INDICATION: Pain following trauma. Large object fell on top of patient. Patient is bleeding from the oropharynx and impacted tooth.

TECHNIQUE: Axial CT images from skull base to vertex without IV contrast. Multiple-row detector helical CT examination of the facial bones and mandible without IV contrast. Axial, sagittal, and coronal reconstructed images. Multiple-row detector helical CT examination of the cervical spine without IV contrast. Axial, sagittal, and coronal reconstructed images.

COMPARISON: None.

Radiology Results (06/01/12 -) (continued)Resulted: 06/01/12 1757, Result Status:
Preliminary result**CT Brain C Spine Face wo Contrast [40573742]****FINDINGS:****HEAD CT:**

No acute intracranial hemorrhage or abnormal extra-axial fluid collections. Focal hypodensities in the right anterior limb of the internal capsule and right thalamus are nonspecific and may represent prior lacunar infarction or dilated perivascular spaces. Mild periventricular the scattered white matter hypodensities also nonspecific, but likely represent microangiopathic white matter changes. No evidence of acute large territory infarction. Density in the larger dural venous sinuses is grossly normal. There is calcified atherosclerotic plaque of the intracranial internal carotid arteries.

No hydrocephalus.

No displaced skull base or calvarium fractures identified, but there is a suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal. There is also patchy opacification of ethmoid sinuses, mucosal thickening of frontal sinuses. Mastoid air cells are clear. There is soft tissue density in the bilateral external auditory canals, which is likely cerumen.

FACE CT:

Complex and comminuted fracture of the mandible involving the left parasymphiseal region extending vertically to involve the root of several mandibular teeth, where there are periapical abscesses about the central and lateral left mandibular incisors, with both buccal and lingual breakthrough, but no noncontrast evidence of soft tissue abscess. The fracture also involves the left body of the mandible, and the left inferior alveolar nerve canal. There are additional bilateral condylar neck and ramus fractures, both with apex lateral angulation. The temporomandibular joints are not involved bilaterally. There is a suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal. Other facial bones show no additional fractures or dislocation. No aggressive osseous lesions.

The globes are normal. The extraocular muscles, intraconal fat, and extraconal fat are within normal limits. The lacrimal glands appear normal. The orbital walls and optic canals are normal.

No lesion of the imaged skull base or calvarium is present. Air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal. There is also patchy opacification of ethmoid sinuses, mucosal thickening of frontal sinuses. Mastoid air cells are clear.

CSPINE CT:

No evidence of acute fracture or subluxation, with likely degenerative minimal retrolisthesis of C6 on C7. The cervical spine demonstrates normal alignment. Vertebral body heights are maintained. No aggressive osseous lesions are identified. Intervertebral disc space heights are maintained. There are mild degenerative changes of the cervical spine and anterior osteophyte at C4, posterior osteophytes at C4, C5 and C7.

No abnormality of the cranio-cervical junction.

Evaluation of the individual levels demonstrates no disc herniation, or central spinal canal stenosis. Facet and uncovertebral hypertrophy cause moderate bilateral neuroforaminal stenosis at C6-C7. No other neural foraminal narrowing.

Radiology Results (06/01/12 -) (continued)**CT Brain C Spine Face w/o Contrast [40573742]**Resulted: 06/01/12 1757, Result Status:
Preliminary result

There is abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma. The prevertebral and paraspinal soft tissues demonstrate no abnormality. Visualized lung apices show bilateral consolidations and paraseptal emphysema, but for complete intrathoracic findings please see separately dictated report for CT of the chest.

IMPRESSION:

1. No intracranial hemorrhage or abnormal extra-axial fluid collection.
2. Focal hypodensities in the right anterior limb internal capsule and right thalamus are nonspecific and may represent prior lacunar infarction or dilated perivascular spaces.
3. Mild periventricular and scattered white matter hypodensities likely represent microangiopathic white matter changes.
4. Soft tissue density in the bilateral external auditory canals, likely cerumen. Correlation with otoscopic exam is recommended.
5. Comminuted fracture of the mandible involving the left parasymphiseal region extending vertically to involve the root of several mandibular teeth. Fracture line extends along the left body of the mandible and involves the inferior alveolar nerve canal.
6. Periapical abscesses about the central and lateral left mandibular incisors, with both buccal and lingual breakthrough, but no noncontrast evidence of soft tissue abscess.
7. Left mandibular ramus fracture with apex lateral angulation. TMJ uninvolved.
8. Right mandibular ramus with minimal apex lateral angulation. TMJ uninvolved.
9. Suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal.
10. No acute abnormality of the cervical spine, with degenerative changes, noted above, including facet and uncovertebral hypertrophy causing moderate bilateral neuroforaminal stenosis at C6-C7.
11. Abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma, especially given reported bleeding from oropharynx.

Visualized lung apices show bilateral consolidations and paraseptal emphysema, but for complete intrathoracic findings please see separately dictated report for CT of the chest.

---INITIAL FINDINGS AND COMMUNICATION--- ADDITIONAL HX: Status post trauma. Large object fell on top of patient. --- COMP: [] --- PRELIMINARY READ: HEAD: No acute intracranial hemorrhage or abnormal extra-axial fluid collections. Focal hypodensities within the right anterior limb internal capsule and right thalamus are nonspecific and may represent dilated perivascular spaces or age-indeterminate lacunar infarctions. Mild periventricular and subcortical white matter hypodensity, nonspecific. No acute calvarial fractures. Soft tissue density within the bilateral external auditory canals likely represents cerumen. C-spine: No acute fracture or subluxation of the cervical spine. There is abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma, although attention on follow-up and/or direct visual inspection is recommended to exclude underlying neoplasm. After speaking with clinician, patient is bleeding from the oro pharynx and impacted tooth in this may explain the findings. Face: There is a comminuted fracture of the mandible involving the left parasymphiseal region extending vertically to involve the root of several mandibular teeth. Fracture line extends along the left angle of the mandible. There is fracture with apex lateral angulation of the left mandibular ramus proximal to the TMJ joint. There is fracture of the right mandibular ramus with



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Radiology Results (06/01/12 -) (continued)

Resulted: 06/01/12 1757, Result Status:
Preliminary result

CT Brain C Spine Face wo Contrast [40573742]

minimal apex lateral angulation as well. Fracture extends through the inferior alveolar nerve canal on the left. There is an additional minimally displaced fracture of the left greater wing of the sphenoid. Scattered mucosal thickening within the bilateral frontal sinuses ethmoid air cells. Foamy debris within the left sphenoid chamber is nonspecific. No obvious skull base fracture. --- The above findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

The final report essentially agrees with the preliminary report.

AK

[Sign Diagnostic]

Resulted: 06/01/12 1407, Result Status: Final
result

CT chest with contrast [40573738]

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1624

Resulted by: Berkowitz, Eugene A., MD
Henson, Nicholas Levi, MD
Tigges, Stefan, MD

Performed: 05/31/12 1711 - 05/31/12 1727
Specimen Collection: 05/31/12 1711

Resulting Lab: GRADY RADIOLOGY

Narrative: CT CHEST WITH CONTRAST

CLINICAL INDICATION: Trauma. Chest pain. Large object fell on patient's back.

TECHNIQUE: Written informed consent was obtained. Noncardiac-gated spiral axial 2.0 mm images of the chest were obtained with intravenous contrast. There were no immediate reported complications.

COMPARISON: No direct comparison available. Portable chest x-ray dated 5/31/2012.

FINDINGS:

LOWER NECK:

Grossly Unremarkable

HEART/MEDIASTINUM:

Aorta: Within normal limits in size.

Heart: Within normal limits in size.

Mediastinal Lymph Nodes: Not Enlarged

LUNGS/PLEURA:

Mild upper lobe predominant centrilobular comparison emphysematous change. Mild bibasilar atelectasis. No lobar consolidation, pleural effusion, or pneumothorax. Upper lobe nodularity and mild pleural thickening likely representing scarring. 4 mm peripheral noncalcified pulmonary nodule in the right lower lobe (image 197 of 316). The tracheobronchial tree is patent.

VISUALIZED ABDOMEN:

Ill-defined left adrenal nodule measuring approximately 18 x 9 mm with an average attenuation of 20 HU, not clearly an adenoma.



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Radiology Results (06/01/12 -) (continued)

Resulted: 06/01/12 1407, Result Status: Final
result

CT chest with contrast [40573738]

SOFT TISSUES/BONE:
No aggressive bone lesions. No acute fractures.

IMPRESSION:

1. No acute intrathoracic abnormality.
2. Mild bibasilar atelectasis.
3. Mild biapical probable scarring.
4. Mild emphysema.
5. Noncalcified upper lobe 4 mm pulmonary nodule. Recommend followup noncontrast CT in 12 months.
6. Indeterminate left adrenal nodule. Routine CT of the abdomen, adrenal mass protocol is suggested to further evaluate.

The final report agrees with the preliminary report by the on-call radiology resident below.

Preliminary findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

Final report dictated by Dr. Nicholas L. Henson, the radiology resident on service.

This study has been personally reviewed by the attending Stefan Tigges MD.

Patient: COX JENNIE
MRN: 100071167
Accession: B5435341

Procedure: CT CHEST W CONTRAST

---INITIAL FINDINGS AND COMMUNICATION--- ADDITIONAL HX: Status post trauma. Large object fell on patient's back. --- COMP: [] --- PRELIMINARY READ: There is moderate emphysema bilaterally with predominantly posterior and biapical scarring. No acute traumatic abnormality within the chest. No displaced fractures. A left adrenal nodule is nonspecific, although primarily low density likely representing an adenoma. --- The above findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

Resulted: 06/01/12 1136, Result Status:
Preliminary result

CT chest with contrast [40573738]

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1624	Resulted by:	Berkowitz, Eugene A., MD Henson, Nicholas Levi, MD Tigges, Stefan, MD
Performed:	05/31/12 1711 - 05/31/12 1727	Resulting Lab:	GRADY RADIOLOGY
Specimen Collection	05/31/12 1711		
Narrative:	CT CHEST WITH CONTRAST		

CLINICAL INDICATION: Trauma. Chest pain. Large object fell on patient's back.

Radiology Results (06/01/12 -) (continued)Resulted: 06/01/12 1136, Result Status:
Preliminary result**CT chest with contrast [40573738]**

TECHNIQUE: Written informed consent was obtained. Noncardiac-gated spiral axial 2.0 mm images of the chest were obtained with intravenous contrast. There were no immediate reported complications.

COMPARISON: No direct comparison available. Portable chest x-ray dated 5/31/2012.

FINDINGS:

LOWER NECK:
Grossly Unremarkable

HEART/MEDIASTINUM:
Aorta: Within normal limits in size.
Heart: Within normal limits in size.
Mediastinal Lymph Nodes: Not Enlarged

LUNGS/PLEURA:
Mild upper lobe predominant centrilobular comparison emphysematous change. Mild bibasilar atelectasis. No lobar consolidation, pleural effusion, or pneumothorax. Upper lobe nodularity and mild pleural thickening likely representing scarring. 4 mm peripheral noncalcified pulmonary nodule in the right lower lobe (image 197 of 316). The tracheobronchial tree is patent.

VISUALIZED ABDOMEN:
Ill-defined left adrenal nodule measuring approximately 18 x 9 mm with an average attenuation of 20 HU, not clearly an adenoma.

SOFT TISSUES/BONE:
No aggressive bone lesions. No acute fractures.

IMPRESSION:

1. No acute intrathoracic abnormality.
2. Mild bibasilar atelectasis.
3. Mild biapical probable scarring.
4. Mild emphysema.
5. Noncalcified upper lobe 4 mm pulmonary nodule. Recommend followup noncontrast CT in 12 months.
6. Indeterminate left adrenal nodule. Routine CT of the abdomen, adrenal mass protocol is suggested to further evaluate.

The final report agrees with the preliminary report by the on-call radiology resident below.

Preliminary findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant



GRADY HOSPITAL
80 Jesse Hill Jr. Drive
Atlanta, GA 30303

COX, JENNIE
MRN: 100071167
DOB: 8/14/1952, Sex: F
Adm: 5/31/2012, D/C: 5/31/2012

Radiology Results (06/01/12 -) (continued)

CT chest with contrast [40573738]

Resulted: 06/01/12 1136, Result Status: Preliminary result

Webber.

Final report dictated by Dr. Nicholas L. Henson, the radiology resident on service.

[ST]

Patient: COX JENNIE

MRN: 100071167

Accession: B5435341

Procedure: CT CHEST W CONTRAST

--- INITIAL FINDINGS AND COMMUNICATION --- ADDITIONAL HX: Status post trauma. Large object fell on patient's back. --- COMP: [] --- PRELIMINARY READ: There is moderate emphysema bilaterally with predominantly posterior and biapical scarring. No acute traumatic abnormality within the chest. No displaced fractures. A left adrenal nodule is nonspecific, although primarily low density likely representing an adenoma. --- The above findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

Resulted: 05/31/12 1633, Result Status: Final result

XR pelvis 1 View [40573727]

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605	Resulted by:	Khosa, Faisal, MD Rampure, Jaideep M., MD
Performed:	05/31/12 1606 - 05/31/12 1610	Resulting Lab:	GRADY RADIOLOGY
Specimen Collection	05/31/12 1606		
Narrative:	Clinical Indication: Pain following trauma		

Technique: AP view view of the pelvis.

Comparison: None available.

Findings:

BONES: There is no evidence of an acute, displaced fracture or dislocation. The symphysis pubis does not appear widened. The hip joint spaces are maintained. Air filled bowel loops obscure assessment of the SI joints.

SOFT TISSUES: No focal abnormality is appreciated.

Impression:

No acute osseous abnormality of the pelvis.

The images were reviewed and interpreted by Dr. Faisal Khosa.

Resulted: 05/31/12 1633, Result Status: Final result

XR Chest PA or AP [40573728]

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605	Resulted by:	Khosa, Faisal, MD Rampure, Jaideep M., MD
Performed:	05/31/12 1606 - 05/31/12 1610	Resulting Lab:	GRADY RADIOLOGY
Specimen Collection	05/31/12 1606		
Narrative:	PROCEDURE: SINGLE AP VIEW OF THE CHEST		

Radiology Results (06/01/12 -) (continued)Resulted: 05/31/12 1633, Result Status: Final
result**XR Chest PA or AP [40573728]**

CLINICAL INDICATION: Pain following trauma

COMPARISON: None.

FINDINGS: The cardiomediastinal silhouette is within normal limits. There are no focal pulmonary consolidations or pleural effusions. There is no evidence of pneumothorax. There are no acute osseous abnormalities.

IMPRESSION:

No acute cardiopulmonary disease.

The images were reviewed and interpreted by Dr. Faisal Khosa.

Resulted: 05/31/12 1623, Result Status:
Preliminary result**XR pelvis 1 View [40573727]**

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605	Resulted by:	Khosa, Faisal, MD Rampure, Jaideep M., MD
Performed:	05/31/12 1606 - 05/31/12 1610	Resulting Lab:	GRADY RADIOLOGY
Specimen Collection	05/31/12 1606		
Narrative:	Clinical Indication: Pain following trauma		

Technique: AP view view of the pelvis.

Comparison: None available.

Findings:

BONES: There is no evidence of an acute, displaced fracture or dislocation. The symphysis pubis does not appear widened. The hip joint spaces are maintained. Air filled bowel loops obscure assessment of the SI joints.

SOFT TISSUES: No focal abnormality is appreciated.

Impression:

No acute osseous abnormality of the pelvis.

{FK}

Resulted: 05/31/12 1621, Result Status:
Preliminary result**XR Chest PA or AP [40573728]**

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605	Resulted by:	Khosa, Faisal, MD Rampure, Jaideep M., MD
Performed:	05/31/12 1606 - 05/31/12 1610	Resulting Lab:	GRADY RADIOLOGY
Specimen Collection	05/31/12 1606		
Narrative:	PROCEDURE: SINGLE AP VIEW OF THE CHEST		

CLINICAL INDICATION: Pain following trauma

COMPARISON: None.



GRADY HOSPITAL
80 Jesse Hill Jr. Drive
Atlanta, GA 30303

COX, JENNIE
MRN: 100071167
DOB: 8/14/1952, Sex: F
Adm: 5/31/2012, D/C: 5/31/2012

Radiology Results (06/01/12 -) (continued)

XR Chest PA or AP [40573728]

Resulted: 05/31/12 1621, Result Status: Preliminary result

FINDINGS: The cardiomedastinal silhouette is within normal limits. There are no focal pulmonary consolidations or pleural effusions. There is no evidence of pneumothorax. There are no acute osseous abnormalities.

IMPRESSION:
No acute cardiopulmonary disease.

{FK}

XR pelvis 1 View [40573727]

Resulted: 0000, Result Status: In process

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605	Resulted by:	Khosa, Faisal, MD Rampure, Jaideep M., MD
Performed:	05/31/12 1606 - 05/31/12 1610	Specimen Collection	05/31/12 1606

XR Chest PA or AP [40573728]

Resulted: 0000, Result Status: In process

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605	Resulted by:	Khosa, Faisal, MD Rampure, Jaideep M., MD
Performed:	05/31/12 1606 - 05/31/12 1610	Specimen Collection	05/31/12 1606

CT Face w/o Contrast [40573730]

Resulted: 0000, Result Status: In process

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605

CT BRAIN FACE WO CONTRAST [40573734]

Resulted: 0000, Result Status: In process

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605

CT chest with contrast [40573738]

Resulted: 0000, Result Status: In process

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1624	Resulted by:	Berkowitz, Eugene A., MD Henson, Nicholas Levi, MD Tigges, Stefan, MD
Performed:	05/31/12 1711 - 05/31/12 1727	Specimen Collection	05/31/12 1711

CT Brain C Spine Face wo Contrast [40573742]

Resulted: 0000, Result Status: In process

Ordering provider:	Gardner, Kimberly R., MD 05/31/12 1605	Resulted by:	Krishnan, Arun R., MD McDermott, Matthew C., MD
Performed:	05/31/12 1710 - 05/31/12 1726	Specimen Collection	05/31/12 1710

Testing Performed By

Lab	Abbreviation	Name	Director	Address	Valid Date Range
9 - GRADYRAD		GRADY RADIOLOGY	Unknown	Unknown	12/11/09 1042 - Present

END OF REPORT

APA #2
AMERICAN MEDICAL RESPONSE OF GEORGIA
05/31/12



ATLANTA
AMERICAN MEDICAL RESPONSE
OF GEORGIA
Patient Care Report

Case #: 60195177

Unit ID: 204

Date: 5/31/2012

Dispatch Information

60195177

Time Call Received: 21:20:18
Time Dispatched: 21:31:04
Time Enroute: 21:33:35
Time at Scene: 22:12:00
Time at Pt Side: 22:12:00

Disposition: -Hospital to Hospital Transport

From Location:

80 JESSE HILL JR DR SE, ATLANTA, GA 30303

Incident Location Type: Medical - Hospital

To Location:

Greenville Memorial Hospital

701 grove rd, greenville, SC 29605

Destination Type: Medical - Hospital

Caller Name: 3RD PARTY

Time Transporting: 22:43:00
Time Transport Arrived: 01:05:00
Time Available: 01:18:00
Final Response Mode:
Final Transport Mode:

ALS Assessment: AMR Paramedic

Patient Demographics

60195177

Name: COX, JENNIE
Address: 222 w chapman rd
City, State, Zip: greenville, SC 29627
Phone: (864)243-0032 Cell: (864)243-0032
SSN: xxxx-xx-8760
Pt. #: 1 of 1

DOB: 8/14/1952
Age: 59 years
Gender: Female
Weight: 0
Ethnicity: Caucasian

Transfer

60195177

Reason for Transport: Other Non-Emergency Impression

Underlying Medical Condition: -

Transfer Reasons:

Was Specialized Observation Required?
Was Pt Able to Sit in W/C During Trans?
Was There Existing Tx To Be Monitored?
Was Special Positioning Required?
Was Patient on Psych Hold?
Was Oxygen Used During Transport?

Physical Findings

60195177

Face: Deformity
Face Remarks: pt had possible fractured jaw.
Chin: Laceration

History Of Present Illness

60195177

Chief Complaint:

Physician:

Safety Equipment:

History Obtained From: Patient
History: None Stated
Allergies: None ,
Medications: NONE STATED

Advanced Directives:

Narrative

60195177

RESPONDED ON A CALL TO GRADY MEMORIAL HOSPITAL FOR A PT BEING DISCHARGED TO A HOSPITAL CLOSER TO HOME. PT WAS 59 Y/O FEMALE. PT WAS WORKING WHEN HEAVY EQUIPMENT FELL ON HER. PT HAD DCAP-BTLS TO HER FACE AND HEAD.

UPON OUR ARRIVAL TO THE SCENE THE PT WAS CA&OX4. PT APPEARED TO BE IN NO DISTRESS. PT STATED SHE HAD PAIN TO HER FACE. PT STATED PAIN WAS ABOUT A 6 ON THE PAIN SCALE. PT WAS PLACED ON THE STRETCHER VIA A DRAWSHEET. PT WAS PLACED IN A POSITION OF COMFORT AND SECURED ON BY SAFETY BELTS. PT HAD 18G IV AND 1000ML OF NS RUNNING. PT WAS BEING TRANSPORTED TO GREENVILLE SC TO A HOSPITAL CLOSER TO HER HOME.

PT SLEPT THE MAJORITY OF THE TRANSPORT. NO FURTHER CHANGES NOTED.

Vitals

Time	BP	Pulse	RR	SPo2 %	GCS	Performed By
22:51	116/74 (88)	88	18			ANDERSON, CHASE,AMR
23:10	117/80 (92)	85	18			ANDERSON, CHASE,AMR
23:55	115/75 (88)	85	18			ANDERSON, CHASE,AMR

Treatment and Response

60195177

PTA	Time	Medic	Procedure
	22:51:00	ANDERSON, CHASE,AMR	Monitor Other Existing Treatment - Peripheral IV , Result: Unchanged .
	22:51:00	ANDERSON, CHASE,AMR	Vital Signs - Blood Pressure Method: Manual Cuff , BP: 116 / 74 , Patient Position: Semi-Fowlers . Pulse at: Radial , Pulse Rate: 88 , Pulse Regularity: Regular , Pulse Strength: Normal , Respirations: 18 , Respiration Depth: Normal , Respiration Effort: Normal ,
	23:10:00	ANDERSON, CHASE,AMR	Vital Signs - Blood Pressure Method: Automated Cuff , BP: 117 / 80 , Patient Position: Semi-Fowlers . Pulse at: Radial , Pulse Rate: 85 , Pulse Regularity: Regular , Pulse Strength: Normal , Respirations: 18 , Respiration Depth: Normal , Respiration Effort: Normal ,
	23:55:00	ANDERSON, CHASE,AMR	Vital Signs - Blood Pressure Method: Automated Cuff , BP: 115 / 75 , Patient Position: Semi-Fowlers . Pulse at: Radial , Pulse Rate: 85 , Pulse Regularity: Regular , Pulse Strength: Normal , Respirations: 18 , Respiration Depth: Normal , Respiration Effort: Normal ,

Patient Disposition

60195177

Mileage Scene: 0.0
Mileage Hospital: 161.5
Total Mileage: 161.5

Destination Decis: Patient/Family Request

Transfer Time:

Patient Medical Insurances

60195177

SELF PAY Policy#:self pay,

Guarantor:

Self
COX, JENNIE
222 w chapman rd, greenville, SC 29627

Employer:

1st Attendant: ANDERSON,
CHASE,AMR

2nd Attendant: ONEILL, BRYAN,AMR

Number: 10491
Certification: Paramedic

Number: 44557
Certification: EMT Intermediate

Hospital Signature:  35-0099-

(Muller)

3701-

American Medical Response

Run Number 60195177 Date and Time of Transport 5/31/2012 at 22:43:00
Patient Name COX, JENNIE
Destination: , 701 grove rd, greenville, SC 29605

I acknowledge that I am legally responsible for the ambulance services provided to me. I request and assign payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to AMR directly for any ambulance services and supplies furnished to me by AMR, whether in the past, now or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as AMR, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now, or in the future. I agree to cooperate with AMR or its agent in collecting any such benefits. I acknowledge that I have been provided with a copy of AMR's Notice of Privacy Practices. I expressly authorize AMR or its agents or associates to contact me or any responsible party at any phone number provided, including any cellular phone number provided, for the purpose of resolving any unpaid balances or other pertinent issues. Nothing herein shall relieve me from direct financial responsibility for any charges not paid by an insurer. I further agree to send promptly to AMR any payments that an insurer forwards to me.

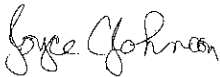
Signature of Patient

Date

REPRESENTATIVE SIGNATURE

Reason Patient could not Sign: Sedated

By signing below, I certify that I am one of the following individuals and that I am authorized to sign on the patient's behalf (check one):
Relative or other person who arranges patient's treatment or manages the patient's affairs (42 CFR 424.36(b)(3))



Signature of Representative

joyce

Printed Name of Representative

6/1/2012

Date

FACILITY SIGNATURE

Complete this section only if you are unable to obtain the signature of the patient or authorized representative listed above.

Reason Patient could not Sign: Sedated

By signing below, I certify that the above named patient was physically or mentally incapable of signing at the time of transport and that none of the individuals listed in 42 C.F.R. §424.36(b)(1)-(3) was available or willing to sign the claim on behalf of the beneficiary.

Crew Signature

Crew Date

This section is to be complete by a representative of the receiving facility, whenever you are unable to obtain the signature of the patient or an authorized representative. Note: The crew must also complete the "Crew Signature" Section above.

Name and Location of Facility

The above named patient, as described by AMR, was received by our facility, which provided care or assistance to the patient, on the date and time set forth above.

Signature of Receiving Representative

Date

Printed Name of Receiving Facility Representative

Title

AMR is required to obtain this form in order to submit a claim for payment to Medicare or other third party payer. This Signature is not an acceptance of financial responsibility for the patient.

Supply Description	Quantity	
Pulse Ox	1	3092
Linen-disposable	1	3056
Gloves / cleaning supplies	1	3013

APA #3
GREENVILLE MEMORIAL
06/01/12 & 06/12/12

Pt Name: COX, JENNIE C MRN: 971202636
Pt ID: 20102920969 Acct No: 03014432629
DOB: 08/14/1952 Age/Sex: 59Y/F
Adm DTime: 01/05/2012 11:30 Attn Dr: Ellis, Jennifer MD
Nurse Sta: Rm/Bed:
Dx:
Allrg: Milk of Magnesia, No Known Food Allergies

Order Name: CT Head W/O Contrast Observation Dtime: 06/01/2012 02:20
Result Name: CT Head Result Status: Final Result

IMPRESSION: NEGATIVE NONCONTRAST HEAD CT EXAM.

ADDENDUM: I have located an old head CT exam of 10/12/06 and I don't see a significant change in the examination in comparison with that study.

ORDERING MD:YULIYA YURKOOP LOCATION:ETC CRITICAL CARE

RC120300 - CT HEAD W/O CONTRAST 6/1/2012 2:20 AMEXAM#: 12481979

ORDERED BY: Dr. YULIYA YURKO

REASON FOR EXAM: HEAD INJURY/FALLTRAUMA PROTOCOL---TRAUMA PROTOCOL---

RESULT:COX, JENNIE

CT HEAD WITHOUT CONTRAST 6/01/12

CLINICAL: Fall with pain.

Skull base to vertex noncontrast head CT images. No comparison exam.

Exam demonstrates no evidence of an acute intracranial hemorrhage, localized mass effect of shift of the midline. The ventricles and other CSF spaces appear normal. No changes of infarction are seen at this time. No abnormalities of the skull are noted.

TRANSCRIPTIONIST:KATHY YARLETT

TRANSCRIBE TIME/DATE:6/1/2012 8:27:00 AM

READ BY:MICHAEL EVERT, MD,

SIGNED BY:

0 ELECTRONIC SIGNATURE / EVERT, MD,MICHAEL

Comments

Result Comments: GCT0112GDT

Requisition Comments:

Ordering Dr: Yurko Yuliya Y

Order Date/Time: 06/01/2012 02:20

Ord#/Occurrence#: 8675145 / 11427588

Pt Name: COX, JENNIE C MRN: 971202636
Pt ID: 20102920969 Acct No: 03014432629
DOB: 08/14/1952 Age/Sex: 59Y/F
Adm DTime: 01/05/2012 11:30 Atn Dr: Ellis, Jennifer MD
Nurse Sta: Rm/Bed:
Dx:
Alrg: Milk of Magnesia, No Known Food Allergies

**** Stat Result ****

Order Name: DX Chest Single View Observation Dtime: 06/01/2012 01:59
Result Name: Chest PA Result Status: Final Result

ORDERING MD: JOHN RINKLIFF, MDOP LOCATION:
UMG - GENERAL SURGERY
35 MEDICAL RIDGE DRIVE
GREENVILLE, SC, 29605
RX410200 - CHEST SINGLE VIEW 6/1/2012 1:59 AMEXAM#: 12481972
ORDERED BY: Dr. JOHN RINKLIFF, MD
REASON FOR EXAM: fall* fall---* fall---
PATIENT - JENNIE MAE COX
PROCEDURE: ONE VIEW CHEST, 6/1/12.
History: Fall.
Findings: Time of study is 2:11 a.m. and comparison is with
8/16/04. Heart size is stable. Pulmonary vasculature is normal. I
see no consolidation and no pneumothorax.
TRANSCRIPTIONIST: GLORIA PARKER
TRANSCRIBE TIME/DATE: 6/1/2012 9:50:00 AM
READ BY: STEVEN C. LOWE, MD,
SIGNED BY:
0 ELECTRONIC SIGNATURE / LOWE, MD, STEVEN C.

Comments

Result Comments: GRD0129GDT

Requisition Comments:

Ordering Dr: Rinkliiff John Order Date/Time: 06/01/2012 01:59
Ord#/Occurrence#: 8675286 / 11428046

Pt Name: COX, JENNIE C

MRN: 971202636

Rm/Bed:

Page 1 of 1

Chest PA Results Report

Shoulder Ap&Lat Results Report

Pt Name: COX, JENNIE C MRN: 971202636
Pt ID: 20102920969 Acct No: 03014432629
DOB: 08/14/1952 Age/Sex: 59Y/F
Adm DTime: 01/05/2012 11:30 Atn Dr: Ellis, Jennifer MD
Nurse Sta: Rm/Bed:
Dx:
Alrg: Milk of Magnesia, No Known Food Allergies

Order Name: DX Shoulder AP Lat Observation Dtime: 06/02/2012 09:59
Result Name: Shoulder Ap&Lat Result Status: Final Result

IMPRESSION:

UNREMARKABLE EXAM.

ORDERING MD: JASON WELLSOP LOCATION: NS VASCULAR

' '
RX495577L - LEFT SHOULDER AP/LAT/AXILARY 6/2/2012 9:59 AM EXAM#: 12484265

ORDERED BY: Dr. JASON WELLS

REASON FOR EXAM: left shoulder pain left shoulder pain left shoulder
xray---left shoulder pain left shoulder xray---

RESULT:

JENNIE MAE COX

LEFT SHOULDER, 6/2/2012:

Internal and external rotation views of the left shoulder as well as
an axillary view are submitted. The clinical history is that of left
shoulder pain. No soft tissue or bony abnormality was identified.

TRANSCRIPTIONIST: J. DAN HIPPS

TRANSCRIBE TIME/DATE: 6/2/2012 7:23:00 PM

READ BY: D. MACK THOMASON, MD,

SIGNED BY:

0 ELECTRONIC SIGNATURE / THOMASON, MD, D. MACK

Comments

Result Comments: GRD0249GDT

Requisition Comments:

Ordering Dr: Wells Jason T Order Date/Time: 06/02/2012 09:59
Ord#/Occurrence#: 8703082 / 11469897

Pt Name: COX, JENNIE C

MRN: 971202636

Rm/Bed:

Page 1 of 1

Shoulder Ap&Lat Results Report

APA #4
JAMES L. FOWLER, M.D.
GHS Plastic Surgery & Aesthetics
06/01/12-10/12/15

OP Notes/GI Lab Results Report

Pt Name:	COX, JENNIE C	MRN:	071202636
Pt ID:	20102920969	Acct No:	08015693988
DOB:	08/14/1952	Age/Sex:	62Y/F
Adm DTime:	07/05/2012 09:35	Attn Dr:	Fowler, James MD
Nurs Sta:	GMH OP Dept	Rm & Bed:	
Dx:			
Allrg:	Milk of Magnesia, No Known Food Allergies		

Order Name:		Observation Dtime:	06/01/2012 08:00
Result Name:	OP Notes/GI Lab	Result Status:	Final Result

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: COX, JENNIE MAE Patient Location: 083C3329AM
PATIENT MR#: 000-971-20-2636 Billing NO: 080015539394
DATE OF PROCEDURE: 06/01/2012
PREOPERATIVE DIAGNOSES:
1. Bilateral subcondylar mandible fractures.
2. Left body comminuted mandible fracture.
3. Avulsed maxillary and mandibular teeth.
POSTOPERATIVE DIAGNOSES:
1. Bilateral subcondylar mandible fractures.
2. Left body comminuted mandible fracture.
3. Avulsed maxillary and mandibular teeth.
PROCEDURE:
1. Maxillomandibular fixation with intramaxillary fixation screws.
2. Open reduction and internal fixation left body mandible fracture.
3. Dental tooth extraction: Left mandibular and maxillary central and lateral incisors, right mandibular and maxillary central incisor.
ATTENDING SURGEON: James L. Fowler, III, M.D.
ANESTHESIA: General endotracheal anesthesia per nasotracheal RAE tube.
ESTIMATED BLOOD LOSS: 50 mL.
SPECIMENS: None.
COMPLICATIONS: None.
INDICATIONS: Status post blunt trauma after falling onto a concrete loading dock. The patient sustained mandible fractures x3. The plan is for maxillomandibular fixation, removal of avulsed teeth, which had several dental caries and are in need of removal. The patient has no dentition distal to the bicusps on the maxilla or mandible. Therefore, plan is for maxillomandibular fixation with very few points of contact for occlusion and open reduction and internal fixation of the body fracture of the mandible to allow early mobilization, and closed reduction of the subcondylar fractures. The risks and benefits were discussed with the patient and patient's family. They understand and they wish to proceed.
DESCRIPTION OF PROCEDURE: The patient was brought to the operating room after informed consent was obtained. General endotracheal anesthesia was administered per nasotracheal RAE tube. The face was prepped with Betadine and draped with sterile towels and sterile drapes. A time-out was held. The self-retaining lip retractor was placed. The throat pack was placed under direct vision. The pharynx appeared without edema or swelling, no

Pt Name: COX, JENNIE C
Rm/ Bed:

MRN: 071202636
Page 1 of 3

OP Notes/GI Lab Results Report

ORE_0126.rpt v1.00

Printed By :Bowens, Julie

Printed On: 31-Mar-15 10:28

OP Notes/GI Lab Results Report

Pt Name:	COX, JENNIE C	MRN:	971202636
Pt ID:	20102920969	Acct No:	08015603960
DOB:	08/14/1952	Age/Sex:	62Y/F
Adm DTime:	07/05/2012 09:35	Attn Dr:	Fowler, James MD
Nurs Sta:	GMH OP Dept	Rm & Bed:	
Dx:			
Allrg:	Milk of Magnesia, No Known Food Allergies		

Order Name:		Observation Dtime:	06/01/2012 08:00
Result Name:	OP Notes/GI Lab	Result Status:	Final Result

epistaxis or blood was noted in the pharynx after nasotracheal intubation. The mouth was irrigated copiously with Peridex. The dentition was examined and multiple teeth were found to be very loose, mobile, and holding on by gingival attachments only. The Freer was used to extract the six teeth described above. This left bipolar bicuspid and canine teeth for occlusion between the maxilla and the mandible. Next, 8 mm intramaxillary fixation screws were placed between the canine and bicuspid of the mandible and maxilla bilaterally. The remaining dentition was readily brought into occlusion. The fracture and the left body of the mandible were injected with 1% Xylocaine containing epinephrine. The Bovie cautery was used to incise through the mucosa and the muscular attachments including the periosteum. Subperiosteal dissection revealed a comminuted fracture of the mandible over the left body, which extended from the parasymphysal region and the menton to the posterior body of the mandible. There was a long oblique fracture low on the mandible and to series of comminuted fractures towards the previous alveolus distal to the bicuspid on the left mandible. Loose, devitalized bone fragments were debrided in this area. The fracture was irrigated copiously with normal saline. The fracture was readily reduced. A four-hole tension band was applied across the superior fracture just below the area of comminution and just above the mental nerve. The mental nerve was readily identified and preserved. The monocortical screws were utilized for the tension band. Once the tension band was in place, bigonial pressure was able to be applied and a six-hole 2.0 Synthes titanium plate was fashioned over a template, which was placed spanning the mandibular margins from the parasymphysal region to the mid body, spanning the fracture. The plate was affixed using bicortical screws holding bigonial pressure. Good reduction resulted. Occlusion remained stable. The dissection was irrigated with thrombin spray. Closure was performed with musculomucosal interrupted sutures of 3-0 Vicryl. The gingiva over the areas of avulsed teeth was loosely approximated using interrupted 3-0 chromic sutures. Again, the mouth was irrigated with Peridex. The occlusal wires were removed. The mandible was arranged. Reduction maneuver was performed with inferior and anterior rotation of the mandible cleaning it back into occlusion after the throat pack had been removed. Occlusal wires were replaced. The patient tolerated the procedure well and a lip retractor was removed. The patient was successfully extubated after passage of a nasogastric tube to allow aspiration of the pharynx and stomach prior to emergence. The patient emerged pain-free and was transferred to the hospital stretcher for transfer to the recovery room, for subsequent admission to the hospital.

Pt Name: COX, JENNIE C
Rm/Bed:

MRN: 971202636
Page 2 of 3

OP Notes/GI Lab Results Report

ORE_0126.rpt v1.00

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OP Notes/GI Lab Results Report

Pt Name:	COX, JENNIE C	MRN:	971202838
Pt ID:	20102920969	Acct No:	08015693988
DOB:	08/14/1952	Age/Sex:	62Y/F
Adm DTime:	07/05/2012 09:35	Atn Dr:	Fowler, James MD
Nurs Sta:	GMH OP Dept	Rm & Bed:	
Dx:			
Allrg:	Milk of Magnesia, No Known Food Allergies		

Order Name:
Result Name: OP Notes/GI Lab

Observation DTime: 06/01/2012 08:00
Result Status: Final Result

James L. Fowler, III, MD
cc: James L. Fowler, III, MD
D: 06/01/2012 02:12 P T: 06/02/2012 07:27 A zst
DVI: 536063 C/S#: 3631856

Comments

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:
Ord#/Occurrence#: /

Pt Name: COX, JENNIE C
Rm/Bed:

MRN: 971202838
Page 3 of 3

OP Notes/GI Lab Results Report

ORE_0126.rpt v1.00

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Outpatient Notes Results Report

Pt Name:	COX, JENNIE C	MRN:	971202636
Pt ID:	20102920969	Acct No:	08015893968
DOB:	08/14/1952	Age/Sex:	62Y/F
Adm DTime:	07/05/2012 09:35	Attn Dr:	Fowler, James MD
Nurs Sta:	GMH OP Dept	Rm & Bed:	
Dx:			
Allrg:	Milk of Magnesia, No Known Food Allergies		

Order Name:		Observation DTime:	06/11/2012 08:00
Result Name:	Outpatient Notes	Result Status:	Final Result

PATIENT: COX, JENNIE

MRN: 971202636

June 11, 2012

She presents today in follow up of ORIF of comminuted symphyseal mandible fracture and closed reduction of two subcondylar fractures.

PHYSICAL EXAMINATION: She remains wired and of good occlusion of four teeth that remain. The incision is closed, hygiene is good. She is taking protein supplements. She is able to eat grits as she has a large space anteriorly and posteriorly through which pureed fractured jaw diet may pass. Pain has been controlled, swelling is decreased considerably.

ASSESSMENT/PLAN: The plan is for continued good oral hygiene in a levered and wired occlusion for one more week. She will follow up next week at which time we will clip the wires.

James L. Fowler III, M.D.

JLF/shc

T: 6/12/2012

Comments

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:

Ord#/Occurrence#: /

Pt Name: COX, JENNIE C

MRN: 971202636

Outpatient Notes Results Report

Rm/ Bed:

Page 1 of 1

ORE_0126.rpt v1.00

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Printed By :Bowens, Julius
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Outpatient Notes Results Report

Pt Name:	COX, JENNIE C	MRN:	971202636
Pt ID:	20102920969	Acct No:	08015693968
DOB:	08/14/1952	Age/Sex:	62Y/F
Adm DTime:	07/05/2012 09:35	Attn Dr:	Fowler, James MD
Nurs Sta:	GMH OP Dept	Rm & Bed:	
Dx:			
Allrg:	Milk of Magnesia, No Known Food Allergies		

Order Name:	Observation DTime:	06/18/2012 08:00
Result Name:	Result Status:	Final Result

PATIENT: COX, JENNIE

MRN: 971202636

June 18, 2012

She is status post ORIF of mandible. She had bilateral subcondylar mandible fractures as well as left body comminuted mandible fracture. She had ORIF of the body fracture and has been in occlusion with IMF screws. She had multiple tooth extractions and had four teeth to occlude. She has had decrease in pain, she is not complaining of pain at all today. Swelling has completely resolved and she has some hollowing of the cheeks. She has no mandibular pain, either in the TMJ's or the left body.

PHYSICAL EXAMINATION: Incision interorally remains closed, the occlusal wires are removed. She has 2 cm of interincisal opening. She is healing well.

ASSESSMENT/PLAN: Plan is to schedule her for removal of IMF screws. She is to remain on soft diet for two additional weeks and we will schedule her for the IMF screw removal in the next week.

James L. Fowler III, M.D.

JLF/sbc

T: 6/19/2012

Comments

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:

Ord#/Occurrence#: 1

Pt Name: COX, JENNIE C

MRN: 971202636

Rm/Bed:

Page 1 of 1

Outpatient Notes Results Report

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Printed On: 31-Mar-16 10:29

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OP Notes/GI Lab Results Report

Pt Name:	COX, JENNIE C	MRN:	971202836
Pt ID:	20102920968	Acct No:	08015693968
DOB:	08/14/1952	Age/Sex:	62Y/F
Adm DTime:	07/05/2012 09:35	Atn Dr:	Fowler, James MD
Nurs Sta:	GMH OP Dept	Rm & Bed:	
Dx:			
Allrg:	Milk of Magnesia, No Known Food Allergies		

Order Name:		Observation Dtime:	07/05/2012 08:00
Result Name:	OP Notes/GI Lab	Result Status:	Final Result

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: COX, JENNIE C Patient Location: 080D1001AM
PATIENT MR#: 000-971-20-2636 Billing NO: 080015693968
DATE OF PROCEDURE: 07/05/2012
PREOPERATIVE DIAGNOSIS: Mandible fracture.
POSTOPERATIVE DIAGNOSIS: Mandible fracture.
PROCEDURE: Removal of IMF screws.
SURGEON: Dr. James L. Fowler, III.
ASSISTANT: None.
ANESTHESIA: Intravenous sedation and 1% Xylocaine with epinephrine 5 mL injected.
ESTIMATED BLOOD LOSS: Less than 1 mL.
COMPLICATIONS: None.
INDICATIONS: Status post open reduction internal fixation, mandible fracture with maxillomandibular fixation with IMF screws. Patient had the occlusal wires removed as jaw has remained stable. She has good range of motion. She has lost multiple teeth, but does have the ability to chew, and the mandible has remained stable with maintaining her current occlusal pattern with her few remaining teeth. The plan is for removal of IMF screws. Risks and benefits were discussed, and the patient wishes to proceed.
DESCRIPTION OF PROCEDURE: The patient was brought to the operating room after informed consent was obtained. The patient was placed supine on the operating room table. The face was prepped with PHisoHex and draped with sterile towels and a sterile drape. Time-out was held. A self-retaining lip retractor was placed. The mucosa was prepped with Peridex. Each screw insertion site was injected with 1 mL of 1% Xylocaine with epinephrine. Each screw was removed using the screwdriver without complications. Pressure was held. Peridex was used to re-prep and cleanse the mucosa. Previous gingivobuccal mucosal closures remained intact. The mandible demonstrated normal range of motion. The mandible was stable to compression and testing with range of motion. The lip retractor was removed after the oral cavity was suctioned, and the patient as transferred to the recovery room hemodynamically stable and awake, tolerating secretions and swallowing well. The patient is given follow up in my office in one month. IMF screws were removed x4.
James L. Fowler, III, MD

Pt Name: COX, JENNIE C
Rm/ Bed:

MRN: 971202836
Page 1 of 2

OP Notes/GI Lab Results Report

ORE_0128.rpt v1.00

Printed By :Bowens, Julius

Printed On: 31-Mar-15 10:30

OP Notes/GI Lab Results Report

Pt Name: COX, JENNIE C MRN: 971202636
Pt ID: 20102920969 Acct No: 08015693988
DOB: 08/14/1952 Age/Sex: 62Y/F
Adm DTime: 07/05/2012 09:35 Attn Dr: Fowler, James MD
Nurs Sta: GMH OP Dept Rm & Bed:
Dx:
Allrg: Milk of Magnesia, No Known Food Allergies

Order Name: Observation DTime: 07/05/2012 08:00
Result Name: OP Notes/GI Lab Result Status: Final Result

cc: James L. Fowler, III, MD
D: 07/05/2012 04:56 P T: 07/06/2012 06:58 A zjt
DVI: 554298 C/S#: 3656035

Comments

Result Comments:

Requisition Comments:

Ordering Dr: Order Date/Time:
Ord#/Occurrence#: /

Pt Name: COX, JENNIE C
Rm/ Bed:

MRN: 971202636
Page 2 of 2

OP Notes/GI Lab Results Report

ORE_0128.rpt v1.00

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Printed On: 31-Mar-15 10:30

Outpatient Notes Results Report

Pt Name:	COX, JENNIE C	MRN:	971202636
Pt ID:	20102820969	Acct No:	08015683968
DOB:	08/14/1952	Age/Sex:	62Y/F
Adm DTime:	07/05/2012 09:35	Atn Dr:	Fowler, James MD
Nurs Sta:	GMH OP Dept	Rm & Bed:	
Dx:			
Allrg:	Milk of Magnesia, No Known Food Allergies		

Order Name:		Observation DTime:	08/03/2012 08:00
Result Name:	Outpatient Notes	Result Status:	Final Result

PATIENT: COX, JENNIE C.

MRN: 971202636

August 3, 2012

She presents today after mandible fracture. She has had the IMF screws removed. She has healed those areas. She does not have any jaw pain, she has good range of motion without clicking, popping or subluxation of TMJ's. Occlusion has remained stable.

PHYSICAL EXAMINATION: On examination there is no malocclusion and interincisal opening is normal. She has no pain at the TMJ or over the left body of the mandible.

ASSESSMENT/PLAN: She has seen Dr. Cobb for dental restoration. He has identified the plates and identified the tension and on the left as a potential problem regrinding denture fit and I am able to take that out if need be. Otherwise the plate would be to stay in place. She may return to a completely normal diet. She is not impaired from a jaw standpoint and she will follow up in our office in three months.

James L. Fowler III, M.D.

JLF/sbc

T: 8/6/2012

Comments

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:

Ord#/Occurrence#: 1

Pt Name: COX, JENNIE C

MRN: 971202636

Outpatient Notes Results Report

Rm & Bed:

Page 1 of 1

ORE_0126.rpt v1.00

Outpatient Notes Results Report

Pt Name:	COX, JENNIE C	MRN:	971202636
Pt ID:	20102920989	Acct No:	08016693968
DOB:	08/14/1952	Age/Sex:	62Y/F
Adm DTime:	07/05/2012 09:35	Attn Dr:	Fowler, James MD
Nurs Sta:	GMH OP Dept	Rm & Bed:	
Dx:			
Allrg:	Milk of Magnesia, No Known Food Allergies		

Order Name:		Observation DTime:	11/05/2012 08:00
Result Name:	Outpatient Notes	Result Status:	Final Result

PATIENT: COX, JENNIE

MRN: 971202636

November 5, 2012

She presents today after ORIF of mandible. She has been seen by a prosthodontist and is scheduled for dental restoration.

PHYSICAL EXAMINATION: On examination the incisions are healed, the swelling is gone. She has a little bit of deviation of the mandible with maximal opening. No pain, no clicking, no popping, no subluxation of the TMJ's.

ASSESSMENT/PLAN: She has done well. She reports that her nutrition has been affected in that she is having to work to get enough nutrition in, particularly when she is on the job. She is eating pureed foods. She does report getting a pork tenderloin the other week and was able to eat it once cut into small bites. We have recommended softer food diet and maintaining her nutrition as needed with calorie supplements including Ensure or Carnation Instant Breakfast. She has not acknowledged any need for a nutritional consult at this time and she will proceed with her dental restoration and she will follow up in this office prn.

James L. Fowler III, M.D.

JLF/sbc

T: 11/6/2012

Comments

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:

Ord#/Occurrence#: 1

Pt Name: COX, JENNIE C

MRN: 971202636

Outpatient Notes Results Report

Rm/ Bed:

Page 1 of 1

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GREENVILLE HEALTH SYSTEM

COX, JENNIE C

62 Y old Female, DOB: 08/14/1952

Account Number: 971202636

222 W CHAPMAN RD, BELTON, SC-29627

Home: 864-243-0032

Guarantor: COX, JENNIE C Insurance: SELF PAY

Appointment Facility: GHS Plastic Surgery

06/08/2015

PROGRESS NOTE: James L. Fowler, MD

Current Medications

Taking

- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)
- Medication List reviewed and reconciled with the patient

Surgical History

Hysterectomy and lap lysis of adhesions

4/2001

ORIF of mandible 6/1/12

Removal of MMF screws 7/5/12

Social History

Alcohol women 18 yrs and older Assessment completed: **today**, Alcohol intake: **patient does not drink alcohol screening complete.**

Smoking Status > 13 years old Are you a:

Current smoker, Pt counseled on the dangers of tobacco use and urged to quit. 06/08/2015.

Allergies

Magnesium

Hospitalization/Major

Diagnostic Procedure

See surgery history

Reason for Appointment

1. EST MANDIBLE FX DOI 5.31.12

Assessments

1. Mandible fracture - 802.20 (Primary)

Nonunion of the body of an atrophic mandible.

We will obtain a CT scan. We will attempt to obtain copies of Dr. Cobb's panoramic views. She will follow-up in a week. We have discussed surgery with removal of hardware as necessary, bone biopsy, and possible staged approach with bone grafting as necessary. She will follow-up next week.

James L. Fowler, III, M.D./pan.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds **Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.**

Patient is to continue all medications as directed by prescribing physicians. Continuations on today's visit are made based on the patient's report of current medications.

Follow Up

1 Week

History of Present Illness

SPLA HPI:

She presents today status post ORIF of the mandible in 2012. She has recently had dental restoration with Dr. Cobb and he has done some nice work with a mandibular dental prosthesis that is fixed into place. He has done panoramics and has noted some scabbing at the body of the mandible on the left side. She has been able to eat and has done fairly well without discomfort to the jaw specifically. She reports the scab not getting better over time. She denies any fever or chills or chronic drainage from the area.

Vital Signs

Wt lbs 113, Wt kg 51.26, BP 122/75, HR 81.

Examination



GREENVILLE HEALTH SYSTEM

COX, JENNIE C

62 Y old Female, DOB: 08/14/1952

Account Number: 971202636

222 W CHAPMAN RD, BELTON, SC-29627

Home: 864-243-0032

Guarantor: COX, JENNIE C Insurance: SELF PAY

Appointment Facility: GHS Plastic Surgery

06/15/2015

PROGRESS NOTE: James L. Fowler, MD

Current Medications

Taking

- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)
- Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

Hysterectomy and lap lysis of adhesions

4/2001

ORIF of mandible 6/1/12

Removal of MMF screws 7/5/12

Family History

No Family History documented.

Social History

Alcohol women 18 yrs and older Assessment completed: **today**, Alcohol intake: **patient does not drink alcohol screening complete**.

Smoking Status > 13 years old Are you a:

Current smoker, Pt counseled on the dangers of tobacco use and urged to quit. 06/08/2015.

Allergies

Magnesium

Hospitalization/Major

Diagnostic Procedure

See surgery history

Reason for Appointment

1. RECK/LT MANDIBLE FX/1 WEEK/DOI 5.31.12

Assessments

1. Mandible fracture - 802.20 (Primary)

Treatment

1. Mandible fracture

Notes: ASSESSMENT: Exposure of left mandibular plate. I have recommended removal of the indwelling device of the mandibular bone and along with removal of plate and screws in then operating room. Risks and benefits have been discussed. She understands that we could obtain a bone culture at surgery that would show osteomyelitis in which case she may need prolonged IV antibiotics and possibly a fixator device. We discussed a trophic mandible and the loss of size and strength of that bone and suggested that she might need to abort an implanted device of the mandible. She understands these risks and we will schedule in the next scheduling with Dr. Cobb's removal of the dental prosthesis and the surgery to remove the plate and screws. James L. Fowler, III, M.D./mad.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds **Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.**

Patient is to continue all medications as directed by prescribing physicians. Continuations on today's visit are made based on the patient's report of current medications.

Follow Up

prn

History of Present Illness

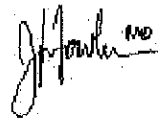
SPLA HPI:

HPI: She presents with a draining sinus to the left jaw in the region of a previous ORIF and plate and screw placement for a compound fracture of an atrophic mandible. The patient was seen by Dr. Cobb in oral surgery and had implanted dental restoration with screw placement in the mandibular bone. The patient reports having some

pressure applied to the mandible during placement of this device over the area of the plate with some pain. She later presented to him with a draining sinus and she was referred here for evaluation for possible infection. She denies fevers or chills, nausea or vomiting. There is no erythema. There is no purulence. She was sent for a CT scan and was found to have osseous healing with a point of prominence of the plate over the body on the left side. This corresponds to the point of drainage. CT reports no evidence of osteomyelitis. No soft tissue gas and the bone does not appear to have findings consistent with osteomyelitis. She is currently not on an antibiotic.

Vital Signs

Ht 67, Ht Cm 170.18, Wt lbs 113, Wt kg 51.26, BMI 17.70, BP 139/84, HR 99.



Electronically signed by James Fowler , MD on 06/30/2015 at 02:39 PM EDT

Sign off status: Completed

GHS Plastic Surgery
200 Patewood Dr, Suite B480
Greenville, SC 29615
Tel: 864-454-4570
Fax: 864-241-9270

Patient: COX, JENNIE C DOB: 08/14/1952 Progress Note: James L. Fowler, MD 06/15/2015

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



GREENVILLE HEALTH SYSTEM

COX, JENNIE C

62 Y old Female, DOB: 08/14/1952

Account Number: 971202636

222 W CHAPMAN RD, BELTON, SC-29627

Home: 864-243-0032

Guarantor: COX, JENNIE C Insurance: SELF PAY

Appointment Facility: GHS Plastic Surgery

06/29/2015

Progress Note: James L. Fowler, MD

Current Medications

Taking

- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)
- Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

Hysterectomy and lap lysis of adhesions

4/2001

ORIF of mandible 6/1/12

Removal of MMF screws 7/5/12

Family History

No Family History documented.

Social History

Alcohol women 18 yrs and older Assessment completed: today, Alcohol intake: patient does not drink alcohol screening complete.

Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit. 06/08/2015.

Allergies

Magnesium

Hospitalization/Major

Diagnostic Procedure

See surgery history

Reason for Appointment

1. POV

Assessments

1. Mandible fracture - 802.20 (Primary)

Plan is for no dentures for a total of one month. She wishes to remain out of work for the period that she cannot wear dentures. She will continue to rinse with Listerine, which is her preferred mouthwash and she is completing the postoperative oral antibiotic course. Once that is completed, she will discontinue antibiotics. She will follow-up in the office for any kind of recurrent swelling in the area and will otherwise follow-up in two weeks. I recommended that she just leave the bone anchors in place for the time being.

James L. Fowler, III, M.D./pan.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

1 Week

History of Present Illness

SPLA HPI:

She presents today postop from removal of mandibular plates and screws. The denture anchors remain in place. Cultures from the removal of the plate, the cortical bone, did not grow anything but sparse skin flora. Clinically she did not have any purulent infection and had complete osseous healing.

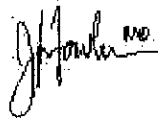
Vital Signs

BP 141/90, HR 70, Pain score 0.

Examination

SPLA-Examination:

The sutures of the skin remain. The closure intraorally remains closed.



**Electronically signed by James Fowler , MD on 07/16/2015 at
04:58 PM EDT**

Sign off status: Completed

**GHS Plastic Surgery
200 Patewood Dr, Suite B480
Greenville, SC 29615
Tel: 864-454-4570
Fax: 864-241-9270**

Patient: COX, JENNIE C DOB: 08/14/1952 Progress Note: James L. Fowler, MD 06/29/2015

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



GREENVILLE HEALTH SYSTEM

Plastic Surgery & Aesthetics
200 Polewood Drive Suite B480
Greenville, SC 29615
864-454-4570 Fax: 864-454-4575

RETURN TO WORK STATUS

Patient Name: Jennie Cox was seen in our
office on 6/29/15

Date of Birth: 8/14/52

☐ May return to Work on 7/20/15 with no restrictions

☐ May return to Work with RESTRICTIONS From: _____ To: _____

☐ Unable to Work From: _____ To: _____

- ☐ Limit standing to no more than _____ hr/day.
- ☐ Limit sitting to no more than _____ hr/day.
- ☐ Limit walking to no more than _____ hr/day.
- ☐ No lifting over _____ pounds.
- ☐ No climbing of stairs/ladders.
- ☐ No reaching above shoulder level.
- ☐ No squatting.
- ☐ No bending or stooping.
- ☐ No use of R / L/ Both hands.
- ☐ Other restrictions _____

Follow-up Appointment Date: _____

Dr. Fowler / E. Akins
Physician's Signature

6-29-15
Date

Wesley Culpepper, MD
Carl de Brux, MD
James Fowler, MD
John Jarrell, MD



GREENVILLE HEALTH SYSTEM

COX, JENNIE C

62 Y old Female, DOB: 08/14/1952

Account Number: 971202636

222 W CHAPMAN RD, BELTON, SC-29627

Home: 864-243-0032

Guarantor: COX, JENNIE C Insurance: SELF PAY

Appointment Facility: GHS Plastic Surgery

07/06/2015

Progress Note: NURSE, SPLA

Current Medications

Taking

- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)

Allergies

Magnesium

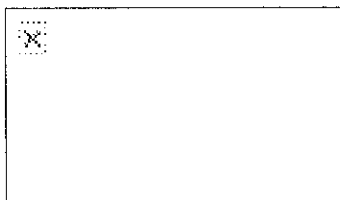
Reason for Appointment

- NURSE CHECK/SUTURE REMOVAL

Treatment

1. Others

Notes: Pt returns to office today to have sutures removed from left side of jaw per Dr. Fowler. Sutures removed with no difficulty, pt tolerated well. No signs of redness, area well approximated, no s/sx of infection noted. Pain under control. Pt has no c/o at this time. Pt to return next week to see Dr. Fowler. E. Akens RN.



Electronically signed by Paula Brown RN on 07/21/2015 at 02:52 PM EDT

Sign off status: Completed

GHS Plastic Surgery
200 Patewood Dr, Suite B480
Greenville, SC 29615
Tel: 864-454-4570
Fax: 864-241-9270

Patient: COX, JENNIE C DOB: 08/14/1952 Progress Note: NURSE, SPLA 07/06/2015

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

SURGERY-PATEWOOD B-480
200 Patewood Dr Ste B480
Greenville SC 29615-6327
Amb Encounter Report

COX, JENNIE C
MRN: 971202636
DOB: 8/14/1952, Sex: F
Enc. Date: 07/17/15

Visit Summary

Reason for Visit

Post-op mandible fracture

Diagnoses

Mandible open fracture, sequela - Primary

Reviewed On: 7/17/2015 By: Etienne Michelle Akens, RN

Allergies as of 7/17/2015

Allergen	Noted	Reaction Type	Reactions	Deletion Reason
Magnesium	07/17/2015		Shortness Of Breath	

Most recent update: 7/17/2015 3:00 PM by Etienne Michelle Akens, RN

Vital Signs

BP	Pulse	Temp(Src)	Ht	Wt	BMI
98/58 mmHg	93	97.9 °F (36.6 °C) (Temporal)	5' 7" (1.702 m)	108 lb (48.988 kg)	16.91 kg/m2

Medical as of 7/17/2015	Past Medical History	Date	Comments	Source
	Mandible fracture			Provider

Surgical as of 7/17/2015	Past Surgical History	Laterality	Date	Comments
	HYSTERECTOMY		4/2001	lap. lysis of adhesions
	ORIF MANDIBULAR FRACTURE		6/1/12	ORIF of mandible
	OTHER SURGICAL HISTORY		7/5/12	Removal of MMF screws

Family as of 7/17/2015	Problem	Relation	Name	Age of Onset	Comments	Source
	Hypertension	Brother				Provider

Family Status as of 7/17/2015 **None**

Tobacco Use as of 7/17/2015	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
	Current Every Day Smoker	Provider		0.0	0.0	urged to quit 8/8/2015			Unknown	

Alcohol Use as of 7/17/2015	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
	No	Provider	0 Not specified	0.0 oz	

Drug Use as of 7/17/2015	Drug Use	Source	Types	Frequency	Comments
	Not Asked	Provider		0.00	

Sexual Activity as of 7/17/2015	Sexually Active	Source	Birth Control	Partners	Comments
	Not Asked	Provider			

Social ADL as of 7/17/2015	ADL Question	Response	Comments	Source
	None			

SURGERY-PATEWOOD B-480
200 Patewood Dr Ste B480
Greenville SC 29615-6327
Amb Encounter Report

COX, JENNIE C
MRN: 971202636
DOB: 8/14/1952, Sex: F
Enc. Date: 07/17/15

Visit Summary (continued)

Occupational ****None****
as of 7/17/2015

Socioeconomic as of 7/17/2015	Marital Status	Spouse Name	Num of Children	Years Education	Source
	Divorced				
	Preferred Language	Ethnicity	Race		
	English	Non-Hispanic or Non-Latino	White or Caucasian		

Medications

Medications the Patient Reported Taking

	Disp	Refills	Start	End

HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet (Taking)

Sig: Take by mouth every 6 (six) hours as needed for moderate pain.

Class: Historical Med

Route: Oral

temazepam (RESTORIL) 30 mg capsule (Taking)

Sig: Take nightly.

Class: Historical Med

Route: Oral

Telephone Encounter

Call Information

	Provider	Department	Center
7/17/2015 2:50 PM	James Lyman Fowler, MD	Plastic Surg-Patewood	PTWD CENTERS

Reason for Call

Post-op mandible fracture

Call Documentation

No notes of this type exist for this encounter.

Care Advice Given

No Care Advice given for this encounter.

Orders

All Orders and Results Except Lab and Imaging

No orders and results found

Result Summary

All Lab and Imaging Orders and Results

No orders and results found

Progress Notes

Progress Notes (continued)

James Lyman Fowler, MD at 7/17/2015 3:04 PM

Author Type: Physician

Status: Signed

Office Visit Note

7/17/2015

Subjective:

Jennie C Cox is a 62 y.o. female.

Chief Complaint

Patient presents with

- Post-op
mandible fracture

HPI

Ms. Cox presents today postop from removal of hardware from the mandible after exposure. She reports decreased pain and swelling. She has not replaced the lower denture at our request. Been off work due to her restriction of a soft diet without this denture.

Review of Systems

Objective:

BP 98/58 mmHg | Pulse 93 | Temp(Src) 97.9 °F (36.6 °C) (Temporal) | Ht 5' 7" (1.702 m) | Wt 108 lb (48.988 kg) | BMI 16.91 kg/m2

Physical Exam

On physical exam H EEE NT: The swelling over the mandible has fully resolved. Her intraoral incision appears healed without dehiscence. She has mild edema that remains at the incision site. There is no fluctuance purulence or instability. Range of motion of the mandible is normal. By gonial pressure does not reveal any instability.

Assessment

Assessment/Plan:

Problem List Items Addressed This Visit

None

Status post exposure of mandibular plate and screws following ORIF. Cortical mandibular integrity was confirmed at the time of surgery. She is to remain on a soft diet for 2 more weeks. I have recommended returning for replacement of her denture at 6 weeks from the time of surgery. She has indicated an interest in returning to work August 1. She is cleared to do so.

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200 Patewood Dr Ste B480
Greenville SC 29615-6327
Amb Encounter Report

COX, JENNIE C
MRN: 971202636
DOB: 8/14/1952, Sex: F
Enc. Date: 07/17/15

Progress Notes (continued)

James Lyman Fowler, MD at 7/17/2015 3:04 PM (continued)

Electronically signed by James Lyman Fowler, MD on 7/17/2015 4:27 PM

Etienne Michelle Akens, RN at 7/17/2015 3:03 PM

Author Type: Registered Nurse Status: Signed

Electronically signed by Etienne Michelle Akens, RN on 7/17/2015 4:27 PM

H&P Notes

No notes of this type exist for this encounter.

Follow-up and Disposition History

User	Date & Time
FOWLER, JAMES	7/17/2015 4:03 PM

Disposition:

Return in about 3 months (around 10/17/2015) for Recheck.

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

Send Reminder:

N/A

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.



**GREENVILLE
HEALTH SYSTEM**

COX, JENNIE C

62 Y old Female, DOB: 08/14/1952

Account Number: 971202636

222 W CHAPMAN RD, BELTON, SC-29627

Home: 864-243-0032

Guarantor: COX, JENNIE C Insurance: SELF PAY

Appointment Facility: GHS Plastic Surgery

07/06/2015

Progress Note: NURSE, SPLA

Current Medications

Taking

- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)

Allergies

Magnesium

Reason for Appointment

1. NURSE CHECK/SUTURE REMOVAL

Treatment

1. Others

Notes: Pt returns to office today to have sutures removed from left side of jaw per Dr. Fowler. Sutures removed with no difficulty, pt tolerated well. No signs of redness, area well approximated, no s/sx of infection noted. Pain under control. Pt has no c/o at this time. Pt to return next week to see Dr. Fowler. E. Akens RN.



Electronically signed by Paula Brown RN on 07/21/2015 at 02:52 PM EDT

Sign off status: Completed

GHS Plastic Surgery
200 Patewood Dr, Suite B480
Greenville, SC 29615
Tel: 864-454-4570
Fax: 864-241-9270

Patient: COX, JENNIE C DOB: 08/14/1952 Progress Note: NURSE, SPLA 07/06/2015

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

**GREENVILLE
HEALTH SYSTEM**

Plastic Surgery & Aesthetics
200 Palewood Drive Suite B480
Greenville, SC 29615
864-454-4570 Fax: 864-454-4575

RETURN TO WORK STATUS

Patient Name: Jennie Cox was seen in our
office on 7-17-15

Date of Birth: 8-14-52

☒ May return to Work on Aug 1, 2015 with no restrictions

☐ May return to Work with RESTRICTIONS From: _____ To: _____

☐ Unable to Work From: _____ To: _____

- ☐ Limit standing to no more than _____ hr/day.
- ☐ Limit sitting to no more than _____ hr/day.
- ☐ Limit walking to no more than _____ hr/day.
- ☐ No lifting over _____ pounds.
- ☐ No climbing of stairs/ladders.
- ☐ No reaching above shoulder level.
- ☐ No squatting.
- ☐ No bending or stooping.
- ☐ No use of R / L/ Both hands.
- ☐ Other restrictions _____

Follow-up Appointment Date: _____

Dr. Fowler / E. Akins MD
Physician's Signature

9-17-15
Date

Wesley Culppepper, MD
Cart de Brux, MD
James Fowler, MD
John Jarrell, MD

SURGERY-PATEWOOD B-480
200 Patewood Dr Ste B480
Greenville SC 29615-6327
Amb Encounter Report

COX, JENNIE C
MRN: 971202636
DOB: 8/14/1952, Sex: F
Enc. Date: 10/12/15

Visit Summary

Reason for Visit
Follow-up

Diagnoses

Open fracture of body of mandible, sequela - Primary

Problem List as of 10/12/2015

Date Reviewed: 10/12/2015

None

Reviewed On: 10/12/2015 By: James Lyman
Fowler, MD

Allergies as of 10/12/2015

Allergen	Noted	Reaction Type	Reactions	Deletion Reason
Magnesium	07/17/2015		Shortness Of Breath	

Most recent update: 10/12/2015 8:45 AM by
Etienne Michelle Akens, RN

Vital Signs

BP	Pulse	Ht	Wt	BMI
118/80 mmHg	87	5' 7" (1.702 m)	112 lb (50.803 kg)	17.54 kg/m2

Medical as of 10/12/2015	Past Medical History	Date	Comments	Source
	Mandible fracture			Provider

Surgical as of 10/12/2015	Past Surgical History	Laterality	Date	Comments
	HYSTERECTOMY		4/2001	lap lysis of adhesions
	ORIF MANDIBULAR FRACTURE		6/1/12	ORIF of mandible
	OTHER SURGICAL HISTORY		7/5/12	Removal of IMF screws

Family as of 10/12/2015	Problem	Relation	Name	Age of Onset	Comments	Source
	Hypertension	Brother				Provider

Family Status **None**
as of 10/12/2015

Tobacco Use as of 10/12/2015	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeles s Tobacco Status	Smokeles s Tobacco Quit Date
	Current Every Day Smoker	Provider		0.0	0.0	urged to quit 6/8/2015			Unknown	

Alcohol Use as of 10/12/2015	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
	No	Provider	0 Not specified	0.0 oz	

Drug Use as of 10/12/2015	Drug Use	Source	Types	Frequency	Comments
	Not Asked	Provider		0.00	

Sexual Activity as of 10/12/2015	Sexually Active	Source	Birth Control	Partners	Comments
	Not Asked	Provider			

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Amb Encounter Report

COX, JENNIE C
MRN: 971202636
DOB: 8/14/1952, Sex: F
Enc. Date: 10/12/15

Visit Summary (continued)

Social ADL	ADL Question	Response	Comments	Source
as of 10/12/2015	**None**			

Occupational	ADL Question
as of 10/12/2015	**None**

Socioeconomic	Marital Status	Spouse Name	Num of Children	Years Education	Source
as of 10/12/2015	Divorced				
	Preferred Language	Ethnicity	Race		
	English	Non-Hispanic or Non-Latino	White or Caucasian		

Medications

Medications the Patient Reported Taking

	Disp	Refills	Start	End

temazepam (RESTORIL) 30 mg capsule
(Taking)

Sig: Take nightly.
Class: Historical Med
Route: Oral

Medications at Start of Encounter

	Disp	Refills	Start	End

temazepam (RESTORIL) 30 mg capsule
(Taking)

Sig - Route: Take nightly. - Oral
Class: Historical Med

HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet

Sig - Route: Take by mouth every 6 (six) hours as needed for moderate pain. - Oral
Class: Historical Med

Telephone Encounter

Call Information

	Provider	Department	Center
10/12/2015 9:40 AM	James Lyman Fowler, MD	Plastic Surg-Patewood	PTWD CENTERS

Reason for Call

Follow-up

Call Documentation

No notes of this type exist for this encounter.

Care Advice Given

No Care Advice given for this encounter.

Orders

Orders (continued)

All Orders and Results Except Lab and Imaging

No orders and results found

Result Summary

All Lab and Imaging Orders and Results

No orders and results found

Progress Notes

James Lyman Fowler, MD at 10/12/2015 8:46 AM

Author Type: Physician
Subjective

Status: Signed

Reason for Visit:

Chief Complaint

Patient presents with

- Follow-up

HPI

Jennie C Cox is a 63 y.o. female who presents with his removal of hardware from the left mandible. She has a healed mandible fracture with an endoprosthesis secured with screws into the mandible. She has healed her incision. She reports some soreness over the area of the left body of the mandible. She reports eating normal regular diet and does not report any pain with eating. She does report some numbness over the chin and the left lower lip..

Review of Systems

Allergies

Allergen

- Magnesium

Reactions

Shortness Of Breath

has a current medication list which includes the following prescription(s): temazepam and hydrocodone-acetaminophen.

Past Medical History

Diagnosis

- Mandible fracture

Date

Past Surgical History

Procedure

- Hysterectomy
lap lysis of adhesions
- Orif mandibular fracture
ORIF of mandible
- Other surgical history
Removal of MMF screws

Laterality

Date

4/2001

6/1/12

7/5/12

History

Progress Notes (continued)

James Lyman Fowler, MD at 10/12/2015 8:48 AM (continued)

Social History

- **Marital Status:** Divorced
- **Spouse Name:** N/A
- **Number of Children:** N/A
- **Years of Education:** N/A

Social History Main Topics

- **Smoking status:** Current Every Day Smoker
- **Smokeless tobacco:** None
Comment: urged to quit. 6/8/2015
- **Alcohol Use:** No
- **Drug Use:** None
- **Sexual Activity:** None

Other Topics

Concern

- None

Social History Narrative

Objective

Physical Exam

HEENT: Swelling has completely resolved. The implantable denture is in place with screws into the mandible including 1 in the left body. The incision is healed. There is no swelling or drainage. By gonial pressure is applied to the mandible and there is no instability. Range of motion of the mandible is normal with good occlusion of the denture. She has tenderness over the body of left mandible. There is no palpable mass, induration, over the left mandible.

BP 118/80 mmHg | Pulse 87 | Ht 5' 7" (1.702 m) | Wt 112 lb (50.803 kg) | BMI 17.54 kg/m2

Assessment

Problem List Items Addressed This Visit

None

Plan

Healed after removal of hardware from the left mandible. The bony integrity of the left mandible was intact at the time of the removal of hardware. The mandible remained stable. She has an implantable denture in place with a screw in the area of the previous fracture that is holding stable. She has residual numbness from the left mental nerve which may be permanent. We should be able to determine that at 12-18 months from her last surgery. Discussed that this could be permanent. She will follow-up in the office as

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Greenville SC 29615-6327
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COX, JENNIE C
MRN: 971202636
DOB: 8/14/1952, Sex: F
Enc. Date: 10/12/15

Progress Notes (continued)

James Lyman Fowler, MD at 10/12/2015 8:46 AM (continued)
needed.

Electronically signed by James Lyman Fowler, MD on 10/12/2015 5:04 PM

H&P Notes

No notes of this type exist for this encounter.

Follow-up and Disposition History

User	Date & Time
FOWLER, JAMES	10/12/2015 9:18 AM

Disposition:

Return if symptoms worsen or fail to improve.

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

Send Reminder:

N/A

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

END OF REPORT

APA #5
GHS CENTER FOR HEALTH AND OCCUPATIONAL
SERVICES
06/12/12-04/08/15

GHS Center for Health and Occupational Services

Phone (864) 455-2300

1020 Grove Road, Greenville, SC 29605

Fax (864) 455-2399

Consent for Occupational Health and Medical Services

Patient Name (PRINT) Last Cox First Jennie M C Sex M ☒ F Race W

Social Security 250-94-3648 Date of Birth 8/14/52 Marital Status D Pref Language Eng

Are you a Veteran? Y ☒ N ☐ Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refuse/Decline

Home Address 222 W. Chapman Rd Belton SC 29627

County Greenville Home # 864-243-0032 Cell (or Primary) # _____

Employer Palmetto State Trans Full Time/ Part Time Full Time Occupation: Truck Driver Length of Employment: 7yrs

Emergency Contact Tammy Wealy Relationship to Patient Daughter Primary Tel # _____

Guarantor Name _____ SS# _____ Address: _____

(If patient is under the age of 18)

The following are the conditions for services by GHS Center for Health and Occupational Services (CHOS) for the patient whose name appears above.

Medical Consent- I consent to all occupational health and medical services, evaluation, and treatment given under the general and special instructions of the physician and/or nurse practitioner, as requested by me, by my employer, and/or as required by municipal, state, or federal statutes that govern my occupation. Services may include, but are not limited to, diagnostic and screening procedures, administration of anesthetics, use of prescribed medication, medical services, the collection and evaluation of cultures and laboratory specimens, and referral to specialty services for radiology, physical therapy, physician consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the physician or designees.

If a health care worker comes in direct contact with my blood or body fluids, I understand that my blood may be tested for Hepatitis B virus, Hepatitis C virus, or HIV (Human Immunodeficiency Virus) to determine whether or not the viruses are present, endangering the health care worker (IN ACCORDANCE WITH South Carolina State Statute title 44, chapter 29, section 44-29-230). The results of testing will be made available to me.

Financial Agreement- I understand that, if my employer requires me to pay for the requested services, then I am required to make full payment at the time service is rendered. Any agreement for reimbursement of these payments is held strictly between the employer and me.

Disclosure / Use of Health Information / Authorization for Release of Medical Information- I request that CHOS provide any health information gathered as a result of the services received to the employer requesting the service, to the insurance company, or to a valid representative of the payor; for purposes of payment for the services provided and to assist me to meet the medical requirements of my employer. I also authorize CHOS to provide health information to other physicians and healthcare facilities for continuing care. I further agree that CHOS can use the health information for operations such as peer review and outcome analysis. My initials here JC will acknowledge that I have received a copy of the CHOS Notice of Privacy Practices. I will be provided with a copy of this signed authorization, at my request.

This authorization for release of information expires 24 months from date of my signature. I may revoke the authorization at any time by writing Center for Health and Occupational Services, Attention: Office Manager, 1020 Grove Road, Greenville, SC 29605. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation.

I may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. Note: There may be a processing fee charged to me, to cover labor, copying, and supplies used to reproduce medical records.

Signatures- I hereby authorize the treatment and the disclosure of personal health information as described above. I understand that this authorization is voluntary. However, if I do not sign this authorization, services will not be provided. Refusing to sign this authorization will not affect any other services I may receive at CHOS. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Patient Signature Jennie Cox Date 6/12/12

Guarantor Name _____ Relationship to Patient _____ Date _____

(If Different from Patient)

Guarantor Signature _____

Witness [Signature] 71 Date 6/12/12

-0138-

**GHS Center for Health and
Occupational Services**

1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jennie Cox SS# 250-94-3648

Company Palmetto State Transportation

Date of Injury 5-31-12

Diagnosis: mandible fracture; chest wall contusions;

Medications: lorazepam at bedtime shoulder pain/weakness

Work Status: May return to work on 6/12/12

☐ Full Duty

☒ Modified Duty:

[None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

☒ Lift, push or pull no more than 5 lbs. [0]

☐ Bend or Twist []

☐ Walk and Stand []

☐ Sit/Stand as needed

☒ Sedentary Work, change positions as needed

☐ No use of _____

☐ Forceful or Repetitive use of (right/left) hand and arm []

☐ Overhead use of (right/left) arm []

☐ Squat or kneel []

☐ Climb or work at heights []

☐ Awkward or Static postures []

☒ No operating heavy machinery or Commercial Motor Vehicle

☐ Elevate affected area _____

☐ Use crutches as needed for ambulation

☐ Use _____ splint as needed

☐ Other _____

Restrictions are for
the chest wall and
shoulder injury -
other restrictions
per Dr. Fowler

[Signature]

Instructions:

☐ Stay active during your recovery.

☒ Use over the counter pain relievers by package directions and/or follow prescription directions.

☒ Report any problems with medications to your provider.

☒ Apply ice or heat to the affected areas as needed.

☒ Begin gentle stretches as demonstrated in clinic or in your self care handout.

☐ Elevate the affected area to reduce swelling.

☒ Wash wound with soap and water 1 times per day.

☒ May apply antibiotic ointment.

☒ Keep bandage clean and dry.

☒ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.

☒ Other: deep breathing 4x/day

Follow Up: after MRI or sooner for any problems

☐ Appointment Date: _____ Time: _____ Provider: _____

☐ Maximum Medical Improvement: Contact your employer prior to making further appointments.

☒ Referral to MRI @ shoulder. You will be contacted with an appointment.

Physician/NP: *[Signature]*

Date: 6-12-12



UNIVERSITY MEDICAL GROUP

Center for Health and Occupational Services

OUTPATIENT VISIT

Name: Jennie Cox
SSN: 250-94-3648

Date of Service: 06-12-12
Date of Injury: 05-31-12

SUBJECTIVE: Patient is a tractor-trailer driver with Palmetto State Transportation for seven years who comes to clinic today for follow up of chest wall pain. She was in an accident on 05-31-12 where she had a piece of equipment fall on her. She was seen in Grady Memorial Hospital and was diagnosed with a mandibular fracture. She is under the care of plastic surgery for her facial injuries. She is here today for chest wall pain and left shoulder pain. She rates the pain as 5/10. She denies any breathing difficulties. No shortness of breath. She denies any previous problems with her chest or shoulder. Review of available records is notable for negative noncontrast head CT. Left shoulder x-ray without sign of fracture or dislocation. Chest x-ray was unremarkable.

PAST MEDICAL HISTORY: Denies.

MEDICATIONS: None.

ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. Respiratory: Negative. Cardiovascular: Negative. GI: Negative.

OBJECTIVE: General: Patient is a pleasant female. She ambulates in the clinic without difficulty. Vital signs are stable. Chest clear to auscultation. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: There is bruising to the anterior chest wall which is resolving. No midline tenderness to the cervical, thoracic or lumbar spine. She has tenderness over the left anterior and lateral chest wall. Also tender over the right lateral chest wall. There are two small abrasions to the right flank without sign of infection. Inspection of the left shoulder reveals no bruising, swelling or deformity. There is tenderness to the anterior and lateral aspect. She has range of motion to 120 degrees. There is weakness with external rotation and supraspinatus testing.

IMPRESSION:

1. Chest wall contusions.
2. Left shoulder contusion with weakness and possible rotator cuff injury.

PLAN:

1. May continue with Lortab for pain. She is given a refill for Lortab 7.5/500 one po qhs prn pain, dispense 15 with no refill.
2. She is instructed on deep breathing exercises.
3. Recommend MRI of the left shoulder.
4. Return to clinic after imaging is completed or sooner for any problems or concerns.

WORK STATUS:

1. Sedentary work.
2. Lift no more than 5 lbs.
3. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH

SN/llr 06-14-12

C: Palmetto State Transportation, Scott Justice, 1050 Park West Boulevard, Greenville, SC 29611

JUN 18 2012

**GHS Center for Health and
Occupational Services**

1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jessie Cox SS# 250-94-3648

Company Palmetto State Transportation

Date of Injury 5-31-12

Diagnosis: Chest wall Contusion

Medications: Lortab 7.5mg PRN

Work Status: May return to work on _____

☐ Full Duty

☐ Modified Duty:

[None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

☒ Lift, push or pull no more than 5 lbs. [0]

☐ Bend or Twist []

☐ Walk and Stand []

☐ Sit/Stand as needed

☒ Sedentary Work, change positions as needed

☐ No use of _____

☐ Forceful or Repetitive use of (right/left) hand and arm []

☐ Overhead use of (right/left) arm []

☐ Squat or kneel []

☐ Climb or work at heights []

☐ Awkward or Static postures []

☒ No operating heavy machinery or Commercial Motor Vehicle

☐ Elevate affected area _____

☐ Use crutches as needed for ambulation

☐ Use _____ splint as needed

☐ Other _____

other Restrictions
per Dr. Fowler
(PC)

Instructions:

☐ Stay active during your recovery.

☒ Use over the counter pain relievers by package directions and/or follow prescription directions.

☒ Report any problems with medications to your provider.

☒ Apply ice or heat to the affected areas as needed.

☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.

☐ Elevate the affected area to reduce swelling.

☐ Wash wound with soap and water _____ times per day.

☐ May apply antibiotic ointment.

☐ Keep bandage clean and dry.

☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.

☒ Other: Deep Breathing 4x day.

Follow Up: 8/7/12 or sooner for any problems.

☐ Appointment Date: _____ Time: _____ Provider: _____

☐ Maximum Medical Improvement: Contact your employer prior to making further appointments.

☐ Referral to _____ You will be contacted with an appointment.

Physician/NP: Janet Chardak, APRN

Date: 7/17/12



UNIVERSITY MEDICAL GROUP

Center for Health and Occupational Services

OUTPATIENT VISIT

Name: Jennie Cox
SSN: 250-94-3648

Date of Service: 07-17-12
Date of Injury: 05-31-12

SUBJECTIVE: Patient is a tractor-trailer driver with Palmetto State Transportation for the past 7 years. She is here today for follow up to an accident that occurred on the 31st of May this year and follow up to her MRI report. Findings of the MRI were reviewed with patient. She states that she still has some left shoulder discomfort with certain movements and some left chest pain with palpation over clavicle and upper chest area and some right-sided posterior back pain. Pain is managed with medication she received from another physician, Dr. Fowler, plastic surgeon as this was a significant injury that caused a fractured mandible and loss of some of her teeth. Musculoskeletal is improving well. See previous dictation for past medical history and specifics of initial injury.

ALLERGIES: She is allergic to Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. Respiratory: Negative.

Cardiovascular: Negative. GI: Negative. Musculoskeletal: Findings as above. We reviewed her MRI from July 6, 2012 that showed degenerative changes with mild tendinopathy of the supra and infraspinatus tendons but no findings to suggest a full thickness rotator cuff tendon tear.

OBJECTIVELY: Patient is a pleasant 59-year old female who moves in the clinic without difficulty. Vital signs are stable. BP: 107/60. HR: 98. T: 98.0 and has 0 complaint of pain at present. Heart: Regular rate and rhythm without murmurs, gallop or rub. Chest clear to auscultation. Ecchymosis, bruising that was noted on previous exam has now resolved. The two small abrasions to the right flank have resolved. There still remains tenderness to the anterior lateral aspect of the left upper chest. Patient has full range of motion of the left arm and shoulder. No weakness noted on external rotation. Patient did relate that she has decreased hearing and feels that the left is worse than the right and decreased sense of smell. I examined both ear canals and they are occluded by cerumen. Unable to visualize TMs. Patient has an appointment with Dr. Fowler on August 3, 2012 and will definitely discuss with him the loss of smell. Advised it could be the result of inflammation of the nerves from the fracture and should resolve. She will also ask Dr. Fowler about cleaning out the impacted ear wax. She denies any dizziness. She is alert and oriented times three. No aphasia, dysarthria. Patient also has an appointment with an orthodontist on July 24, 2012 to discuss replacement of the teeth that she lost in this accident.

DIAGNOSIS: Chest wall contusions resolving. Left shoulder contusion improving.

PLAN: She will continue with her pain medication as prescribed by Dr. Fowler and work restrictions as dictated to her by Dr. Fowler. She is instructed to continue doing the deep breathing exercises as previously recommended and she is to return to the clinic after her next appointment with Dr. Fowler. I recommended she make the appointment for around August 7, 2012 or sooner if any problems arise. Work status remains sedentary work, lifting no more than 5 pounds and no operating of commercial vehicle. Patient verbalized understanding of these instructions.

Lizanne Olyarchuk, APRN

LO/llr 07-18-12

C: Palmetto State Transportation, Scott Justice, 1050 Park West Boulevard, Greenville, SC 29611

JUL 24 2012

**GHS Center for Health and
Occupational Services**

1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jennie Cox SS# 250-94-3648
Company Palmetto State Transportation
Date of Injury 5-31-12

Diagnosis: ② Shoulder weakness / tenderness ; Chest wall
Medications: contusion

Work Status: May return to work on 8/7/12

☐ Full Duty

☒ Modified Duty:

[None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☒ Lift, push or pull no more than 15 lbs. [O]
- ☐ Bend or Twist []
- ☐ Walk and Stand []
- ☐ Sit/Stand as needed
- ☐ Sedentary Work, change positions as needed
- ☐ No use of _____
- ☐ Forceful or Repetitive use of (right/left) hand and arm []
- ☐ Overhead use of (right/left) arm []
- ☐ Squat or kneel []
- ☐ Climb or work at heights []
- ☐ Awkward or Static postures []
- ☒ No operating heavy machinery or Commercial Motor Vehicle
- ☐ Elevate affected area _____
- ☐ Use crutches as needed for ambulation
- ☐ Use _____ splint as needed
- ☐ Other _____

Instructions:

- ☒ Stay active during your recovery.
- ☒ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☒ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water _____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☒ Other: Don't start aerobic exercise - walking

Follow Up: 2 wks or sooner for any problems

- ☐ Appointment Date: _____ Time: _____ Provider: _____
- ☐ Maximum Medical Improvement: Contact your employer prior to making further appointments.
- ☐ Referral to physical therapy. You will be contacted with an appointment.

Physician/NP: [Signature] Date: 8-7-12

UNIVERSITY MEDICAL GROUP
Center for Health and Occupational Services
OUTPATIENT VISIT

Name: Jennie Cox
SSN: 250-94-3648

Date of Service: 08-07-12
Date of Injury: 05-31-12

SUBJECTIVE: Patient follows up in clinic for her left shoulder pain and chest wall contusion. She states that she has had some improvement. She rates her pain as 0/10. She reports feeling weakness in the shoulder. She states that she has a physical job to return to as a commercial motor vehicle driver.

We reviewed the MRI of her left shoulder dated 07-06-12. The report is notable for degenerative changes and mild tendinopathy in the supra and infraspinatus tendons. No findings to suggest full thickness rotator cuff tear.

MEDICATIONS: None.
ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. HEENT: Reports some improvement in jaw range of motion, although she still has some limitations there. Respiratory: Negative. Cardiovascular: Negative. GI: Negative.

OBJECTIVE: General: Patient is a pleasant female in no distress. She ambulates in the clinic without difficulty. Chest clear to auscultation. No chest wall tenderness. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: No tenderness to the left shoulder. Good range of motion. She continues to have decreased strength in external rotation and supraspinatus testing. Distal sensation, motor and circulation in the extremities are intact.

IMPRESSION:

1. Left shoulder weakness and tendinosis.
2. Chest wall contusion.

PLAN:

1. Tylenol as needed.
2. Recommend physical therapy referral for strengthening prior to return to full duty.
3. Return in 3 weeks or sooner for any problems or concerns.

WORK STATUS: May return to work on 08-07-12 with the following restrictions:

1. Lift, push or pull no more than 15 pounds occasionally.
2. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH
C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd., Greenville, SC 29611

SN/1lr 08-13-12

St Justice
#44-900-934
#12-3810

FAXED
8/28/12

GHS Center for Health and Occupational Services

1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jennie Mae Cox SS# 250-94-3648

Company Palmetto State Transportation

Date of Injury 5-31-12

Diagnosis: ④ Shoulder weakness / tendinitis; chest wall

Medications: Ibuprofen etc contusion

Work Status: May return to work on 8/28/12

☐ Full Duty

☒ Modified Duty:

[None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

☒ Lift, push or pull no more than 15 lbs. (0)

☐ Bend or Twist []

☐ Walk and Stand []

☐ Sit/Stand as needed

☐ Sedentary Work, change positions as needed

☐ No use of _____

☐ Forceful or Repetitive use of (right/left) hand and arm []

☐ Overhead use of (right/left) arm []

☐ Squat or kneel []

☐ Climb or work at heights []

☐ Awkward or Static postures []

☒ No operating heavy machinery or Commercial Motor Vehicle

☐ Elevate affected area _____

☐ Use crutches as needed for ambulation

☐ Use _____ splint as needed

☐ Other _____

Instructions:

☒ Stay active during your recovery.

☒ Use over the counter pain relievers by package directions and/or follow prescription directions.

☒ Report any problems with medications to your provider.

☒ Apply ice or heat to the affected areas as needed.

☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.

☐ Elevate the affected area to reduce swelling.

☐ Wash wound with soap and water _____ times per day.

☐ May apply antibiotic ointment.

☐ Keep bandage clean and dry.

☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.

☐ Other: continue PT

Follow Up: 3-4 wks or sooner for any problems

☐ Appointment Date: _____ Time: _____ Provider: _____

☐ Maximum Medical Improvement: Contact your employer prior to making further appointments.

☐ Referral to continue PT x6. You will be contacted with an appointment.

Physician/NP: [Signature]

Date: 8/28/12



UNIVERSITY MEDICAL GROUP

Center for Health and Occupational Services

OUTPATIENT VISIT

Name: Jennie Cox
SSN: 250-94-3648

Date of Service: 08-28-12
Date of Injury: 05-31-12

SUBJECTIVE: Patient follows up in clinic for her left shoulder tendinosis, weakness and chest wall contusion. She states that she has had a little improvement. She denies any pain today. She states that she has been going to physical therapy and has been noting some improvement in strength. She has follow up with the oral surgeon scheduled for September 4. No new complaints today.

MEDICATIONS: Tylenol.

ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. Respiratory: Negative. Cardiovascular: Negative. GI: Negative. Musculoskeletal: Per HPI.

OBJECTIVE: General: Patient is a pleasant female. She ambulates in the clinic without difficulty. Chest clear to auscultation. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: Left shoulder is nontender to palpation. She has full range of motion. There is weakness with external rotation. Distal strength and grip strength is improved. Neurologic Exam: Alert and oriented. Grossly nonfocal.

IMPRESSION: Left shoulder weakness and tendinosis.

PLAN:

1. Tylenol as needed.
2. She is making good progress in physical therapy. Would recommend an additional six visits to continue strengthening and conditioning.
3. Return to clinic in 3 weeks or sooner for any problems or concerns.

WORK STATUS: May return to work on 08-28-12 with the following restrictions:

1. Lift, push or pull no more than 15 pounds occasionally.
2. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH

SN/lr 08-29-12

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd., Greenville, SC 29611

AUG 31 2012

GHS Center for Health and Occupational Services

1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jessie Mae Cook SS# 25D-94-3648

Company Palmetto State Transportation

Date of Injury 5-31-12

Diagnosis: ① Shoulder weakness

Medications:

Work Status: May return to work on 9/27/12

☐ Full Duty

☒ Modified Duty:

[None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

☒ Lift, push or pull no more than 15 lbs. [0]

☐ Bend or Twist []

☐ Walk and Stand []

☐ Sit/Stand as needed

☐ Sedentary Work, change positions as needed

☐ No use of _____

☐ Forceful or Repetitive use of (right/left) hand and arm []

☐ Overhead use of (right/left) arm []

☐ Squat or kneel []

☐ Climb or work at heights []

☐ Awkward or Static postures []

☒ No operating heavy machinery or Commercial Motor Vehicle

☐ Elevate affected area _____

☐ Use crutches as needed for ambulation

☐ Use _____ splint as needed

☐ Other _____

Instructions:

- ☐ Stay active during your recovery.
- ☐ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☐ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water _____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☐ Other: _____

Follow Up: 1 month - will need to consider functional test if unable to return to full duty by next visit

☐ Appointment Date: _____ Time: _____ Provider: _____

☐ Maximum Medical Improvement: Contact your employer prior to making further appointments.

☐ Referral to _____ You will be contacted with an appointment.

Physician/NP: [Signature]

Date: 9/27/12



UNIVERSITY MEDICAL GROUP

Center for Health and Occupational Services

OUTPATIENT VISIT

Name: Jennie Cox
SSN: 250-94-3648

Date of Service: 09-27-12
Date of Injury: 05-31-12

SUBJECTIVE: Patient follows up in clinic for her left shoulder weakness and chest wall contusion. She denies any pain today. She states that she has been attending physical therapy and that therapy is going well. She currently does not feel able to pull pins on trailers as she states this is a very forceful activity. Discussed her progress with her physical therapist who states that she is continuing to make progress and that an additional two visits a week for four weeks is recommended. Patient states that she continues to await further treatment with the oral surgeon and that they are waiting for further healing before moving forward with her dental implants.

MEDICATIONS: Tylenol.
ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. HEENT: Negative. Respiratory: Negative.
Cardiovascular: Negative. GI: Negative. Musculoskeletal: Per HPI.

OBJECTIVE: General: Patient is a pleasant female in no distress. She ambulates in clinic without difficulty. Chest clear to auscultation. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: Neck and shoulders have full range of motion. She continues with weakness in external rotation.

IMPRESSION:

1. Left shoulder weakness.
2. Chest wall contusion.

PLAN:

1. Tylenol on an as needed basis.
2. Continue with physical therapy.
3. Follow up in one month or seek care sooner for any problems or concerns. At follow up visit if she continues to have significant weakness and potential limitation for her work duties we may need to consider a functional capacity test to clarify her safe lifting, pushing and pulling limitations.

WORK STATUS: May return to work on 09-27-12 with the following restrictions:

1. Lift, push or pull no more than 15 pounds occasionally.
2. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH
C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd., Greenville, SC 29611

SN/llr 09-28-12

OCT 02 2012



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Sep 27, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 11
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

proaxistherapy

Plan of Care

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

Assessment

Presentation:

- Improved AROM, improved SA strength, ER at 45 degrees, decreased pain but continued RTC ER and scapular stabilizer weakness.

Problems & Goals

Problem #1 Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

LTG Achieve by Oct 02, 2012.

Symptomatic Improvements:

- Decreasing Pain: to 0/10.

Problem #2 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.

LTG Achieve by Oct 25, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #3 Range of Motion: Shoulder: Pre-Treatment.

Left AROM | Left PROM | Right AROM

• Abduction(no pain with overpressure 9/18)	180	180
• Flexion(no pain with overpressure 9/18)	175	180
• Horizontal Adduction(9/18)	50	60

Goal Achieved Sep 27, 2012.

Range of Motion Improvements to: Shoulder:

Left AROM

• Flexion	170
• Abduction	170

Problem #4 Muscle Testing: Upper Extremity MMT.

Left

Right

• Scaption	4/5	-5/5
• Shoulder Abduction	4/5	-5/5
• Shoulder External Rotation(at side 4/5; at 45 4/5)	-4/5	-4/5
• Shoulder Flexion	4/5	-5/5
• Shoulder Internal Rotation(improved)	+4/5	-5/5

LTG Achieve by Oct 25, 2012. Progress: Some progress.

Musculoskeletal Improvements In: Shoulder

Left

Muscle Strength to:

Please sign and return

I have reviewed this Plan of Care and certify that the skilled therapy services identified are required to meet the patient's need. Comments and/or revisions to this Plan of Care are noted below.

Comments/Revisions

Physician/NPP Signature

Date

Print Name and Credentials

Document ID: 00114D94.013
Mason Rockwell,PT(SC Lic: 5456)

Status: Signed off (secure electronic signature)

Page 1 of 2

To Proaxis
Grove
10-1-12
[Signature]

- Gross Assessment +4/5

Problem #5 Questionnaires: Additional.

- Assessment Reassessment
- Date 09/27/2012
- Score 1 pain 8/30
- Score 2 function 35/60
- Test Name Penn Shoulder Score
- Total 64/100

LTG Achieve by Oct 25, 2012. Progress: No change. improve strength for painfree ADL's

Questionnaire Improvements: Additional:

- Test Name Penn Shoulder Score
- Assessment Reassessment
- Total 80/100
- Score 1 pain decrease by 3 points or greater
- Score 2 function score improve by 10 points or more

Problem #6 Muscle Testing: Shoulder.

	Left	Right
• Serratus Anterior(improved)	+4/5	+4/5
• Trapezius, Lower	-4/5	+4/5
• Trapezius, Middle	+4/5	+4/5
• Trapezius, Upper	5/5	5/5

LTG Achieve by Oct 25, 2012. Progress: Some progress.

Musculoskeletal Improvements In: Shoulder

Muscle Strength to:

- Gross Assessment -5/5

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Daily Plan:

- Continue w/ Current Rehabilitation Program. Progression Under Current Plan. Advance as tolerated.

Therapeutic Contents:

- RTC and scapular strengthening and functional activities at shoulder level and overhead.



Mason Rockwell, PT(SC Lic: 5456)

Signed on Sep 27, 2012 14:17:24

Justice 866-900-9381

FAXED 10/26/12

GHS Center for Health and Occupational Services

1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jennie Cop SS# 3648
Company Palmetto State Transportation
Date of Injury 5/3/12

Diagnosis: Shoulder weakness spr fall
Medications: -

Work Status: May return to work on 10/26/12

☐ Full Duty

☒ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

☒ Lift, push or pull no more than 25 lbs. [0]

☐ Bend or Twist []

☐ Walk and Stand []

☐ Sit/Stand as needed

☐ Sedentary Work, change positions as needed

☐ No use of _____

☐ Forceful or Repetitive use of (right/left) hand and arm []

☐ Overhead use of (right/left) arm []

☐ Squat or kneel []

☐ Climb or work at heights []

☐ Awkward or Static postures []

☒ No operating heavy machinery or Commercial Motor Vehicle

☐ Elevate affected area _____

☐ Use crutches as needed for ambulation

☐ Use _____ splint as needed

☐ Other _____

*Please fax a job description to
CHRS at 455-2335*

*She is approaching MMT
Test is needed to determine
if she can safely return
to the essential functions
of her job.*

Instructions:

- ☐ Stay active during your recovery.
- ☐ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☐ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water _____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☐ Other: _____

Follow Up: 2 wks

- ☐ Appointment Date: _____ Time: _____ Provider: _____
- ☐ Maximum Medical Improvement: Contact your employer prior to making further appointments.
- ☐ Referral to FCE. You will be contacted with an appointment.

Physician/NP: [Signature] Date: 10/26/12



UNIVERSITY MEDICAL GROUP

Center for Health and Occupational Services

OUTPATIENT VISIT

Name: Jennie Cox
SSN: 250-94-3648

Date of Service: 10-26-12
Date of Injury: 05-31-12

SUBJECTIVE: Patient returns to clinic for follow up of her left shoulder. She states that her shoulder is doing well. She feels that she is making improvements in physical therapy. She denies any pain. She is still concerned about her ability to do heavy pushing and pulling required at her job. She states that she is concerned about being reinjured when she returns to full duty.

MEDICATIONS: Ibuprofen.

ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. Respiratory: Negative. Cardiovascular: Negative. GI: Negative. Musculoskeletal: Per HPI.

OBJECTIVE: General: Patient is a pleasant female in no distress. She ambulates in clinic without difficulty and moves easily about the exam room. Chest clear to auscultation. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: Cervical spine is nontender and has full range of motion. Shoulders are nontender and have good range of motion. She has some mild weakness in external rotation on the left as compared to the right. She has good grip strength. Full range of motion of the lumbar spine and lower extremities. Sensation and circulation in the extremities are intact.

IMPRESSION: Left shoulder weakness after a fall.

PLAN:

1. Finish two remaining approved physical therapy visits and transition to home exercise program.
2. Recommend a functional capacity test to determine her ability to safely return to the essential functions of her job.
3. Follow up in two weeks or seek care sooner for any problems or concerns.

WORK STATUS: May return to work on 10-26-12 with the following restrictions:

1. Lift, push or pull no more than 25 pounds occasionally.
2. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH

SN/llr 10-29-12

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd., Greenville, SC 29611

Scott Justice
4666-400
9381

FAXED
11-9-12

GHS Center for Health and Occupational Services

1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jennie Mae Cox SS# 250943648

Company Palmetto State Transportation

Date of Injury 5-31-12

Diagnosis: Shoulder weakness improved

Medications: _____

Work Status: May return to work on 11/9/12

☒ Full Duty

☐ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☐ Lift, push or pull no more than ____ lbs. []
- ☐ Bend or Twist []
- ☐ Walk and Stand []
- ☐ Sit/Stand as needed
- ☐ Sedentary Work, change positions as needed
- ☐ No use of _____
- ☐ Forceful or Repetitive use of (right/left) hand and arm []
- ☐ Overhead use of (right/left) arm []
- ☐ Squat or kneel []
- ☐ Climb or work at heights []
- ☐ Awkward or Static postures []
- ☐ No operating heavy machinery or Commercial Motor Vehicle
- ☐ Elevate affected area _____
- ☐ Use crutches as needed for ambulation
- ☐ Use _____ splint as needed
- ☐ Other _____

Instructions:

- ☐ Stay active during your recovery.
- ☐ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☐ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water ____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☐ Other: _____

Follow Up:

- ☐ Appointment Date: _____ Time: _____ Provider: _____
- ☒ Maximum Medical Improvement: Contact your employer prior to making further appointments.
- ☐ Referral to _____ You will be contacted with an appointment.

Physician/NP: [Signature] Date: 11/9/12



OUTPATIENT VISIT

Patient: Jennie Cox
MRN: 250-94-3648

Date: 11/09/12
DOI: 5/31/12

Subjective: Patient follows up in clinic for her right shoulder. She states that she has had a lot of improvement. She is not having any pain and not requiring any pain medications. She states that she is continuing her physical therapy exercises as home and feels able to return to work.

We reviewed the job description sent by the company. There was a lifting requirement of 100 lbs. Ms. Cox stated that the amount was much more than she was required to lift at work. This was discussed with Scott Justice of the company who concurred that maximum lifting would be approximately 35 lbs.

Medications: Ibuprofen.
Allergies: Ativan.

Review of Systems: Constitutional: Negative. Musculoskeletal: Per HPI.

Objective: General: Patient is a pleasant female. She ambulates in the clinic without difficulty and moves easily about the exam room. Full range of motion of bilateral extremities. She continues to have some mild weakness with external rotation of the left shoulder. Internal rotation and supraspinatus testing within normal limits. She has excellent grip strength. Sensation and circulation in the arms are intact.

Impression: Left shoulder injury at MMI.

Plan:

1. Continue exercises at home.
2. Impairment rating for the left shoulder best fits in class I in the shoulder regional grid on page 401 in the *Guides to the Evaluation of Permanent Impairment, 6th Edition*. There was a shoulder contusion with soft tissue injury. There are residual symptoms and consistent objective findings at MMI. Impairment rating of the left shoulder is 2%.

Work Status: May return to work on 11/09/12 without restriction.

Stacey Newsom, M.D., MPH

SN/md 11/12/12

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd, Greenville, SC 29611

GHS Center for Health and Occupational Services

Phone (864) 455-2300

3026 Grove Road, Greenville, SC 29605

Fax (864) 455-2399

Consent for Occupational Health and Medical Services

Patient Name (PRINT) Last Corbin, James M SSN 011-11-1111
 Social Security 250-94-3688 Date of Birth 3/16/52 Marital Status D Preferred Language English
 Are you a Veteran? Y ☒ No ☐ Military: U.S. Marine Corps ☐ Non-Veteran: None ☐ Refused to Answer
 Home Address 232 W. Chapman Rd. Batten SC 29607
 County Cherokee Phone 864-243-1232 Cell or Primary
 Primary Care Provider Dr. Sandra Ellis
 Employer Palmatech State Full Time Occupation Truck Driver Length of Employment 8 yrs
 Emergency Contact Tammy Hardy Relationship to Patient Daughter Primary Tel. 864-730-5000

The following are the conditions for services by GHS Center for Health and Occupational Services (GHS) for the patient whose name appears above:

Medical Concerns: I consent to all occupational health and medical services, evaluation, and investigation under the general and special instructions of the physician and/or other practitioner, as requested by the employer, either as required by state, local, state, or federal agencies that govern my occupation. Services may include, but are not limited to, physical and chemical exposure assessment, administration of vaccines, and of personal protective equipment, infectious diseases, occupational and environmental health and laboratory testing, and efforts to identify and/or prevent occupational and/or environmental health hazards, all of which may be considered medically necessary or indicated in the treatment of the condition of concern.

I understand that while working in an occupation with very few or no toxic risks, I understand that my blood may be tested for Hepatitis B and Hepatitis C virus, as well as other bloodborne viruses, and that the results of these tests will be made available to my employer. I understand that the results of these tests will be made available to my employer. I understand that the results of these tests will be made available to my employer.

Financial Arrangements: I understand that I am responsible for payment for the services provided, which may include co-payment for services and/or payment for services not covered by my insurance. I understand that the results of these tests will be made available to my employer.

Disclosure / Use of Health Information / Authorization for Release of Medical Information: I understand that GHS receives my health information gathered as a result of the services provided to the employer requesting the service, to the insurance company, or to a third party representative of the patient, for purposes of payment for the services provided and to assist me in meeting the medical requirements of my employer. I also authorize GHS to provide health information to other persons and organizations for occupational health and safety purposes. I understand that GHS can use the health information for occupational health and safety purposes. I understand that GHS can use the health information for occupational health and safety purposes.

This authorization for release of information expires 12 months from date of my signature. I may revoke this authorization at any time by writing Center for Health and Occupational Services, Attention: Office Manager, 3026 Grove Road, Greenville, SC 29605. However, such revocation will not affect any actions taken in reliance on this authorization prior to the date of receipt of the revocation.

I may request or request a copy of the health information to be used or disclosed, consistent with federal law. Note: There may be a processing fee charged to me to cover labor, copying, and supplies used to reproduce medical records.

Signatures: I hereby authorize the treatment and the disclosure of personal health information as indicated above. I understand that this authorization is voluntary. However, if I do not sign this authorization, services will not be provided. Refusing to sign this authorization will not affect any other services I may receive at GHS. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Patient Signature James M. Corbin Date 10/5/14
 Witness A. M. Nye Date 10/6/14

**GHS Center for Health and
Occupational Services**

1020 Grove Road
Greenville, SC 29605
Phone (864)455-2300
Fax (864) 455-2399

Name Jennie Cox DOB 8-14-52
Company Palmetto State Transportation
Date of Injury 5-31-12

Diagnosis: ② Shoulder Contusion

Medications: Tylenol otc

Work Status: May return to work on 6 Oct 2014

☒ Full Duty

☐ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☐ Lift, push or pull no more than _____ lbs. []
- ☐ Bend or Twist []
- ☐ Walk and Stand []
- ☐ Sit/Stand as needed.
- ☐ No climbing ladders or work at unprotected heights.
- ☐ Forceful or Repetitive use of (right/left) hand and arm []
- ☐ Overhead use of (right/left) arm []
- ☐ Squat or kneel []
- ☐ Awkward or Static postures []
- ☐ No use of _____
- ☐ No operating heavy machinery or Commercial Motor Vehicle.
- ☐ Elevate affected area _____
- ☐ Use crutches as needed.
- ☐ Use _____ splint.
- ☐ Other _____

Instructions:

- ☐ Stay active during your recovery.
- ☐ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☐ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water _____ times per day.
- ☐ Apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain, or drainage.
- ☐ Other: _____

Follow Up:

- ☐ Appointment Date: _____ Time: _____ Provider: _____
- ☒ Maximum Medical Improvement : Contact your employer prior to making further appointments.
- ☐ Referral to _____: You will be contacted with and appointment.

Physician/NP: [Signature] Date: 10-6-14



OUTPATIENT VISIT

Name: Jennie Cox
DOB: 08/14/52

Date of Service: 10/06/14

SUBJECTIVE: Ms. Cox is being sent today for reevaluation of her left shoulder. She states that she has some residual difficulties in the left shoulder and wishes for these to be noted. The difficulties that she is having is in the lateral aspect of the left shoulder blade. She points to this location. Aggravating factors are when she reaches behind her or when she drives her zero-clearance lawnmower (she does have a sizable property that she mows). She states that after mowing for an hour in this capacity she will have some difficulties in this same area. In terms of her range of motion and strength, she is agreeable that these are doing quite well. She states that she has been sore after some of her long truck runs because she uses the left hand to secure the steering wheel while reaching up to flip switches or doing gear shifts with her right hand. She says that she will be quite sore in this area after one of these long road trips. When asked about sleeping on that side, she states that she typically does not sleep on that side. She says if she has to sleep in her truck berth she does not sleep on the left side due to difficulties with pain in her left jaw. She otherwise has no other difficulties with the left shoulder area. Of note, on this visit she does talk about some difficulties with the left ear, with intermittent hearing diminution. She gives the example of singing in church last night, being able to hear her voice in her right ear but not hearing on the left side. This prompted her to have a relative who is in the medical profession flush her left ear. She states some improvement after that, but has noted intermittent difficulties with the left ear on occasion.

PAST MEDICAL HISTORY: No significant factors identified.

MEDICATIONS: She is just taking over-the-counter Tylenol for her cervical pain and the left shoulder pain.

REVIEW OF SYSTEMS: Negative in terms of any respiratory complaints. Denies any cough or any wheezes. Does not have any effect on the left scapular region with deep breathing. Cardiovascular: She does not have any chest pain. No shortness of breath. GI: She has no complaints in this regard. As mentioned in the ENT arena, she does complain of some difficulties with occasional perceived left hearing loss, as if the left ear is clogged.

OBJECTIVE: On examination of the left shoulder, she is able to put the shoulder through full range of motion, both actively and passively. Crossover arm stretch does not elicit any pain. She is pain-free on both supraspinatus and infraspinatus testing. There is no weakness noted with these maneuvers. She demonstrates that when she reaches behind her the left lateral scapular border is painful. When performing this maneuver I hear an audible click and also can palpate a click within the soft tissue in this region. Performed provocative maneuvers for latissimus dorsi and these did not elicit any pain or click. Again, on external abduction and external rotation, another click was elicited in the same area of the scapular region. When palpating the lateral scapular border, no pain is elicited. The tissues do appear to be somewhat sinewy, that is less supple than on the unaffected right side. Lungs are clear to auscultation. Heart S1, S2. No murmurs or extra sounds. Abdomen is soft. Bowel sounds are positive. Ears canals patent bilaterally. TM's mobile with valsalva.

Name: Jennie Cox
DOB: 08/14/52

Date of Service: 10/06/14
Page 2

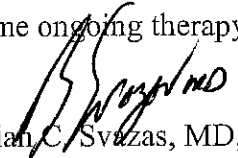
ASSESSMENT:

1. Individual with residual symptoms to the left shoulder region. I do believe that the complaints she has in the left scapular border are likely related to her previous injury to the shoulder.
2. Upon review of the chart, there was similar complaints of hearing loss on the left side.

PLAN:

1. I did advise Ms. Cox that, should she wish to pursue the left ear issues, she should request to see an ENT physician.
2. I do find that the patient is functioning at 100%, as she has returned to her truck driver position and is thriving in this career.
3. The left shoulder still appears to be somewhat problematic for this individual. I did suggest that physical therapy may help clear some of the soft tissue areas. Ms. Cox did express some reluctance to enter into physical therapy again, as she had a quite extensive course post injury. As the pain appears to be amenable to Tylenol over-the-counter, she should continue with this for symptomatic treatment.

WORK STATUS: I do find that she is fit for full duty as a truck driver. I find her at MMI. Due to the ongoing issues with the left shoulder, this clinic previously rated her at 2%. I would rate her at 6%, as she may need some ongoing therapy to this shoulder going forward.


Brian C. Svazas, MD, MPH

BCS/bts/nw 10/07/14

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd, Greenville, SC 29611



Physician's Statement

Claimant's Name: Jennie Cox
Physician's Name: Stacey Newman
Practice/Clinic: CHS
Preparer's Name: _____
Phone: (____) _____

Employer's Name: Palmetto State Transportation
Insurance Carrier: _____
SCWCC File No: _____

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

Date of Injury or Illness: _____

Date of first office visit: 9/27/12 Date of last visit: 11/9/12

Diagnosis or nature of injury or illness: Chest and L shoulder contusions

Body part(s) injured: Chest, L shoulder Body part(s) affected: Chest, L shoulder

Date of Maximum Medical Improvement: 11/9/12

Based on the **AMA Guidelines**, the claimant has sustained a 2 % medical impairment to Upper extremity injured body part(s) and a 0 % medical impairment to Chest other affected body part(s).

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

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

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

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

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

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

Treating Physician: [Signature]

Date: 11/9/12



OUTPATIENT VISIT

Name: Jennie Cox
DOB: 08/14/52

Date of Service: 10/06/14

SUBJECTIVE: Ms. Cox is being sent today for reevaluation of her left shoulder. She states that she has some residual difficulties in the left shoulder and wishes for these to be noted. The difficulties that she is having is in the lateral aspect of the left shoulder blade. She points to this location. Aggravating factors are when she reaches behind her or when she drives her zero-clearance lawnmower (she does have a sizable property that she mows). She states that after mowing for an hour in this capacity she will have some difficulties in this same area. In terms of her range of motion and strength, she is agreeable that these are doing quite well. She states that she has been sore after some of her long truck runs because she uses the left hand to secure the steering wheel while reaching up to flip switches or doing gear shifts with her right hand. She says that she will be quite sore in this area after one of these long road trips. When asked about sleeping on that side, she states that she typically does not sleep on that side. She says if she has to sleep in her truck berth she does not sleep on the left side due to difficulties with pain in her left jaw. She otherwise has no other difficulties with the left shoulder area. Of note, on this visit she does talk about some difficulties with the left ear, with intermittent hearing diminution. She gives the example of singing in church last night, being able to hear her voice in her right ear but not hearing on the left side. This prompted her to have a relative who is in the medical profession flush her left ear. She states some improvement after that, but has noted intermittent difficulties with the left ear on occasion.

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OBJECTIVE: On examination of the left shoulder, she is able to put the shoulder through full range of motion, both actively and passively. Crossover arm stretch does not elicit any pain. She is pain-free on both supraspinatus and infraspinatus testing. There is no weakness noted with these maneuvers. She demonstrates that when she reaches behind her the left lateral scapular border is painful. When performing this maneuver I hear an audible click and also can palpate a click within the soft tissue in this region. Performed provocative maneuvers for latissimus dorsi and these did not elicit any pain or click. Again, on external abduction and external rotation, another click was elicited in the same area of the scapular region. When palpating the lateral scapular border, no pain is elicited. The tissues do appear to be somewhat sinewy, that is less supple than on the unaffected right side. Lungs are clear to auscultation. Heart S1, S2. No murmurs or extra sounds. Abdomen is soft. Bowel sounds are positive. Ears canals patent bilaterally. TM's mobile with valsalva.

Name: Jennie Cox
DOB: 08/14/52

Date of Service: 10/06/14
Page 2

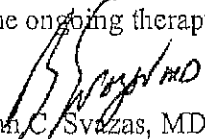
ASSESSMENT:

1. Individual with residual symptoms to the left shoulder region. I do believe that the complaints she has in the left scapular border are likely related to her previous injury to the shoulder.
2. Upon review of the chart, there was similar complaints of hearing loss on the left side.

PLAN:

1. I did advise Ms. Cox that, should she wish to pursue the left ear issues, she should request to see an ENT physician.
2. I do find that the patient is functioning at 100%, as she has returned to her truck driver position and is thriving in this career.
3. The left shoulder still appears to be somewhat problematic for this individual. I did suggest that physical therapy may help clear some of the soft tissue areas. Ms. Cox did express some reluctance to enter into physical therapy again, as she had a quite extensive course post injury. As the pain appears to be amenable to Tylenol over-the-counter, she should continue with this for symptomatic treatment.

WORK STATUS: I do find that she is fit for full duty as a truck driver. I find her at MMI. Due to the ongoing issues with the left shoulder, this clinic previously rated her at 2%. I would rate her at 6%, as she may need some ongoing therapy to this shoulder going forward.


Brian C. Svazas, MD, MPH

BCS/bts/nw 10/07/14

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd, Greenville, SC 29611



Physician's Statement

Claimant's Name: Jennie Cox Employer's Name: Palmetto State Transportation
Physician's Name: Brian Svaras, M.D., MPH, FACOEM Insurance Carrier: Cherokee Insurance Company
Practice/Clinic: Center for Health & Occupational Services SCWCC File No: 1206236
Preparer's Name: _____
Phone: _____

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

Date of Injury or Illness: May 31, 2012

Date of first office visit: 6 Oct 2014 Date of last visit: 6 Oct 2014

Diagnosis or nature of injury or illness: ② Shoulder

Body part(s) injured: ② Shoulder Body part(s) affected: _____

Date of Maximum Medical Improvement: 6 Oct 2014

Based on the AMA Guidelines, the claimant has sustained a 6 % medical impairment to ② Shoulder
injured body part(s) and a _____ % medical impairment to
other affected body part(s).

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

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

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

_____ Claimant possesses retained hardware casually related to this injury.

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

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

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

Physical Therapy

Brian Svaras
Treating Physician

8 Apr 2015
Date

APA #6
INNVERSION MRI & IMAGING
07/06/12 & 07/17/12

INNERVISION MRI & IMAGING

Innervision
Innervision at Grove
Open MRI of Simpsonville

Grove

One Cannon Drive Greenville, SC 29605

Phone (864) 242-4011 Fax (864) 233-2677

PATIENT: Cox, Jennie
DOB: 8/14/1952
MRN: 850738
PATIENT PHONE: 864-243-0032
PHYSICIAN: Stacey Newsom, MD
DATE: 7/6/2012

EXAM: MRI OF THE LEFT SHOULDER WITHOUT CONTRAST

HISTORY: Left shoulder pain and weakness.

TECHNIQUE: Multisequential, multiplanar MRI of the left shoulder performed without contrast.

COMPARISON: There is no previous available for comparison.

FINDINGS: Acromion is flat. Mild acromioclavicular joint hypertrophy appreciated. There is tendinopathy appreciated within the supra and infraspinatus tendons. There are no findings to suggest a full-thickness tear. No significant rotator cuff muscular atrophy. There are mild degenerative changes appreciated in the lateral aspect of the humeral head. Marrow signal intensities in the imaged humerus and bony glenoid are otherwise unremarkable. Mild AC joint hypertrophy. Cartilaginous labrum and biceps labral anchor appear grossly unremarkable. Imaged biceps tendon is appreciated within its groove.

IMPRESSION: Degenerative changes and mild tendinopathy in the supra and infraspinatus tendons. No findings to suggest full-thickness rotator cuff tendon tear.

Christopher Sidden, M.D.
CS / lb

DD: 7/6/2012
DT: 7/6/2012
Job: 15460259

(Signature) 7/9/12

This document has been electronically reviewed and signed by Christopher Sidden, M.D.

INNERVISION MRI & IMAGINGInnervision
Innervision at Grove
Open MRI of Simpsonville

Grove

One Cannon Drive Greenville, SC 29605

Phone (864) 242-4011 Fax (864) 233-2677

PATIENT: Cox, Jennie
DOB: 8/14/1952
MRN: 850738
PATIENT PHONE: 864-243-0032
PHYSICIAN: Stacey Newsom, MD
DATE: 7/17/2012

EXAM: X-RAY OF THE CHEST, TWO VIEWS**HISTORY:** Chest wall contusion.

FINDINGS: PA and lateral views of the chest show heart size within normal limits. There are some atherosclerotic changes of the aortic arch. The lungs show hyperaeration indicative of COPD with associated retrosternal airspace increase and flattening of the hemidiaphragms. No effusion or pneumothorax.

IMPRESSION: COPD without acute findings.

Perry Edenfield, MD
WE / ab

DD: 7/17/2012
DT: 7/17/2012
Job: 15516220

This document has been reviewed and electronically signed.



APA #7
PROAXIS THERAPY
08/21/12-11/29/12



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Aug 21, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 1
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Initial Evaluation

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

The patient's medical history has been verbally reviewed with the patient by the evaluating therapist. The medical history questionnaire has been completed and signed by the patient, reviewed by the evaluating therapist, and is on file. The patient has read and signed the Patient Rights and Consent for Treatment forms, they have been reviewed by the evaluating therapist, and are on file.

ADL / Functional Status:

- Premorbid status:
 - Basic care: Independent Without Difficulty. Work status: Full time / Full duty.
- Current status:
 - Basic care: Independent With Increased Time. Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Extremity Dominance:

- Right.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012



- Assessment
- Physical Activity Score

Initial
8

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach
- ER - Combined
- IR - Combined

Left

Posterior Opposite Shoulder
To T4
To T6

Right

Lateral Opposite Shoulder
To T4
To T5

Muscle Testing:

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

Muscle Testing: Upper Extremity MMT:

- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation
- Shoulder Internal Rotation

Left

4/5
4/5
4/5
-4/5
4/5

Right

-5/5
-5/5
-5/5
-4/5
-5/5

Muscle Testing: Shoulder:

- Serratus Anterior
- Trapezius, Lower
- Trapezius, Middle
- Trapezius, Upper

Left

+3/5
-4/5
4/5
5/5

Right

+4/5
4/5
4/5
5/5

Palpation: Musculature: Tenderness:

- Teres Minor

Left

1=Complaint of pain

Range of Motion: Shoulder: Pre-Treatment:

- Flexion(no pain with overpressure)
- Abduction(no pain with overpressure)

Left AROM

142
160

Right AROM

180
180

Treatments

Exercise Activities: Isotonics:

- Isotonic Activity 1

Time Elapsed: 4 Minutes, Repetitions: 30, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Tubing/Bands:

- ER 0 deg
- IR 0 deg
- Tubing/Bands 1

Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Description: forward punch, Charge As: Therapeutic Exercise, Billing Code: 97110.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Therapeutic Activities, Billing Code: 97530.

Pt./Family Education:

- Pathology/Involved Anatomy
- Written Home Exercise Program

Time Elapsed: 5 Minutes, Additional Detail: RTC, impingement, scapular position., Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Activity: Provided & Reviewed, Description: Diagnosis Specific, Charge As: Therapeutic Exercise, Billing Code: 97110.

Assessment

In my professional opinion, this client requires skilled physical therapy in conjunction with a home exercise program to address the problems and achieve the goals outlined below. Overall rehabilitation potential is excellent. The expected length of this episode of skilled therapy services required to address the patient's condition is estimated to be 6 weeks. The patient and/or family were educated regarding their diagnosis, prognosis and related pathology. The client exhibits fair understanding and performance of the therapeutic activity and instructions outlined in this skilled rehabilitation session.

Presentation:

- Symptoms consistent with referring diagnosis. Displays signs and symptoms of: Shoulder: scapular stabilizer and RTC ER weakness.

Treatment Emphasis to focus on:

- Postural Improvements. Muscle Function Improvements. Enhanced Dynamic Stability.

Problems & Goals

Problem #1 Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

LTG Achieve by Oct 02, 2012.

Symptomatic Improvements:

- Decreasing Pain: to 0/10.

Problem #2 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.

LTG Achieve by Oct 02, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #3 Range of Motion: Shoulder: Pre-Treatment.

LTG Achieve by Oct 02, 2012.

Range of Motion Improvements to: Shoulder:

- Flexion
- Abduction

Left AROM

170

170

Problem #4 Muscle Testing: Upper Extremity MMT.

LTG Achieve by Oct 02, 2012.

Musculoskeletal Improvements In: Shoulder

Muscle Strength to:

Left



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Aug 21, 2012

- Gross Assessment +4/5

Problem #5 Questionnaires: Additional.

LTG Achieve by Oct 02, 2012. improve strength for painfree ADL's

Questionnaire Improvements: Additional:

- Test Name Penn Shoulder Score
- Assessment Reassessment
- Total 80/100
- Score 1 pain decrease by 3 points or greater
- Score 2 function score improve by 10 points or more

Problem #6 Muscle Testing: Shoulder.

LTG Achieve by Oct 02, 2012.

Musculoskeletal Improvements In: Shoulder Left

Muscle Strength to:

- Gross Assessment -5/5

Plan

The goals and plan were discussed with the patient and/or family and they concur. The patient and/or family were instructed to call therapist regarding problems or questions. The patient was instructed in the independent performance of a home exercise program that addresses the problems and achieving the goals outlined in the plan of care.

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 3 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Therapeutic Contents:

- Active Range of Motion Activities. Client Education. Aerobic Conditioning: Upper Body Ergometer. Home Exercise Program. Proprioceptive/Closed Kinetic Chain Activities. Therapeutic Activities.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Aug 21, 2012 19:55:40



proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Aug 21, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 1
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Plan of Care

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

Assessment

In my professional opinion, this client requires skilled physical therapy in conjunction with a home exercise program to address the problems and achieve the goals outlined below. Overall rehabilitation potential is excellent. The expected length of this episode of skilled therapy services required to address the patient's condition is estimated to be 6 weeks. The patient and/or family were educated regarding their diagnosis, prognosis and related pathology. The client exhibits fair understanding and performance of the therapeutic activity and instructions outlined in this skilled rehabilitation session.

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Treatment Emphasis to focus on:

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Problems & Goals

Problem #1 Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHE currently describes pain as 2/10.

LTG Achieve by Oct 02, 2012.

Symptomatic Improvements:

- Decreasing Pain: to 0/10.

Problem #2 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.

LTG Achieve by Oct 02, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #3 Range of Motion: Shoulder: Pre-Treatment.

Left AROM

Right AROM

- Abduction(no pain with overpressure)

160

180

- Flexion(no pain with overpressure)

142

180

LTG Achieve by Oct 02, 2012.

Range of Motion Improvements to: Shoulder:

Left AROM

- Flexion

170

- Abduction

170

Problem #4 Muscle Testing: Upper Extremity MMT.

Left

Right

- Scaption

4/5

-5/5

- Shoulder Abduction

4/5

-5/5

Please sign and return

I have reviewed this Plan of Care and certify that the skilled therapy services identified are required to meet the patient's need.

Comments and/or revisions to this Plan of Care are noted below.

Comments/Revisions

Physician/NPP Signature

Date

Print Name and Credentials

• Shoulder External Rotation	-4/5	-4/5
• Shoulder Flexion	4/5	-5/5
• Shoulder Internal Rotation	4/5	-5/5

LTG Achieve by Oct 02, 2012.

Musculoskeletal Improvements In: Shoulder Left

Muscle Strength to:

- Gross Assessment +4/5

Problem #5 Questionnaires: Additional.

• Assessment	Initial
• Date	08/21/2012
• Score 1	pain 9/30
• Score 2	function 38/60
• Test Name	Penn SHoulder Score
• Total	65/100

LTG Achieve by Oct 02, 2012. improve strength for painfree ADL's

Questionnaire Improvements: Additional:

• Test Name	Penn Shoulder Score
• Assessment	Reassessment
• Total	80/100
• Score 1	pain decrease by 3 points or greater
• Score 2	function score improve by 10 points or more

Problem #6 Muscle Testing: Shoulder.

	Left	Right
• Serratus Anterior	+3/5	+4/5
• Trapezius, Lower	-4/5	4/5
• Trapezius, Middle	4/5	4/5
• Trapezius, Upper	5/5	5/5

LTG Achieve by Oct 02, 2012.

Musculoskeletal Improvements In: Shoulder Left

Muscle Strength to:

- Gross Assessment -5/5

Plan

The goals and plan were discussed with the patient and/or family and they concur. The patient and/or family were instructed to call therapist regarding problems or questions. The patient was instructed in the independent performance of a home exercise program that addresses the problems and achieving the goals outlined in the plan of care.

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 3 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Therapeutic Contents:

- Active Range of Motion Activities. Client Education. Aerobic Conditioning: Upper Body Ergometer. Home Exercise Program. Proprioceptive/Closed Kinetic Chain Activities. Therapeutic Activities.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Aug 21, 2012

Mason Rockwell, PT(SC Lic: 5456)
Signed on Aug 21, 2012 19:55:40



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Aug 24, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 2
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

Daily Comments:

- Able to sleep on left side but really weak with left arm use.

Questionnaires: Additional:

• Test Name	Penn SShoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012
• Assessment	Initial
• Physical Activity Score	8

Objective Examination

Functional Tests: Apley's Scratch Test:

	Left	Right
• Cross Body Reach	Posterior Opposite Shoulder	Lateral Opposite Shoulder
• ER - Combined	To T4	To T4

• IR - Combined	To T6	To T5
Muscle Testing:		
• Strong and painless biceps; Weak and painless shoulder ABD and ER.		
Muscle Testing: Upper Extremity MMT:	Left	Right
• Scaption	4/5	-5/5
• Shoulder Abduction	4/5	-5/5
• Shoulder Flexion	4/5	-5/5
• Shoulder External Rotation	-4/5	-4/5
• Shoulder Internal Rotation	4/5	-5/5
Muscle Testing: Shoulder:	Left	Right
• Serratus Anterior	+3/5	+4/5
• Trapezius, Lower	-4/5	4/5
• Trapezius, Middle	4/5	4/5
• Trapezius, Upper	5/5	5/5
Palpation: Musculature: Tenderness:	Left	
• Teres Minor	1=Complaint of pain	
Range of Motion: Shoulder: Pre-Treatment:	Left AROM	Right AROM
• Flexion(no pain with overpressure)	142	180
• Abduction(no pain with overpressure)	160	180

Treatments

Exercise Activities: Isotonics:

- Prone Extension.
- Isotonic Activity 1
- Isotonic Activity 2

Exercise Activities: Tubing/Bands:

- ER 0 deg
- IR 0 deg
- Tubing/Bands 1

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Exercise Activities: Pulleys: Upper Extremity:

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 30, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Description: prone scapular set over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Description: forward punch, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Aug 24, 2012

- G-H Flexion

Time Elapsed: 4 Minutes, Repetitions: 0, Sets: 0, Charge As:
Therapeutic Exercise, Billing Code: 97110.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional
Detail: 90 FE and scapular plane ER/IR, Charge As: Therapeutic
Activities, Billing Code: 97530.

Therapy Session Time

- Total Therapy Session Time 44 Minutes

Assessment

The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Aug 24, 2012 15:05:25



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Aug 28, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 3
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Daily Comments: Report of outcome from Doctors visit:

- Continue with rehab. Was pleased with progress. Follow-up in 3-4 weeks with Dr.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012
• Assessment	Initial
• Physical Activity Score	8

Objective Examination

Functional Tests: Apley's Scratch Test:

	Left	Right
• Cross Body Reach	Posterior Opposite Shoulder	Lateral Opposite Shoulder
• ER - Combined	To T4	To T4



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Aug 28, 2012

• IR - Combined	To T6	To T5
Muscle Testing:		
• Strong and painless biceps; Weak and painless shoulder ABD and ER.		
Muscle Testing: Upper Extremity MMT:	Left	Right
• Scaption	4/5	-5/5
• Shoulder Abduction	4/5	-5/5
• Shoulder Flexion	4/5	-5/5
• Shoulder External Rotation	-4/5	-4/5
• Shoulder Internal Rotation	4/5	-5/5
Muscle Testing: Shoulder:	Left	Right
• Serratus Anterior	+3/5	+4/5
• Trapezius, Lower	-4/5	4/5
• Trapezius, Middle	4/5	4/5
• Trapezius, Upper	5/5	5/5
Palpation: Musculature: Tenderness:	Left	
• Teres Minor	1=Complaint of pain	
• Trapezius, Upper	1=Complaint of pain	
Range of Motion: Shoulder: Pre-Treatment:	Left AROM	Right AROM
• Flexion(no pain with overpressure)	142	180
• Abduction(no pain with overpressure)	160	180
• Horizontal Adduction	30	
Range of Motion: Shoulder: Post-Treatment:	Left AROM	
• Adduction(improved after stretching)	41	

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
- Prone Extension.
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Prone Row.
Time Elapsed: 4 Minutes, Repetitions: 30, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Supine Punch
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.
- Isotonic Activity 1
- Isotonic Activity 2

Exercise Activities: Tubing/Bands:

- ER 0 deg(This visit)
Did Not Perform: This visit
- IR 0 deg(This visit)
Did Not Perform: This visit
- Tubing/Bands 1(This visit)
Did Not Perform: This visit



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Aug 28, 2012

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion

Time Elapsed: 4 Minutes, Repetitions: 0, Sets: 0, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1

Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Upper Quarter Joint Complex:

- Glenohumeral Joint

Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Upper Trapezius

Time Elapsed: 8 Minutes, Tx Depth: Moderate, Technique: Sustained Pressure, Assisting Technique: after sustained pressure with strumming, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Therapy Session Time

- Total Therapy Session Time 62 Minutes

Assessment

The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.

Impairments Identified:

- Weakness with RTC Primarily ER.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)

Signed on Aug 28, 2012 12:23:28



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Aug 30, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 4
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

proaxistherapy

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Daily Comments:

- Feels better but still very weak.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012
• Assessment	Initial
• Physical Activity Score	8

Objective Examination

Functional Tests: Apley's Scratch Test:

	Left	Right
• Cross Body Reach	Posterior Opposite Shoulder	Lateral Opposite Shoulder
• ER - Combined	To T4	To T4



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Aug 30, 2012

- IR - Combined

To T6

To T5

Muscle Testing:

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

Muscle Testing: Upper Extremity MMT:

- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation
- Shoulder Internal Rotation(improved)

Left

4/5
4/5
4/5
-4/5
+4/5

Right

-5/5
-5/5
-5/5
-4/5
-5/5

Muscle Testing: Shoulder:

- Serratus Anterior
- Trapezius, Lower
- Trapezius, Middle
- Trapezius, Upper

Left

+3/5
-4/5
4/5
5/5

Right

+4/5
4/5
4/5
5/5

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper

Left

1=Complaint of pain
1=Complaint of pain

Range of Motion: Shoulder: Pre-Treatment:

- Flexion(no pain with overpressure)
- Abduction(no pain with overpressure)
- Horizontal Adduction

Left AROM

160
160
30

Right AROM

180
180

Range of Motion: Shoulder: Post-Treatment:

- Adduction(improved after stretching)

Left AROM

41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.(This visit)
- Prone Extension.
- Prone Row.(This visit)
- Supine Punch(This visit)
- Isotonic Activity 1(This visit)
- Isotonic Activity 2

Did Not Perform: This visit

Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

Exercise Activities: Tubing/Bands:

- ER 0 deg(This visit)
- IR 0 deg(This visit)
- Pull Downs

Did Not Perform: This visit

Did Not Perform: This visit

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Scapular Retraction

- Tubing/Bands 1(This visit)

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Manual Interventions: Upper Quarter Joint Complex:

- Glenohumeral Joint

Manual Interventions: Soft Tissue:

- Upper Trapezius

Therapy Session Time

- Total Therapy Session Time 54 Minutes

Assessment

Assessment of Improvement:

- Improved FE.

Impairments Identified:

- weakness (L) ER and scapular stabilizers.

Presentation:

- No winging, anterior tilt with prone extension, rows or scapular reverse punches prone.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program.

Did Not Perform: This visit

Time Elapsed: 9 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 0, Sets: 0, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Time Elapsed: 8 Minutes, Tx Depth: Moderate, Technique: Sustained Pressure, Assisting Technique: after sustained pressure with strumming, Charge As: Manual Therapy Techniques, Billing Code: 97140.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Aug 30, 2012

Mason Rockwell, PT(SC Lic: 5456)
Signed on Aug 30, 2012 15:30:23



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Sep 06, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 5
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Daily Comments:

- No changes to report with left shoulder and jaw, teeth surgery delayed until more bone healing.

Questionnaires: Additional:

• Test Name	Penn SShoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012
• Assessment	Initial
• Physical Activity Score	8

Objective Examination

Functional Tests: Apley's Scratch Test:

	Left	Right
• Cross Body Reach	Posterior Opposite Shoulder	Lateral Opposite Shoulder
• ER - Combined	To T4	To T4



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 06, 2012

• IR - Combined	To T6	To T5
Muscle Testing:		
• Strong and painless biceps; Weak and painless shoulder ABD and ER.		
Muscle Testing: Upper Extremity MMT:		
• Scaption	Left 4/5	Right -5/5
• Shoulder Abduction	4/5	-5/5
• Shoulder Flexion	4/5	-5/5
• Shoulder External Rotation	-4/5	-4/5
• Shoulder Internal Rotation(improved)	+4/5	-5/5
Muscle Testing: Shoulder:		
• Serratus Anterior	Left +3/5	Right +4/5
• Trapezius, Lower	-4/5	4/5
• Trapezius, Middle	4/5	4/5
• Trapezius, Upper	5/5	5/5
Palpation: Musculature: Tenderness:		
• Teres Minor	Left 1=Complaint of pain	
• Trapezius, Upper	1=Complaint of pain	
Range of Motion: Shoulder: Pre-Treatment:		
• Flexion(no pain with overpressure)	Left AROM 160	Right AROM 180
• Abduction(no pain with overpressure)	160	180
• Horizontal Adduction	30	
Range of Motion: Shoulder: Post-Treatment:		
• Adduction(improved after stretching)	Left AROM 41	

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
- Prone Extension.(6 reps with 2 # before compensation)
- Prone Row.
- Supine Punch(This visit)
- Isotonic Activity 1(This visit)
- Isotonic Activity 2

Exercise Activities: Tubing/Bands:

- ER 0 deg(This visit)
- IR 0 deg

Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit
Did Not Perform: This visit
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

Did Not Perform: This visit
Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Pull Downs

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit

- Scapular Retraction

Time Elapsed: 9 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Tubing/Bands 1(This visit)

Did Not Perform: This visit

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Did Not Perform: This visit

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion(This visit)

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1(This visit)

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Upper Quarter Joint Complex:

- Glenohumeral Joint

Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Upper Trapezius(This visit)

Did Not Perform: This visit

Therapy Session Time

- Total Therapy Session Time 50 Minutes

Assessment

Presentation:

- Symptoms consistent with referring diagnosis.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 06, 2012 15:04:50



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Sep 11, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 6
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Daily Comments:

- soreness in left shoulder and tired feeling when driving.

Questionnaires: Additional:

• Test Name	Penn SShoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012
• Assessment	Initial
• Physical Activity Score	8

Objective Examination

Functional Tests: Apley's Scratch Test:

	Left	Right
• Cross Body Reach	Posterior Opposite Shoulder	Lateral Opposite Shoulder
• ER - Combined	To T4	To T4



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 11, 2012

• IR - Combined	To T6	To T5
Muscle Testing:		
• Strong and painless biceps; Weak and painless shoulder ABD and ER.		
Muscle Testing: Upper Extremity MMT:	Left	Right
• Scaption	4/5	-5/5
• Shoulder Abduction	4/5	-5/5
• Shoulder Flexion	4/5	-5/5
• Shoulder External Rotation	-4/5	-4/5
• Shoulder Internal Rotation(improved)	+4/5	-5/5
Muscle Testing: Shoulder:	Left	Right
• Serratus Anterior	+3/5	+4/5
• Trapezius, Lower	-4/5	4/5
• Trapezius, Middle	4/5	4/5
• Trapezius, Upper	5/5	5/5
Palpation: Musculature: Tenderness:	Left	
• Teres Minor	1=Complaint of pain	
• Trapezius, Upper	1=Complaint of pain	
Range of Motion: Shoulder: Pre-Treatment:	Left AROM	Right AROM
• Flexion(no pain with overpressure)	160	180
• Abduction(no pain with overpressure)	160	180
• Horizontal Adduction	30	
Range of Motion: Shoulder: Post-Treatment:	Left AROM	
• Adduction(improved after stretching)	41	

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
- Prone Extension.(6 reps with 2 # before compensation)
- Prone Row.
- Scaption/External Rotation.
- Supine Punch(This visit)
- Isotonic Activity 1(This visit)
- Isotonic Activity 2

Exercise Activities: Tubing/Bands:

- ER 0 deg(This visit)
- IR 0 deg

Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit
Did Not Perform: This visit
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

Did Not Perform: This visit
Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 11, 2012

- Pull Downs

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit

- Scapular Retraction

Time Elapsed: 9 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Tubing/Bands 1(This visit)

Did Not Perform: This visit

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion(This visit)

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1

Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Upper Quarter Joint Complex:

- Glenohumeral Joint

Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Upper Trapezius(This visit)

Did Not Perform: This visit

Therapy Session Time

- Total Therapy Session Time 58 Minutes

Assessment

Presentation:

- Symptoms consistent with referring diagnosis.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 11, 2012 14:59:40



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Sep 14, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 7
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Daily Comments:

- Soreness in the left side of the shoulder.

Questionnaires: Additional:

• Test Name	Penn SShoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012
• Assessment	Initial
• Physical Activity Score	8

Objective Examination

Functional Tests: Apley's Scratch Test:

	Left	Right
• Cross Body Reach	Posterior Opposite Shoulder	Lateral Opposite Shoulder
• ER - Combined	To T4	To T4



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 14, 2012

• IR - Combined	To T6	To T5
Muscle Testing:		
• Strong and painless biceps; Weak and painless shoulder ABD and ER.		
Muscle Testing: Upper Extremity MMT:	Left	Right
• Scaption	4/5	-5/5
• Shoulder Abduction	4/5	-5/5
• Shoulder Flexion	4/5	-5/5
• Shoulder External Rotation	-4/5	-4/5
• Shoulder Internal Rotation(improved)	+4/5	-5/5
Muscle Testing: Shoulder:	Left	Right
• Serratus Anterior	+3/5	+4/5
• Trapezius, Lower	-4/5	4/5
• Trapezius, Middle	4/5	4/5
• Trapezius, Upper	5/5	5/5
Palpation: Musculature: Tenderness:	Left	
• Teres Minor	1=Complaint of pain	
• Trapezius, Upper	1=Complaint of pain	
Range of Motion: Shoulder: Pre-Treatment:	Left AROM	Right AROM
• Flexion(no pain with overpressure)	160	180
• Abduction(no pain with overpressure)	160	180
• Horizontal Adduction	30	
Range of Motion: Shoulder: Post-Treatment:	Left AROM	
• Adduction(improved after stretching)	41	

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
- Prone Extension.
- Prone Row.
- Scaption/External Rotation.
- Supine Punch
- Isotonic Activity 1(This visit)
- Isotonic Activity 2

Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

Exercise Activities: Tubing/Bands:

- ER 0 deg(This visit)
- IR 0 deg(This visit)
- Pull Downs(This visit)

Did Not Perform: This visit
Did Not Perform: This visit
Did Not Perform: This visit



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 14, 2012

- Scapular Retraction

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit

- Tubing/Bands 1(This visit)

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion(This visit)

Did Not Perform: This visit

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1(This visit)

Did Not Perform: This visit

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Upper Quarter Joint Complex:

- Glenohumeral Joint

Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Deltoid

Time Elapsed: 8 Minutes, Tx Depth: Superficial, Technique: Strumming, Additional Detail: middle deltoid, Charge As: Manual Therapy Techniques, Billing Code: 97140.
Did Not Perform: This visit

- Upper Trapezius(This visit)

Therapy Session Time

- Total Therapy Session Time 56 Minutes

Assessment

Presentation:

- Symptoms consistent with referring diagnosis.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 14, 2012 15:09:56



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 18, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 8
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Daily Comments:

- Pain in the shoulder not as sore this week. She still reports reaching around the hook/unhook bra is painful and describes as a dull ache.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012
• Assessment	Initial
• Physical Activity Score	8

Objective Examination

Functional Tests: Apley's Scratch Test:

	Left	Right
• Cross Body Reach	Posterior Opposite Shoulder	Lateral Opposite Shoulder
• ER - Combined	To T4	To T4



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 18, 2012

• IR - Combined	To T6	To T5
Muscle Testing:		
• Strong and painless biceps; Weak and painless shoulder ABD and ER.		
Muscle Testing: Upper Extremity MMT:	Left	Right
• Scaption	4/5	-5/5
• Shoulder Abduction	4/5	-5/5
• Shoulder Flexion	4/5	-5/5
• Shoulder External Rotation	-4/5	-4/5
• Shoulder Internal Rotation(improved)	+4/5	-5/5
Muscle Testing: Shoulder:	Left	Right
• Serratus Anterior	+3/5	+4/5
• Trapezius, Lower	-4/5	4/5
• Trapezius, Middle	4/5	4/5
• Trapezius, Upper	5/5	5/5
Palpation: Musculature: Tenderness:	Left	
• Teres Minor	1=Complaint of pain	
• Trapezius, Upper	1=Complaint of pain	
Range of Motion: Shoulder: Pre-Treatment:	Left AROM	Left PROM Right AROM
• Flexion(no pain with overpressure 9/18)	160	175 180
• Abduction(no pain with overpressure 9/18)	180	180
• Horizontal Adduction(9/18)	50	60
Range of Motion: Shoulder: Post-Treatment:	Left AROM	
• Adduction(improved after stretching)	41	

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
- Prone Extension.
- Prone Row.
- Scaption/External Rotation.
- Supine Punch(Tbis visit)
- Isotonic Activity 1
- Isotonic Activity 2

Exercise Activities: Tubing/Bands:

Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit
Time Elapsed: 4 Minutes, Repetitions: 30, Side: Bilateral, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

- IR 0 deg
- Pull Downs
- Scapular Retraction

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion(This visit)

Did Not Perform: This visit

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1(This visit)

Did Not Perform: This visit

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Upper Quarter Joint Complex:

- Glenohumeral Joint

Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Deltoid(This visit)
- Upper Trapezius(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Therapy Session Time

- Total Therapy Session Time 55 Minutes

Assessment

Continued weakness with ER but no scapular winging during prone scaption. Added PNF with minimal verbal and tactile cues to prevent biceps compensation.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program. Assess soreness after PNF added.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 18, 2012

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 18, 2012 15:03:02



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 20, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 9
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Questionnaires: Additional:

• Test Name	Penn SHoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012
• Assessment	Initial
• Physical Activity Score	8

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach
- ER - Combined
- IR - Combined

Muscle Testing:

Left

Posterior Opposite Shoulder
To T4
To T6

Right

Lateral Opposite Shoulder
To T4
To T5



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 20, 2012

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

Muscle Testing: Upper Extremity MMT:

- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation
- Shoulder Internal Rotation(improved)

Left

4/5
4/5
4/5
-4/5
+4/5

Right

-5/5
-5/5
-5/5
-4/5
-5/5

Muscle Testing: Shoulder:

- Serratus Anterior
- Trapezius, Lower
- Trapezius, Middle
- Trapezius, Upper

Left

+3/5
-4/5
4/5
5/5

Right

+4/5
4/5
4/5
5/5

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper

Left

1=Complaint of pain

1=Complaint of pain

Range of Motion: Shoulder: Pre-Treatment:

- Flexion(no pain with overpressure 9/18)
- Abduction(no pain with overpressure 9/18)
- Horizontal Adduction(9/18)

Left AROM

160
180
50

Left PROM

175
180
60

Right AROM

180
180

Range of Motion: Shoulder: Post-Treatment:

- Horizontal Adduction(improved WNL after stretching 9/18)

Left AROM

41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
- Prone Extension.
- Prone Row.
- Scaption/External Rotation.
- Supine Punch(This visit)
- Isotonic Activity 1
- Isotonic Activity 2

Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110.

Did Not Perform: This visit

Time Elapsed: 4 Minutes, Repetitions: 30, Side: Bilateral, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

Exercise Activities: Tubing/Bands:



- IR 0 deg
- Pull Downs
- Scapular Retraction

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion(This visit)

Did Not Perform: This visit

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1

Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Therapeutic Activities, Billing Code: 97530.

- Stabilization Training 2

Time Elapsed: 4 Minutes, Repetitions: 15, Additional Detail: BOING, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Upper Quarter Joint Complex:

- Glenohumeral Joint(This visit)

Did Not Perform: This visit

Manual Interventions: Soft Tissue:

- Deltoid(This visit)
- Upper Trapezius(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Therapy Session Time

- Total Therapy Session Time 58 Minutes

Assessment

The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty. Improved tolerance with scapular strengthening and less medial angle winging.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 20, 2012

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 20, 2012 14:48:39



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 25, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 10
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	08/21/2012
• Assessment	Initial
• Total	65/100
• Score 1	pain 9/30
• Score 2	function 38/60

Questionnaires: Fear Avoidance:

• Date	08/21/2012
• Assessment	Initial
• Physical Activity Score	8

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)
- IR - Combined(equal and symmetrical)

Muscle Testing:

Left

Posterior Opposite Shoulder
To T4
To T6

Right

Posterior Opposite Shoulder
To T4
To T5



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 25, 2012

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

Muscle Testing: Upper Extremity MMT:

- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation
- Shoulder Internal Rotation(improved)

Left	Right
4/5	-5/5
4/5	-5/5
4/5	-5/5
-4/5	-4/5
+4/5	-5/5

Muscle Testing: Shoulder:

- Serratus Anterior
- Trapezius, Lower
- Trapezius, Middle
- Trapezius, Upper

Left	Right
+3/5	+4/5
-4/5	4/5
4/5	4/5
5/5	5/5

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper

Left
1=Complaint of pain
1=Complaint of pain

Range of Motion: Shoulder: Pre-Treatment:

- Flexion(no pain with overpressure 9/18)
- Abduction(no pain with overpressure 9/18)
- Horizontal Adduction(9/18)

Left AROM	Left PROM	Right AROM
160	175	180
180		180
50	60	

Range of Motion: Shoulder: Post-Treatment:

- Horizontal Adduction(improved WNL after stretching 9/18)

Left AROM
41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
- Prone Extension.
- Prone Row.
- Scaption/External Rotation.
- Supine Punch(This visit)
- Isotonic Activity 1
- Isotonic Activity 2

Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110.

Did Not Perform: This visit

Time Elapsed: 4 Minutes, Repetitions: 30, Side: Bilateral,
Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

Exercise Activities: Tubing/Bands:



- IR 0 deg
- Pull Downs
- Scapular Retraction

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion(This visit)

Did Not Perform: This visit

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1

Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Did Not Perform: This visit

- Stabilization Training 2(This visit)

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Manual Interventions: Upper Quarter Joint Complex:

- Glenohumeral Joint(This visit)

Did Not Perform: This visit

Manual Interventions: Soft Tissue:

- Deltoid(This visit)
- Upper Trapezius(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Therapy Session Time

- Total Therapy Session Time 54 Minutes

Assessment

Presentation:

- weakness with ER but no compensation during RS and PNF on left.

Plan

Daily Plan:

- Reassess objective measurements next visit. (patient given Penn outcome to return).

Therapeutic Contents:

- RTC and scapular strengthening.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 25, 2012

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 25, 2012 14:25:41



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 27, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 11
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Re-Evaluation

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Daily Comments:

- Pain has: Pain 2/10 on average.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	09/27/2012
• Assessment	Reassessment
• Total	64/100
• Score 1	pain 8/30
• Score 2	function 35/60

Questionnaires: Fear Avoidance:

• Date	09/27/2012
• Assessment	Reassessment
• Physical Activity Score	17

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)

Left

Posterior Opposite Shoulder
To T4

Right

Posterior Opposite Shoulder
To T4



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 27, 2012

- IR - Combined(equal and symmetrical)

To T6

To T5

Muscle Testing:

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

Muscle Testing: Upper Extremity MMT:

- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation(at side 4-/5; at 45 4/5)
- Shoulder Internal Rotation(improved)

Left

Right

Left

Right

4/5

-5/5

4/5

-5/5

4/5

-5/5

4/5

-5/5

4/5

-5/5

4/5

-5/5

-4/5

-4/5

-4/5

-4/5

4/5

-5/5

+4/5

-5/5

Aug 21, 2012

Sep 27, 2012

Muscle Testing: Shoulder:

- Serratus Anterior(improved)
- Trapezius, Lower
- Trapezius, Middle
- Trapezius, Upper

Left

Right

Left

Right

+3/5

+4/5

+4/5

+4/5

-4/5

4/5

-4/5

+4/5

4/5

4/5

+4/5

+4/5

5/5

5/5

5/5

5/5

Aug 21, 2012

Sep 27, 2012

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper(improved)

Left

1=Complaint of pain

0=No tenderness noted

Aug 21, 2012

Sep 27, 2012

Range of Motion: Shoulder: Pre-Treatment:

- Flexion(no pain with overpressure 9/18)
- Abduction(no pain with overpressure 9/18)
- Horizontal Adduction(9/18)

L. Act.

R. Act.

142

180

160

180

L. Act.

Pas.

R. Act.

175

180

180

180

180

50

60

Sep 27, 2012

Range of Motion: Shoulder: Post-Treatment:

- Horizontal Adduction(improved WNL after stretching 9/18)

L. Act.

41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
- Prone Extension.
- Prone Row.
- Scaption/External Rotation.
- Supine Punch(This visit)
- Isotonic Activity 1

Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110.

Did Not Perform: This visit

Time Elapsed: 4 Minutes, Repetitions: 30, Side: Bilateral, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Isotonic Activity 2

Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

Exercise Activities: Tubing/Bands:

- IR 0 deg(This visit)
- IR 90 deg Slow

Did Not Perform: This visit

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Pull Downs

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit

- Scapular Retraction(This visit)

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion(This visit)

Did Not Perform: This visit

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1(This visit)
- Stabilization Training 2(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Manual Interventions: Soft Tissue:

- Deltoid(This visit)
- Upper Trapezius(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Therapy Session Time

- Total Therapy Session Time 54 Minutes

Assessment

Presentation:

- Improved AROM, improved SA strength, ER at 45 degrees, decreased pain but continued RTC ER and scapular stabilizer weakness.

Problems & Goals

Problem #1 Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHE currently describes pain as 2/10.

LTG Achieve by Oct 02, 2012.

Symptomatic Improvements:

- Decreasing Pain: to 0/10.

Problem #2 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.

LTG Achieve by Oct 25, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #3 Range of Motion: Shoulder: Pre-Treatment.

Goal Achieved Sep 27, 2012.

Range of Motion Improvements to: Shoulder:	Left AROM
• Flexion	170
• Abduction	170

Problem #4 Muscle Testing: Upper Extremity MMT.

LTG Achieve by Oct 25, 2012. Progress: Some progress.

Musculoskeletal Improvements In: Shoulder	Left
Muscle Strength to:	
• Gross Assessment	+4/5

Problem #5 Questionnaires: Additional.

LTG Achieve by Oct 25, 2012. Progress: No change. improve strength for painfree ADL's

Questionnaire Improvements: Additional:	
• Test Name	Penn Shoulder Score
• Assessment	Reassessment
• Total	80/100
• Score 1	pain decrease by 3 points or greater
• Score 2	function score improve by 10 points or more

Problem #6 Muscle Testing: Shoulder.

LTG Achieve by Oct 25, 2012. Progress: Some progress.

Musculoskeletal Improvements In: Shoulder	Left
Muscle Strength to:	
• Gross Assessment	-5/5

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Daily Plan:

- Continue w/ Current Rehabilitation Program. Progression Under Current Plan. Advance as tolerated.

Therapeutic Contents:

- RTC and scapular strengthening and functional activities at shoulder level and overhead.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 27, 2012

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 27, 2012 14:17:24



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 27, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 11
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Plan of Care

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

Assessment

Presentation:

- Improved AROM, improved SA strength, ER at 45 degrees, decreased pain but continued RTC ER and scapular stabilizer weakness.

Problems & Goals

Problem #1 Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHE currently describes pain as 2/10.

LTG Achieve by Oct 02, 2012.

Symptomatic Improvements:

- Decreasing Pain: to 0/10.

Problem #2 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.

LTG Achieve by Oct 25, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #3 Range of Motion: Shoulder: Pre-Treatment.

- Abduction(no pain with overpressure 9/18)
- Flexion(no pain with overpressure 9/18)
- Horizontal Adduction(9/18)

Left AROM	Left PROM	Right AROM
180		180
175	180	180
50	60	

Goal Achieved Sep 27, 2012.

Range of Motion Improvements to: Shoulder:

- Flexion
- Abduction

Left AROM
170
170

Problem #4 Muscle Testing: Upper Extremity MMT.

- Scaption
- Shoulder Abduction
- Shoulder External Rotation(at side 4-/5; at 45 4/5)
- Shoulder Flexion
- Shoulder Internal Rotation(improved)

Left	Right
4/5	-5/5
4/5	-5/5
-4/5	-4/5
4/5	-5/5
+4/5	-5/5

LTG Achieve by Oct 25, 2012. Progress: Some progress.

Musculoskeletal Improvements In: Shoulder

Muscle Strength to:

Left

Please sign and return

I have reviewed this Plan of Care and certify that the skilled therapy services identified are required to meet the patient's need.
Comments and/or revisions to this Plan of Care are noted below.

Comments/Revisions

Physician/NPP Signature

Date

Print Name and Credentials



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Sep 27, 2012

- Gross Assessment +4/5

Problem #5 Questionnaires: Additional.

- Assessment Reassessment
- Date 09/27/2012
- Score 1 pain 8/30
- Score 2 function 35/60
- Test Name Penn SHoulder Score
- Total 64/100

LTG Achieve by Oct 25, 2012. Progress: No change. improve strength for painfree ADL's

Questionnaire Improvements: Additional:

- Test Name Penn Shoulder Score
- Assessment Reassessment
- Total 80/100
- Score 1 pain decrease by 3 points or greater
- Score 2 function score improve by 10 points or more

Problem #6 Muscle Testing: Shoulder.

	Left	Right
• Serratus Anterior(improved)	+4/5	+4/5
• Trapezius, Lower	-4/5	+4/5
• Trapezius, Middle	+4/5	+4/5
• Trapezius, Upper	5/5	5/5

LTG Achieve by Oct 25, 2012. Progress: Some progress.

Musculoskeletal Improvements In: Shoulder

Muscle Strength to:

- Gross Assessment -5/5

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Daily Plan:

- Continue w/ Current Rehabilitation Program. Progression Under Current Plan. Advance as tolerated.

Therapeutic Contents:

- RTC and scapular strengthening and functional activities at shoulder level and overhead.

Mason Rockwell, PT(SC Lic: 5456)

Signed on Sep 27, 2012 14:17:24



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 12, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 12
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHE suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHE currently describes pain as 2/10.

Questionnaires: Additional:

• Test Name	Penn SShoulder Score
• Date	09/27/2012
• Assessment	Reassessment
• Total	64/100
• Score 1	pain 8/30
• Score 2	function 35/60

Questionnaires: Fear Avoidance:

• Date	09/27/2012
• Assessment	Reassessment
• Physical Activity Score	17

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)
- IR - Combined(equal and symmetrical)

Muscle Testing:

Left	Right
Posterior Opposite Shoulder	Posterior Opposite Shoulder
To T4	To T4
To T6	To T5

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

Muscle Testing: Upper Extremity MMT:

- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation(improved @ 0 and 45 ABD 10/12/12)
- Shoulder Internal Rotation(improved)

Left	Right
4/5	-5/5
4/5	-5/5
4/5	-5/5
4/5	4/5
+4/5	-5/5

Muscle Testing: Shoulder:

- Serratus Anterior(improved)
- Trapezius, Lower
- Trapezius, Middle
- Trapezius, Upper

Left	Right
+4/5	+4/5
-4/5	+4/5
+4/5	+4/5
5/5	5/5

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper(improved)

Left
1=Complaint of pain
0=No tenderness noted

Range of Motion: Shoulder: Post-Treatment:

- Horizontal Adduction(improved WNL after stretching 9/18)

Left AROM

41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
- Prone Extension.
- Prone Row.
- Scaption/External Rotation.(This visit)
- Supine Punch
- Isotonic Activity 1(This visit)
- Isotonic Activity 2

Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit
Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit
Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

Exercise Activities: Tubing/Bands:

- ER 0 deg
- IR 0 deg(This visit)
- IR 90 deg Slow(This visit)
- Pull Downs

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Redx15, yellow 2x10, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit
Did Not Perform: This visit
Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 12, 2012

- Scapular Retraction

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion(This visit)

Did Not Perform: This visit

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1

Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

- Stabilization Training 2

Time Elapsed: 4 Minutes, Repetitions: 15, Additional Detail: BOING, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 12 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Manual Interventions: Soft Tissue:

- Deltoid(This visit)
- Upper Trapezius(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Therapy Session Time

- Total Therapy Session Time 55 Minutes

Assessment

Presentation:

- Improved ER at side and 45 degrees without scapular winging.

Plan

Client tolerated longer session due to early arrival.

Daily Plan:

- Continue w/ Current Rehabilitation Program. 2-3 times a week for 8 sessions for RTC and scapular strengthening.

Mason Rockwell, PT(SC Lic: 5456)

Signed on Oct 12, 2012 10:04:47



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Timothy Marinelli
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Oct 15, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 13
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Daily Comments:

- Patient states that her shoulder is feeling a little sore today.

Questionnaires: Additional:

• Test Name	Penn SHoulder Score
• Date	09/27/2012
• Assessment	Reassessment
• Total	64/100
• Score 1	pain 8/30
• Score 2	function 35/60

Questionnaires: Fear Avoidance:

• Date	09/27/2012
• Assessment	Reassessment
• Physical Activity Score	17

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)

Left

Posterior Opposite Shoulder
To T4

Right

Posterior Opposite Shoulder
To T4



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 15, 2012

- IR - Combined(equal and symmetrical)

To T6

To T5

Muscle Testing:

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

Muscle Testing: Upper Extremity MMT:

- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation(improved @ 0 and 45 ABD 10/12/12)
- Shoulder Internal Rotation(improved)

Left

Right

4/5

-5/5

4/5

-5/5

4/5

-5/5

4/5

4/5

+4/5

-5/5

Muscle Testing: Shoulder:

- Serratus Anterior(improved)
- Trapezius, Lower
- Trapezius, Middle
- Trapezius, Upper

Left

Right

+4/5

+4/5

-4/5

+4/5

+4/5

+4/5

5/5

5/5

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper(improved)

Left

1=Complaint of pain

0=No tenderness noted

Range of Motion: Shoulder: Post-Treatment:

- Horizontal Adduction(improved WNL after stretching 9/18)

Left AROM

41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.

- Prone Extension.

- Prone Row.

- Scaption/External Rotation.(This visit)
- Supine Punch(This visit)
- Isotonic Activity 1(This visit)
- Isotonic Activity 2

Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over holster, Charge As: Therapeutic Activities, Billing Code: 97530.

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Exercise Activities: Tubing/Bands:

- ER 0 deg(This visit)
- IR 0 deg(This visit)
- IR 90 deg Slow(This visit)
- Pull Downs(This visit)
- Scapular Retraction(This visit)

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 15, 2012

Exercise Activities: Pulleys: Upper Extremity:

- G-H Flexion(This visit)

Did Not Perform: This visit

Exercise Activities: Stabilization Training: Standing Position:

- Stabilization Training 1(This visit)
- Stabilization Training 2(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization(This visit)

Did Not Perform: This visit

Manual Interventions: Soft Tissue:

- Deltoid

Time Elapsed: 8 Minutes, Tx Depth: Superficial, Technique:
Strumming, Additional Detail: middle deltoid, Charge As: Manual
Therapy Techniques, Billing Code: 97140.

Did Not Perform: This visit

- Upper Trapezius(This visit)

Therapy Session Time

- Total Therapy Session Time 30 Minutes

Assessment

Tolerance:

- Patient tolerated exercises well. Resistance was progressed with shoulder strengthening/rotator cuff strengthening exercises.

Plan

Recommendations:

- Progress next visit with shoulder strengthening/stabilization activities as tolerated.

Timothy Marinelli, PT(SC Lic: 6704)
Signed on Oct 15, 2012 14:32:48



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Jeffery Gearhart
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 17, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 14
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHE suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHE currently describes pain as 2/10.

Daily Comments:

- Overall Condition is: Client reports that she continues to have soreness, primarily lateral and superior shoulder. Client reports overall that her shoulder continues to improve.

Questionnaires: Additional:

• Test Name	Penn SHoulder Score
• Date	09/27/2012
• Assessment	Reassessment
• Total	64/100
• Score 1	pain 8/30
• Score 2	function 35/60

Questionnaires: Fear Avoidance:

• Date	09/27/2012
• Assessment	Reassessment
• Physical Activity Score	17

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)

Left

Posterior Opposite Shoulder

Right

Posterior Opposite Shoulder



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 17, 2012

- ER - Combined(equal and symmetrical)
- IR - Combined(equal and symmetrical)

To T4
To T6

To T4
To T5

Muscle Testing:

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

Muscle Testing: Upper Extremity MMT:

- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation(improved @ 0 and 45 ABD 10/12/12)
- Shoulder Internal Rotation(improved)

Left
4/5
4/5
4/5
4/5

Right
-5/5
-5/5
-5/5
4/5

Muscle Testing: Shoulder:

- Serratus Anterior(improved)
- Trapezius, Lower
- Trapezius, Middle
- Trapezius, Upper

Left
+4/5
-4/5
+4/5
5/5

Right
+4/5
+4/5
+4/5
5/5

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper(improved)

Left
1=Complaint of pain
0=No tenderness noted

Range of Motion: Shoulder: Post-Treatment:

- Horizontal Adduction(improved WNL after stretching 9/18)

Left AROM
41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.

Time Elapsed: 8 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Tubing/Bands:

- D1 Flexion/Extension.

Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Extension, Shoulder

Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Rows

Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Manual Interventions: Upper Quarter Joint Complex:



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 17, 2012

- Scapulothoracic Joint

Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory,
Technique 1: All Glides, Charge As: Manual Therapy Techniques,
Billing Code: 97140.

Therapy Session Time

- Total Therapy Session Time 50 Minutes

Assessment

Tolerance:

- Client reported decreased soreness with treatment. Client required verbal cues for posture and form. Client continues to have strength and muscle endurance deficits. She would benefit from progression of strength and posture.

Plan

Daily Plan:

- Progress with strength and muscle endurance. Progress with posture.

Jeffery Gearhart, PT(SC Lic: 5945)
Signed on Oct 17, 2012 15:25:01



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Jeffery Gearhart
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Oct 19, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 15
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Daily Comments:

- Overall Condition is: Client reports that overall her shoulder continues to improve.

Questionnaires: Additional:

• Test Name	Penn SShoulder Score
• Date	09/27/2012
• Assessment	Reassessment
• Total	64/100
• Score 1	pain 8/30
• Score 2	function 35/60

Questionnaires: Fear Avoidance:

• Date	09/27/2012
• Assessment	Reassessment
• Physical Activity Score	17

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)

Left

Posterior Opposite Shoulder
To T4

Right

Posterior Opposite Shoulder
To T4



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 19, 2012

- IR - Combined(equal and symmetrical)

To T6

To T5

Muscle Testing:

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

Muscle Testing: Upper Extremity MMT:

Left

Right

- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation(improved @ 0 and 45 ABD 10/12/12)
- Shoulder Internal Rotation(improved)

4/5
4/5
4/5
4/5

-5/5
-5/5
-5/5
4/5

Muscle Testing: Shoulder:

Left

Right

- Serratus Anterior(improved)
- Trapezius, Lower
- Trapezius, Middle
- Trapezius, Upper

+4/5
-4/5
+4/5
5/5

+4/5
+4/5
+4/5
5/5

Palpation: Musculature: Tenderness:

Left

- Teres Minor
- Trapezius, Upper(improved)

1=Complaint of pain
0=No tenderness noted

Range of Motion: Shoulder: Post-Treatment:

Left AROM

- Horizontal Adduction(improved WNL after stretching 9/18)

41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.

Time Elapsed: 2 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Tubing/Bands:

- D1 Flexion/Extension.

Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- D2 Flexion/Extension.

Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Extension, Shoulder

Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- IR 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Rows

Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 19, 2012

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Manual Interventions: Upper Quarter Joint Complex:

- Scapulothoracic Joint

Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: All Glides, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Therapy Session Time

- Total Therapy Session Time 55 Minutes

Assessment

Tolerance:

- Client continues to require verbal cues for posture and form. She continues to have strength deficits, specifically at or above shoulder height. Client would benefit from progression of range and strength.

Plan

Daily Plan:

- Progress with strength and posture.

Jeffery Gearhart, PT(SC Lic: 5945)

Signed on Oct 19, 2012 14:18:19



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Oct 22, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 16
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Re-Evaluation

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Chief Complaint:

- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. She currently describes pain as 2/10.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	10/22/2012
• Assessment	Reassessment
• Total(improved)	70/100
• Score 1(goal met)	pain 6/30
• Score 2	function 39/60

Questionnaires: Fear Avoidance:

• Date	10/22/2012
• Assessment	Reassessment
• Physical Activity Score(improved)	11

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)
- IR - Combined(equal and symmetrical)

Left

Posterior Opposite Shoulder
To T4
To T5

Right

Posterior Opposite Shoulder
To T4
To T5

Muscle Testing:

- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

	Sep 27, 2012		Oct 22, 2012	
Muscle Testing: Upper Extremity MMT:	Left	Right	Left	Right
• Scaption(improved 10/22)	4/5	-5/5	+4/5	-5/5
• Shoulder Abduction	4/5	-5/5	+4/5	-5/5
• Shoulder Flexion(improved 10/22)	4/5	-5/5	+4/5	-5/5
• Shoulder External Rotation(improved @ 0 and 45 ABD 10/22/12)	-4/5	-4/5	4/5	4/5
• Shoulder Internal Rotation(improved 10/22/12)	+4/5	-5/5	-5/5	-5/5

	Sep 27, 2012		Oct 22, 2012	
Muscle Testing: Shoulder:	Left	Right	Left	Right
• Serratus Anterior(improved 10/22/12)	+4/5	+4/5	+4/5	+4/5
• Trapezius, Lower(improved 10/22)	-4/5	+4/5	4/5	+4/5
• Trapezius, Middle(improved 10/22)	+4/5	+4/5	-5/5	-5/5
• Trapezius, Upper	5/5	5/5	5/5	5/5

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper(improved)

1=Complaint of pain
0=No tenderness noted

	Sep 27, 2012		Oct 22, 2012	
Range of Motion: Shoulder: Post-Treatment:	L. Act.		L. Act.	
• Horizontal Adduction(improved WNL after stretching 9/18)	41		41	

Treatments

Exercise Activities: Isotonies:

- External Rotation Sidelying.(This visit)

Did Not Perform: This visit

Exercise Activities: Tubing/Bands:

- D1 Flexion/Extension.

Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- D2 Flexion/Extension.

Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 90 deg Slow

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Extension, Shoulder

Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 22, 2012

- IR 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Rows

Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Manual Interventions: Upper Quarter Joint Complex:

- Scapulothoracic Joint

Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: All Glides, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Therapy Session Time

- Total Therapy Session Time 54 Minutes

Assessment

Presentation:

- Improving RTC strength and scapular stabilizer strength, continued endurance weakness.

Problems & Goals

Problem #1 Chief Complaint: Pain in the left shoulder and able to sleep on left side bnt can't pick anything up heavy. SHE currently describes pain as 2/10.

Goal Achieved Oct 12, 2012. able to sleep on left side without shoulder pain

Symptomatic Improvements:

- Decreasing Pain: to 0/10.

Problem #2 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.

LTG Achieve by Oct 27, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #3 Muscle Testing: Upper Extremity MMT.

Goal Achieved Oct 22, 2012. : 90% of Goal Met

Musculoskeletal Improvements In: Shoulder Left

Muscle Strength to:

- Gross Assessment +4/5

Problem #4 Questionnaires: Additional.

LTG Achieve by Oct 27, 2012. Progress: No change. 90% of Goal Met

Questionnaire Improvements: Additional:



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 22, 2012

• Test Name	Penn Shoulder Score
• Assessment	Reassessment
• Total	80/100
• Score 1	pain decrease by 3 points or greater
• Score 2	function score improve by 10 points or more

Problem #5 Muscle Testing: Shoulder.

LTG Achieve by Oct 25, 2012. Progress: Some progress. partially met

Musculoskeletal Improvements In: Shoulder Left

Muscle Strength to:

• Gross Assessment	-5/5

Plan

Daily Plan:

- 2 more sessions remaining before MD follow-up.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 22, 2012 14:11:01



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Oct 22, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 16
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Plan of Care

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

Assessment

Presentation:

- Improving RTC strength and scapular stabilizer strength, continued endurance weakness.

Problems & Goals

Problem #1 Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

Goal Achieved Oct 12, 2012. able to sleep on left side without shoulder pain

Symptomatic Improvements:

- Decreasing Pain: to 0/10.

Problem #2 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.

LTG Achieve by Oct 27, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #3 Muscle Testing: Upper Extremity MMT.

	Left	Right
• Scaption(improved 10/22)	+4/5	-5/5
• Shoulder Abduction	+4/5	-5/5
• Shoulder External Rotation(improved @ 0 and 45 ABD 10/22/12)	4/5	4/5
• Shoulder Flexion(improved 10/22)	+4/5	-5/5
• Shoulder Internal Rotation(improved 10/22/12)	-5/5	-5/5

Goal Achieved Oct 22, 2012. : 90% of Goal Met

Musculoskeletal Improvements In: Shoulder Muscle Strength to:

- Gross Assessment +4/5

Problem #4 Questionnaires: Additional.

• Assessment	Reassessment
• Date	10/22/2012
• Score 1(goal met)	pain 6/30
• Score 2	function 39/60
• Test Name	Penn SShoulder Score

Please sign and return

I have reviewed this Plan of Care and certify that the skilled therapy services identified are required to meet the patient's need.
Comments and/or revisions to this Plan of Care are noted below.

Comments/Revisions

Physician/NPP Signature

Date

Print Name and Credentials



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 22, 2012

- Total(improved) 70/100

LTG Achieve by Oct 27, 2012. Progress: No change. 90% of Goal Met

Questionnaire Improvements: Additional:

- Test Name Penn Shoulder Score
- Assessment Reassessment
- Total 80/100
- Score 1 pain decrease by 3 points or greater
- Score 2 function score improve by 10 points or more

Problem #5 Muscle Testing: Shoulder.

	Left	Right
• Serratus Anterior(improved 10/22/12)	+4/5	+4/5
• Trapezius, Lower(improved 10/22)	4/5	+4/5
• Trapezius, Middle(improved 10/22)	-5/5	-5/5
• Trapezius, Upper	5/5	5/5

LTG Achieve by Oct 25, 2012. Progress: Some progress. partially met

Musculoskeletal Improvements In: Shoulder Left

Muscle Strength to:

- Gross Assessment -5/5

Plan

Daily Plan:

- 2 more sessions remaining before MD follow-up.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 22, 2012 14:11:01



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 24, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 17
Cxl/Ns: 0

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Questionnaires: Additional:

• Test Name	Penn SShoulder Score
• Date	10/22/2012
• Assessment	Reassessment
• Total(improved)	70/100
• Score 1(goal met)	pain 6/30
• Score 2	function 39/60

Questionnaires: Fear Avoidance:

• Date	10/22/2012
• Assessment	Reassessment
• Physical Activity Score(improved)	11

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)
- IR - Combined(equal and symmetrical)

Left

Posterior Opposite Shoulder
To T4
To T5

Right

Posterior Opposite Shoulder
To T4
To T5

Muscle Testing:

- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

Muscle Testing: Shoulder:

Left

Right



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 24, 2012

• Serratus Anterior(improved 10/22/12)	+4/5	+4/5
• Trapezius, Lower(improved 10/22)	4/5	+4/5
• Trapezius, Middle(improved 10/22)	-5/5	-5/5
• Trapezius, Upper	5/5	5/5

Palpation: Musculature: Tenderness:

- Teres Minor
 - Trapezius, Upper(improved)
- 1=Complaint of pain
0=No tenderness noted

Range of Motion: Shoulder: Post-Treatment:

- Horizontal Adduction(improved WNL after stretching 9/18)
- Left AROM**
41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.

Time Elapsed: 2 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Tubing/Bands:

- D1 Flexion/Extension.

Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- D2 Flexion/Extension.

Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 90 deg Slow

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Extension, Shoulder

Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- IR 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Rows

Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Tubing/Bands 1

Time Elapsed: 3 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Description: forward punch, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 24, 2012

- Rhythmic Stabilization

Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Manual Interventions: Upper Quarter Joint Complex:

- Scapulothoracic Joint

Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: All Glides, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Assessment

Tolerance:

- Fatigue with sidelying ER. No abnormal scapular winging with ER or theraband. Compensation of elbow flexion with PNF patterns.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program. one more session before MD appointment.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 24, 2012 14:28:35



proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 26, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 17
Cxl/Ns: 1

Employer:
Insured: PALM STATE TRANS

Cancel/No Show *Patient cancelled appointment*

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Cancel Reasoning:
• SICK MICHELEG

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 26, 2012 10:48:51



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 30, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 18
Cxl/Ns: 1

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Daily Comments: Report of outcome from Doctors visit:

- Continue with rehab. asked for specific job descriptions and follow-up November 9.

Questionnaires: Additional:

• Test Name	Penn SShoulder Score
• Date	10/22/2012
• Assessment	Reassessment
• Total(improved)	70/100
• Score 1(goal met)	pain 6/30
• Score 2	function 39/60

Questionnaires: Fear Avoidance:

• Date	10/22/2012
• Assessment	Reassessment
• Physical Activity Score(improved)	11

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)
- IR - Combined(equal and symmetrical)

Left

Posterior Opposite Shoulder
To T4
To T5

Right

Posterior Opposite Shoulder
To T4
To T5

Muscle Testing:



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 30, 2012

- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

Muscle Testing: Shoulder:

- Serratus Anterior(improved 10/22/12)
- Trapezius, Lower(improved 10/22)
- Trapezius, Middle(improved 10/22)
- Trapezius, Upper

Left

+4/5

4/5

-5/5

5/5

Right

+4/5

+4/5

-5/5

5/5

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper(improved)

Left

1=Complaint of pain

0=No tenderness noted

Range of Motion: Shoulder: Post-Treatment:

- Horizontal Adduction(improved WNL after stretching 9/18)

Left AROM

41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.
- Isotonic Activity 1

Time Elapsed: 2 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Side: Left, Description: prone reverse punch, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Tubing/Bands:

- D1 Flexion/Extension.

Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

Did Not Perform: This visit

- D2 Flexion/Extension.(This visit)
- ER 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 90 deg Slow

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Extension, Shoulder

Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- IR 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Rows

Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Tubing/Bands 1(This visit)

Did Not Perform: This visit

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Oct 30, 2012

Exercise Activities: Range of Motion:

- ROM Activity 1

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Technique: Active, Hold.: 6 Seconds, Description: wall roller, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ROM Activity 2

Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Side: Left, Technique: Active, Description: prone hor abd at 90, Charge As: Therapeutic Exercise, Billing Code: 97110.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization

Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Manual Interventions: Upper Quarter Joint Complex:

- Scapulothoracic Joint

Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: All Glides, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Therapy Session Time

- Total Therapy Session Time 59 Minutes

Assessment

Presentation:

- Symptoms consistent with referring diagnosis.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program. Progression Under Current Plan.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 30, 2012 12:38:56



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Nov 01, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 19
Cxl/Ns: 1

Employer:
Insured: PALM STATE TRANS

Re-Evaluation *Progress Report (No Re-eval Charge)*

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Daily Comments:

- Endurance level the problem when using left arm.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	10/22/2012
• Assessment	Reassessment
• Total(improved)	70/100
• Score 1(goal met)	pain 6/30
• Score 2	function 39/60

Questionnaires: Fear Avoidance:

• Date	10/22/2012
• Assessment	Reassessment
• Physical Activity Score(improved)	11

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)
- IR - Combined(equal and symmetrical)

Muscle Testing:

Left

Posterior Opposite Shoulder
To T4
To T5

Right

Posterior Opposite Shoulder
To T4
To T5



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Nov 01, 2012

- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

		Oct 22, 2012		Nov 01, 2012	
Muscle Testing: Shoulder:		Left	Right	Left	Right
• Serratus Anterior(improved 10/22/12)		+4/5	+4/5	+4/5	+4/5
• Trapezius, Lower(improved 10/22)		4/5	+4/5	4/5	+4/5
• Trapezius, Middle(improved 10/22)		-5/5	-5/5	-5/5	-5/5
• Trapezius, Upper		5/5	5/5	5/5	5/5
Palpation: Musculature: Tenderness:		Left			
• Teres Minor		1=Complaint of pain			
• Trapezius, Upper(improved)		0=No tenderness noted			

		Oct 22, 2012	Nov 01, 2012
Range of Motion: Shoulder: Post-Treatment:		L. Act.	L. Act.
• Horizontal Adduction(improved WNL after stretching 9/18)		41	41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.

Time Elapsed: 2 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit

- Isotonic Activity 1(This visit)

Exercise Activities: Tubing/Bands:

- D1 Flexion/Extension.

Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- D2 Flexion/Extension.

Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 90 deg Slow

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Extension, Shoulder

Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- IR 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Rows

Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Tubing/Bands 1(This visit)

Did Not Perform: This visit

- Tubing/Bands 2

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Description: lower trapezius wall slides, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Range of Motion:

- ROM Activity 1

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Technique: Active, Hold.: 6 Seconds, Description: wall roller, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ROM Activity 2

Time Elapsed: 4 Minutes, Repetitions: 5, Sets: 2, Side: Left, Technique: Active, Description: prone hor abd at 90, Charge As: Therapeutic Exercise, Billing Code: 97110.

Functional/ADL Activities: Functional Task Training:

- Overhead Reach

Time Elapsed: 8 Minutes, Weight - Pounds: 2.5 round and hexagon weights Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.

- Pulling/Pushing

Time Elapsed: 4 Minutes, Weight - Pounds: 1 rep max 30, 40, 50 Pounds, Repetitions: 10 reps for 35 feet, Additional Detail: sled with stop during push/pull for biceps curl movement, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization(This visit)

Did Not Perform: This visit

Manual Interventions: Upper Quarter Joint Complex:

- Scapulothoracic Joint(This visit)

Did Not Perform: This visit

Therapy Session Time

- Total Therapy Session Time 55 Minutes

Assessment

The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.

Impairments Identified:

- weakness with lower trapezius endurance during wall slides but no scapular upward rotation or tilt with palpation.

Problems & Goals

Problem #1 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.

LTG Achieve by Nov 29, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #2 Questionnaires: Additional.

LTG Achieve by Nov 29, 2012. Progress: No change. allow getting into/out of trunk

Questionnaire Improvements: Additional:

- Test Name

Penn Shoulder Score



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Nov 01, 2012

• Assessment	Reassessment
• Total	80/100
• Score 1	pain decrease by 3 points or greater
• Score 2	function score improve by 10 points or more

Problem #3 Muscle Testing: Shoulder.

LTG Achieve by Nov 10, 2012. Progress: Some progress. partially met

Musculoskeletal Improvements In: Shoulder Left

Muscle Strength to:

• Gross Assessment	-5/5

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Recommendations:

- Awaiting approval for further sessions and possible functional capacity evaluation for objective data for return to work abilities.

Therapeutic Contents:

- scapular strengthening, RTC strengthening.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Nov 01, 2012 13:01:32



proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Jeremy W. Skoog
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Note Date: Nov 01, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 19
Cxl/Ns: 1

Employer:
Insured: PALM STATE TRANS

Expiration Override to Re-Evaluation from Nov 01, 2012 *Physician Script*

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

Justification

Pending response.

Jeremy W. Skoog, PT(SC Lic: 5127)
Signed on Nov 01, 2012 13:01:52



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Nov 01, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 19
Cxl/Ns: 1
Employer:
Insured: PALM STATE TRANS

Plan of Care

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

Assessment

The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.

Impairments Identified:

- weakness with lower trapezius endurance during wall slides but no scapular upward rotation or tilt with palpation.

Problems & Goals

Problem #1 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.

LTG Achieve by Nov 29, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #2 Questionnaires: Additional.

• Assessment	Reassessment
• Date	10/22/2012
• Score 1(goal met)	pain 6/30
• Score 2	function 39/60
• Test Name	Penn Shoulder Score
• Total(improved)	70/100

LTG Achieve by Nov 29, 2012. Progress: No change. allow getting into/out of trunk

Questionnaire Improvements: Additional:

• Test Name	Penn Shoulder Score
• Assessment	Reassessment
• Total	80/100
• Score 1	pain decrease by 3 points or greater
• Score 2	function score improve by 10 points or more

Problem #3 Muscle Testing: Shoulder.

	Left	Right
• Serratus Anterior(improved 10/22/12)	+4/5	+4/5
• Trapezius, Lower(improved 10/22)	4/5	+4/5
• Trapezius, Middle(improved 10/22)	-5/5	-5/5
• Trapezius, Upper	5/5	5/5

LTG Achieve by Nov 10, 2012. Progress: Some progress. partially met

Musculoskeletal Improvements In: Shoulder Left

Muscle Strength to:

Please sign and return

I have reviewed this Plan of Care and certify that the skilled therapy services identified are required to meet the patient's need.
Comments and/or revisions to this Plan of Care are noted below.

Comments/Revisions

Physician/NPP Signature

Date

Print Name and Credentials



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Nov 01, 2012

• Gross Assessment

-5/5

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Recommendations:

- Awaiting approval for further sessions and possible functional capacity evaluation for objective data for return to work abilities.

Therapeutic Contents:

- scapular strengthening, RTC strengthening.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Nov 01, 2012 13:01:32



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Nov 06, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 20
Cxl/Ns: 1

Employer:
Insured: PALM STATE TRANS

Daily Note

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Daily Comments:

- Sees MD this Friday and reports no changes with pain in the left shoulder.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	10/22/2012
• Assessment	Reassessment
• Total(improved)	70/100
• Score 1(goal met)	pain 6/30
• Score 2	function 39/60

Questionnaires: Fear Avoidance:

• Date	10/22/2012
• Assessment	Reassessment
• Physical Activity Score(improved)	11

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)
- IR - Combined(equal and symmetrical)

Muscle Testing:

Left

Posterior Opposite Shoulder
To T4
To T5

Right

Posterior Opposite Shoulder
To T4
To T5

- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

Muscle Testing: Shoulder:

- Serratus Anterior(improved 10/22/12)
- Trapezius, Lower(improved 10/22)
- Trapezius, Middle(improved 10/22)
- Trapezius, Upper

Left

+4/5
4/5
-5/5
5/5

Right

+4/5
+4/5
-5/5
5/5

Palpation: Musculature: Tenderness:

- Teres Minor
- Trapezius, Upper(improved)

Left

1=Complaint of pain
0=No tenderness noted

Range of Motion: Shoulder: Post-Treatment:

- Horizontal Adduction(improved WNL after stretching 9/18)

Left AROM

41

Treatments

Exercise Activities: Isotonics:

- External Rotation Sidelying.

Time Elapsed: 2 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Did Not Perform: This visit

- Isotonic Activity 1(This visit)

Exercise Activities: Tnbing/Bands:

- D1 Flexion/Extension.

Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- D2 Flexion/Extension.

Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ER 90 deg Slow

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Extension, Shoulder

Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- IR 0 deg

Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Rows

Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Tubing/Bands 1(This visit)

Did Not Perform: This visit

- Tubing/Bands 2

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Description: lower trapezius wall slides, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Upper Body Ergometer

Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Range of Motion:

- ROM Activity 1

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Technique: Active, Hold.: 6 Seconds, Description: wall roller, Charge As: Therapeutic Exercise, Billing Code: 97110.

- ROM Activity 2

Time Elapsed: 4 Minutes, Repetitions: 5, Sets: 2, Side: Left, Technique: Active, Description: prone hor abd at 90, Charge As: Therapeutic Exercise, Billing Code: 97110.

Functional/ADL Activities: Functional Task Training:

- Overhead Reach

Time Elapsed: 8 Minutes, Weight - Pounds: 2.5 round and hexagon weights Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.

- Pulling/Pushing

Time Elapsed: 4 Minutes, Weight - Pounds: 1 rep max 30, 40, 50 Pounds, Repetitions: 10 reps for 35 feet, Additional Detail: sled with stop during push/pull for biceps curl movement, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Proprioceptive Neuromuscular Facilitation:

- Rhythmic Stabilization(This visit)

Did Not Perform: This visit

Manual Interventions: Upper Quarter Joint Complex:

- Scapulothoracic Joint(This visit)

Did Not Perform: This visit

Therapy Session Time

- Total Therapy Session Time 55 Minutes

Assessment

Presentation:

- Symptoms consistent with referring diagnosis. Displays signs and symptoms of: Improved strength and endurance with reaching and strengthening.

Plan

Daily Plan:

- Continue w/ Current Rehabilitation Program.



Acct #: 314925
Patient: JENNIE M. COX

Visit Date: Nov 06, 2012

Mason Rockwell, PT(SC Lic: 5456)
Signed on Nov 06, 2012 14:27:53



Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Note Date: Nov 29, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 20
Cxl/Ns: 1

Employer:
Insured: PALM STATE TRANS

Discharge Summary

Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

General Information

Disease/Disorder/Condition:

- Unremarkable. MRI negative for Left RTC tear.

History of Injury:

- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. She suffered facial fractures, chest contusion and left shoulder, rib pain.

Occupation:

- Truck driver interstate travel from Atlanta to Mexico.

Subjective Examination

Client last seen 11/6/12.

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Questionnaires: Additional:

• Test Name	Penn Shoulder Score
• Date	10/22/2012
• Assessment	Reassessment
• Total(improved)	70/100
• Score 1(goal met)	pain 6/30
• Score 2	function 39/60

Questionnaires: Fear Avoidance:

• Date	10/22/2012
• Assessment	Reassessment
• Physical Activity Score(improved)	11

Objective Examination

Functional Tests: Apley's Scratch Test:

- Cross Body Reach(improved left)
- ER - Combined(equal and symmetrical)
- IR - Combined(equal and symmetrical)

Left

Posterior Opposite Shoulder
To T4
To T5

Right

Posterior Opposite Shoulder
To T4
To T5

Muscle Testing:

- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

	Aug 21, 2012		Nov 06, 2012	
Muscle Testing: Shoulder:	Left	Right	Left	Right
• Serratus Anterior(improved 10/22/12)	+3/5	+4/5	+4/5	+4/5
• Trapezius, Lower(improved 10/22)	-4/5	4/5	4/5	+4/5
• Trapezius, Middle(improved 10/22)	4/5	4/5	-5/5	-5/5
• Trapezius, Upper	5/5	5/5	5/5	5/5
Palpation: Musculature: Tenderness:	Left			
• Teres Minor	1=Complaint of pain			
• Trapezius, Upper(improved)	0=No tenderness noted			

Range of Motion: Shoulder: Post-Treatment:	Nov 06, 2012
• Horizontal Adduction(improved WNL after stretching 9/18)	L. Act. 41

Assessment

Presentation:

- Symptoms consistent with referring diagnosis. Displays signs and symptoms of: Improved strength and endurance with reaching and strengthening.

Problems & Goals

Problem #1 ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.
LTG Achieve by Nov 29, 2012.

Functional Improvements In:

- Work Capacity, Returning to: Modified Duty.

Problem #2 Questionnaires: Additional.

LTG Achieve by Nov 29, 2012. Progress: No change. allow getting into/out of trunk

Questionnaire Improvements: Additional:

- Test Name Penn Shoulder Score
- Assessment Reassessment
- Total 80/100
- Score 1 pain decrease by 3 points or greater
- Score 2 function score improve by 10 points or more

Problem #3 Muscle Testing: Shoulder.

LTG Achieve by Nov 10, 2012. Progress: Some progress. partially met

Musculoskeletal Improvements In: Shoulder Left

Muscle Strength to:

- Gross Assessment -5/5

Plan

Discharge to Independent Home Exercise Program.

Discharge due to:

- Physician Direction.



Acct #: 314925
Patient: JENNIE M. COX

Note Date: Nov 29, 2012

Mason Rockwell, PT(SC Lic: 5456)
Signed on Nov 29, 2012 10:59:59

APA #8
JENNIFER T. ELLIS, M.D.
HILLCREST FAMILY PRACTICE
08/28/12-09/28/16

Progress Note

Patient Name: Jennie Cox
Patient ID: 55780
Sex: Female
Birthdate: August 14, 1952

Visit Date: August 28, 2012
Provider: Jennifer T. Ellis, MD
Location: Hillcrest Family Practice
Location Address: 717 SE Main Street
 Simpsonville, SC 296813237
Location Phone: (864) 963-1548

Chief Complaint

- F/U Anxiety Disorder & Rx Refill

History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been getting worse. She is currently taking the following prescription medications: A prazolam 0.25mg and Restoril Oral Capsule 30 mg She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: none have improved. And she feels like the following symptoms have worsened: depression. She is is currently experiencing loss of appetite and loss of interest in pleasurable activities. She denies difficulty concentrating and difficulty performing routine daily activities. She has the following issues going on that are affecting the condition: a recent accident at work = 6/2012- machine fell on her- see mandible fx notes and chest trauma. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

She returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She remains on dietary management alone for intervention and claims to be adhering well to it thus far. She does not exercise but is very active. She is not fasting today.

Past Medical History

Significant for Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Significant for Adenoidectomy; Appendectomy; Colonoscopy; EGD; hysterectomy; Lysis of adhesions; Tonsillectomy

Medication List

Significant for Alprazolam Oral 0.5mg; pravastatin Oral Tablet 20 mg; Restoril Oral Capsule 30 mg

Allergy List

Significant for Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Significant for Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Significant for Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

Constitutional

- o Denies : weight loss, weight gain, loss of appetite

HENT

- o Denies : headaches

Cardiovascular

- o Denies : chest pain, dyspnea on exertion

182

-0252-

Respiratory

- Denies : shortness of breath

Gastrointestinal

- Denies : nausea, vomiting, diarrhea, abdominal pain, jaundice

Integument

- Denies : rash, itching

Neurologic

- Denies : tingling or numbness

Musculoskeletal

- Denies : additional musculoskeletal symptoms except as noted in the HPI

Endocrine

- Denies : polyuria, polydipsia, cold intolerance, heat intolerance

Psychiatric

- Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L\R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
08/28/2012	02:13 PM	114/76	Sitting						97.9	107lbs Box	5' 6.5"	17.09	1.51		

Physical Examination**Constitutional**

- Appearance : well nourished, well developed, alert, oriented, in no acute distress

Eyes

- Conjunctivae : conjunctiva normal
- Sclerae : sclera white
- Pupils and Irises : pupils equal, round, and reactive to light and accommodation bilaterally

Respiratory

- Respiratory Effort : breathing unlabored
- Auscultation of Lungs : normal breath sounds

Cardiovascular

- Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Gastrointestinal

- Abdominal Examination : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

Skin and Subcutaneous Tissue

- General Inspection : no rashes present, no lesions present, no areas of discoloration present
- General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- Judgement and Insight : judgement and insight intact
- Mood and Affect : normal, appropriate

Assessment

- Depression 311
 - Insomnia 307.40
 - Anxiety Disorder 300.00
 - Hypercholesterolemia 272.0
- has been off medicine since CPE b/c labs were norma. will call with results

Plan

Orders

- Hillcrest Profile (HCFP PRO) - - 09/04/2012
 - General health panel This panel must include the following: Comp (80050) - - 09/04/2012
 - Lipoprotein, direct measurement; high density cholesterol (HDL c (83718) - - 09/04/2012

Medications

- Alprazolam Oral 0.5mg
SIG: take 1 tablet by mouth three times daily prn anxiety
DISP: (30) tablets with 0 refills
Adjusted on 08/28/2012

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- CPX
- Return Visit Request In/on 4 months +/- 2 days (28815).

Electronically Signed by: Jennifer T. Ellis, MD -Author on August 28, 2012 02:48:30 PM

Progress Note

Patient Name:	Jennie Cox	Visit Date:	July 15, 2013
Patient ID:	55780	Provider:	Jennifer T. Ellis, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main Street Simpsonville, SC 296813237
		Location Phone:	(854) 963-1548

Chief Complaint

- Pt would like to have medications refilled.

History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: Alprazolam Oral 0.5mg, Restoril Oral Capsule 30 mg, and only uses alprazolam few q 1-2 months She is not taking any over the counter medications for the symptoms. She has not been compliant with the medication regiment. She feels like the following symptoms have improved: none have improved. And she feels like the following symptoms have worsened: none have worsened and but still having blue spells due to frustration over accident, tires easy. She is currently experiencing fatigue, weight loss, loss of appetite, and gets hungry, tries to eat but hurts, does get lortab from surgeon. The patient reports losing 25 pounds loss over the past 1 year. She denies difficulty concentrating, difficulty performing routine daily activities, loss of interest in pleasurable activities, and does enjoy the new baby- her youngest daughter's baby. She has the following issues going on that are affecting the condition: a chronic medical illness. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

She returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She remains on dietary management alone for intervention and claims to be adhering well to it thus far.

She does not exercise but is very active.

She is not fasting today.

Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

Past Medical History

Significant for Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Significant for Adenoidectomy; Appendectomy; Colonoscopy; EGD; hysterectomy; Lysis of adhesions; Tonsillectomy

Medication List

Significant for Alprazolam Oral 0.5mg; Restoril Oral Capsule 30 mg

Allergy List

Significant for Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Significant for Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Significant for Children; Divorced; Grandchildren; Nondrinker; Smoker, Tobacco (Current every day); Truck Driver

Review of Systems**Constitutional**

- Denies : weight loss, weight gain, loss of appetite

HENT

- Denies : headaches

Cardiovascular

- Denies : chest pain, dyspnea on exertion

Respiratory

- Denies : shortness of breath

Gastrointestinal

- Denies : nausea, vomiting, diarrhea, abdominal pain, jaundice

Integument

- Denies : rash, itching

Neurologic

- Denies : tingling or numbness

Musculoskeletal

- Denies : additional musculoskeletal symptoms except as noted in the HPI

Endocrine

- Denies : polyuria, polydipsia, cold intolerance, heat intolerance

Psychiatric

- Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L\R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
07/15/2013	08:36 AM	100/62	Sitting						98.9	95lbs 6oz	5' 6.25"	15.28	1.42		

Physical Examination**Constitutional**

- Appearance : well nourished, well developed, alert, oriented, in no acute distress

Eyes

- Conjunctivae : conjunctiva normal
- Sclerae : sclera white
- Pupils and Irises : pupils equal, round, and reactive to light and accommodation bilaterally

Respiratory

- Respiratory Effort : breathing unlabored
- Auscultation of Lungs : normal breath sounds

Cardiovascular

- Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Gastrointestinal

- Abdominal Examination : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

Skin and Subcutaneous Tissue

- General Inspection : no rashes present, no lesions present, no areas of discoloration present
- General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- Judgement and Insight : judgement and insight intact
- Mood and Affect : normal, appropriate

Assessment

- Depression 311
- Insomnia 307.40
- Anxiety Disorder 300.00
- Hypercholesterolemia 272.0

has been off medicine since CPE 2011 b/c labs were normal. will call with results

Plan

Orders

- Hillcrest Profile (HCFP PRO) - - 07/15/2013
 - General health panel This panel must include the following: Comp (80050) - - 07/15/2013
 - Lipoprotein, direct measurement; high density cholesterol (HDL c (83718) - - 07/15/2013

Medications

- Alprazolam Oral
SIG: take 1 tablet by mouth three times daily prn anxiety
DISP: (30) tablets with 2 refills
Refilled on 07/15/2013
- Restoril Oral capsule 30 mg
SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days
DISP: (30) capsules with 5 refills
Refilled on 07/15/2013

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- Appointment Requested (42647)
Careprovider : Ellis, Jennifer T. MD (1007)
Location : Hillcrest Family Practice
Appointment : Follow Up / Office Visit
Date : 6 months +/- 2 days
Override : No
Comments/Instructions :

Electronically Signed by: Jennifer T. Ellis, MD -Author on July 15, 2013 09:10:12 AM

LabCorp - Lab - General Lab**Specimen #:** 196-076-5801-0 **Report Status:** Final Results**Patient Information:**

Name: Cox, Jennie C **PatientID:** 55780 **Sex:** F **DOB:** 08/14/1952
Address: 222 W Chapman Road **Phone #:** (864)243-0032 **SSN:**
 Belton, SC 29627-

Date of Specimen: 07/15/2013 09:09 **Date Received:** 07/15/2013 21:33 **Specimen Source:**
Date Reported: 07/16/2013 11:38 **Physician:** Ellis, J **Information:** 1SST, 1LAV

Test Name	Result	Flags	Reference Range	Lab

Comments:**CMP12+LP+6AC+CBC/D/Plt+TSH+Fer**

Glucose, Serum	92 mg/dL		65-99 mg/dL	BN
Uric Acid, Serum	4.2 mg/dL		2.5-7.1 mg/dL	BN
	Therapeutic target for gout patients: <6.0			
BUN	9 mg/dL		8-27 mg/dL	BN
Creatinine, Serum	0.84 mg/dL		0.57-1.00 mg/dL	BN
eGFR If NonAfricn Am	76 mL/min/1.73		>59 mL/min/1.73	BN
eGFR If Africn Am	87 mL/min/1.73		>59 mL/min/1.73	BN
Sodium, Serum	137 mmol/L		134-144 mmol/L	BN
Potassium, Serum	5.1 mmol/L		3.5-5.2 mmol/L	BN
Chloride, Serum	98 mmol/L		97-108 mmol/L	BN
Calcium, Serum	9.9 mg/dL		8.6-10.2 mg/dL	BN
Phosphorus, Serum	3.9 mg/dL		2.5-4.5 mg/dL	BN
Protein, Total, Serum	7.5 g/dL		6.0-8.5 g/dL	BN
Albumin, Serum	4.5 g/dL		3.6-4.8 g/dL	BN
Globulin, Total	3.0 g/dL		1.5-4.5 g/dL	BN
Bilirubin, Total	0.2 mg/dL		0.0-1.2 mg/dL	BN
Alkaline Phosphatase, S	99 IU/L		42-107 IU/L	BN
	Please note reference interval change			
LDH	200 IU/L		0-214 IU/L	BN
AST (SGOT)	20 IU/L		0-40 IU/L	BN
ALT (SGPT)	9 IU/L		0-32 IU/L	BN
GGT	25 IU/L		0-60 IU/L	BN
Iron, Serum	34 ug/dL	L	35-155 ug/dL	BN
Ferritin, Serum	53 ng/mL		15-150 ng/mL	BN
Cholesterol, Total	232 mg/dL	H	100-199 mg/dL	BN
Triglycerides	131 mg/dL		0-149 mg/dL	BN
HDL Cholesterol	61 mg/dL		>39 mg/dL	BN
According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD.				
LDL Cholesterol Calc	145 mg/dL	H	0-99 mg/dL	BN
Comment:				BN
T. Chol/HDL Ratio	3.8 ratio units		0.0-4.4 ratio units	BN
Estimated CHD Risk	0.7 times avg.		0.0-1.0 times avg.	BN

		T. Chol/HDL Ratio	
		Men	Women
1/2 Avg.Risk	3.4	3.3	
Avg.Risk	5.0	4.4	
2X Avg.Risk	9.6	7.1	
3X Avg.Risk	23.4	11.0	

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

TSH	1.860 uIU/mL		0.450-4.500 uIU/mL	BN
WBC	7.4 x10E3/uL	188	4.0-10.5 x10E3/uL	BN
RBC	4.36 x10E6/uL	-0258-	3.77-5.28 x10E6/uL	BN

Hemoglobin	13.6 g/dL	11.1-15.9 g/dL	BN
Hematocrit	41.5 %	34.0-46.6 %	BN
MCV	95 fL	79-97 fL	BN
MCH	31.2 pg	26.6-33.0 pg	BN
MCHC	32.8 g/dL	31.5-35.7 g/dL	BN
RDW	13.5 %	12.3-15.4 %	BN
Platelets	398 x10E3/uL	140-415 x10E3/uL	BN
Neutrophils	59 %	40-74 %	BN
Lymphs	33 %	14-46 %	BN
Monocytes	4 %	4-13 %	BN
Eos	2 %	0-7 %	BN
Basos	2 %	0-3 %	BN
Immature Cells			BN
Neutrophils (Absolute)	4.4 x10E3/uL	1.8-7.8 x10E3/uL	BN
Lymphs (Absolute)	2.4 x10E3/uL	0.7-4.5 x10E3/uL	BN
Monocytes(Absolute)	0.3 x10E3/uL	0.1-1.0 x10E3/uL	BN
Eos (Absolute)	0.1 x10E3/uL	0.0-0.4 x10E3/uL	BN
Baso (Absolute)	0.1 x10E3/uL	0.0-0.2 x10E3/uL	BN
Immature Granulocytes	0 %	0-2 %	BN
Immature Grans (Abs)	0.0 x10E3/uL	0.0-0.1 x10E3/uL	BN
NRBC			BN
Hematology Comments:			BN

Lab Name: LabCorp Burlington (BN)
Address: 1447 York Court
 Burlington, NC 27215-3361

Director: William F Hancock
Phone #: 8007624344

Progress Note

Patient Name: Jennie Cox
Patient ID: 55780
Sex: Female
Birthdate: August 14, 1952

Visit Date: April 14, 2014
Provider: Jennifer T. Ellis, MD
Location: Hillcrest Family Practice
Location Address: 717 SE Main Street
 Simpsonville, SC 296813237
Location Phone: (864) 963-1548

Chief Complaint

- Pt here for medication refills.

History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: Alprazolam Oral 0.5mg, Restoril Oral Capsule 30 mg, and only uses alprazolam few q 1-2 months She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is is currently experiencing out of control feelings and somewhat overwhelmed by keeping up with items at home. She denies difficulty concentrating, difficulty performing routine daily activities, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She remains on medication but does not follow the recommended diet. She does not exercise but is very active. She is not fasting today.

alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week; restoril takes prn- approx a wednesdays when home and weekend

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; Lysis of adhesions; Tonsillectomy

Medication List

Alprazolam 0.5 MG; Restoril Oral capsule 30 mg

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

190

-0260-

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems**Constitutional**

- Denies : weight loss, weight gain, loss of appetite

HENT

- Denies : headaches

Cardiovascular

- Denies : chest pain, dyspnea on exertion

Respiratory

- Denies : shortness of breath

Gastrointestinal

- Denies : nausea, vomiting, diarrhea, abdominal pain, jaundice

Integument

- Denies : rash, itching

Neurologic

- Denies : tingling or numbness

Musculoskeletal

- Denies : additional musculoskeletal symptoms except as noted in the HPI

Endocrine

- Denies : polyuria, polydipsia, cold intolerance, heat intolerance

Psychiatric

- Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L\R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
04/14/2014	08:45 AM	96/72	Sitting						98.1	101lbs 2oz	5' 6"	16.32	1.46		

Physical Examination**Constitutional**

- Appearance : well nourished, well developed, alert, oriented, in no acute distress

Eyes

- Conjunctivae : conjunctiva normal
- Sclerae : sclera white
- Pupils and Irises : pupils equal, round, and reactive to light and accommodation bilaterally

Respiratory

- Respiratory Effort : breathing unlabored
- Auscultation of Lungs : normal breath sounds

Cardiovascular

- Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Gastrointestinal

- Abdominal Examination : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

Skin and Subcutaneous Tissue

- General Inspection : no rashes present, no lesions present, no areas of discoloration present
- General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- Judgement and Insight : judgement and insight intact
- Mood and Affect : normal, appropriate

191

-0261-

Assessment

- Depression Stable 311
 - Insomnia Stable 307.40
 - Anxiety Disorder Stable 300.00
 - Hypercholesterolemia Stable 272.0
- has been off medicine since CPE 2011 b/c labs were normal. will call with results

Plan**Orders**

- Hillcrest Profile (HCFP PRO) - - 04/17/2014
 - General health panel This panel must include the following: Comp (80050) - - 04/17/2014
 - Lipoprotein, direct measurement; high density cholesterol (HDL c (83718) - - 04/17/2014

Medications

- Alprazolam Oral 0.5 MG
SIG: take 1 tablet by mouth three times daily prn anxiety
DISP: (30) tablets with 2 refills
Refilled on 04/14/2014
- Restoril oral capsule 30 mg
SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days
DISP: (30) capsules with 5 refills
Refilled on 04/14/2014

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- CPX
- Return Visit Request In/on 1 month +/- 2 days (54114).

Electronically Signed by: Jennifer T. Ellis, MD -Author on April 14, 2014 09:50:22 AM

LabCorp - Lab - General Lab
Specimen #: 272-076-6872-0 **Report Status:** Final Results
Patient Information:

Name: Cox, Jennie C **PatientID:** 55780 **Sex:** F **DOB:** 08/14/1952
Address: 222 W CHAPMAN ROAD **Phone #:** (864)243-0032 **SSN:** ###-##-3648
 BELTON, SC 29627-

Date of Specimen: 09/29/2014 08:41 **Date Received:** 09/29/2014 22:18 **Specimen Source:**
Date Reported: 09/30/2014 08:42 **Physician:** ELLIS, J **Information:**

Test Name	Result	Flags	Reference Range	Lab

Comments: Fasting=Y
CMP12+LP+6AC+CBC/D/Plt+TSH+Fer

Glucose, Serum	90 mg/dL		65-99 mg/dL	BN
Uric Acid, Serum	5.3 mg/dL		2.5-7.1 mg/dL	BN
	Therapeutic target for gout patients: <6.0			
BUN	10 mg/dL		8-27 mg/dL	BN
Creatinine, Serum	0.85 mg/dL		0.57-1.00 mg/dL	BN
eGFR If NonAfricn Am	74 mL/min/1.73		>59 mL/min/1.73	BN
eGFR If Africn Am	85 mL/min/1.73		>59 mL/min/1.73	BN
Sodium, Serum	140 mmol/L		134-144 mmol/L	BN
Potassium, Serum	5.2 mmol/L		3.5-5.2 mmol/L	BN
Chloride, Serum	100 mmol/L		97-108 mmol/L	BN
Calcium, Serum	9.9 mg/dL		8.6-10.2 mg/dL	BN
Phosphorus, Serum	3.4 mg/dL		2.5-4.5 mg/dL	BN
Protein, Total, Serum	7.2 g/dL		6.0-8.5 g/dL	BN
Albumin, Serum	4.7 g/dL		3.6-4.8 g/dL	BN
Globulin, Total	2.5 g/dL		1.5-4.5 g/dL	BN
Bilirubin, Total	0.3 mg/dL		0.0-1.2 mg/dL	BN
Alkaline Phosphatase, S	101 IU/L		39-117 IU/L	BN
LDH	210 IU/L		0-214 IU/L	BN
AST (SGOT)	19 IU/L		0-40 IU/L	BN
ALT (SGPT)	6 IU/L		0-32 IU/L	BN
GGT	13 IU/L		0-60 IU/L	BN
Iron, Serum	88 ug/dL		35-155 ug/dL	BN
Ferritin, Serum	34 ng/mL		15-150 ng/mL	BN
Cholesterol, Total	224 mg/dL	H	100-199 mg/dL	BN
Triglycerides	125 mg/dL		0-149 mg/dL	BN
HDL Cholesterol	62 mg/dL		>39 mg/dL	BN
According to ATP-III guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD.				

LDL Cholesterol Calc	137 mg/dL	H	0-99 mg/dL	BN
T. Chol/HDL Ratio	3.6 ratio units		0.0-4.4 ratio units	BN

T. chol/HDL Ratio		
	Men	Women
1/2 Avg. Risk	3.4	3.3
Avg. Risk	5.0	4.4
2X Avg. Risk	9.6	7.1
3X Avg. Risk	23.4	11.0

Estimated CHD Risk	0.6 times avg.	0.0-1.0 times avg.	BN

T. chol/HDL Ratio		
	Men	Women
1/2 Avg. Risk	3.4	3.3
Avg. Risk	5.0	4.4
2X Avg. Risk	9.6	7.1
3X Avg. Risk	23.4	11.0

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

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TSH	1.490 uIU/mL	-0263-	0.450-4.500 uIU/mL	BN

WBC	7.5 x10E3/uL	3.4-10.8 x10E3/uL	BN
RBC	4.38 x10E6/uL	3.77-5.28 x10E6/uL	BN
Hemoglobin	13.7 g/dL	11.1-15.9 g/dL	BN
Hematocrit	41.2 %	34.0-46.6 %	BN
MCV	94 fL	79-97 fL	BN
MCH	31.3 pg	26.6-33.0 pg	BN
MCHC	33.3 g/dL	31.5-35.7 g/dL	BN
RDW	13.9 %	12.3-15.4 %	BN
Platelets	283 x10E3/uL	150-379 x10E3/uL	BN
Neutrophils	65 %		BN
Lymphs	25 %		BN
Monocytes	6 %		BN
Eos	2 %		BN
Basos	2 %		BN
Neutrophils (Absolute)	4.9 x10E3/uL	1.4-7.0 x10E3/uL	BN
Lymphs (Absolute)	1.9 x10E3/uL	0.7-3.1 x10E3/uL	BN
Monocytes(Absolute)	0.5 x10E3/uL	0.1-0.9 x10E3/uL	BN
Eos (Absolute)	0.1 x10E3/uL	0.0-0.4 x10E3/uL	BN
Baso (Absolute)	0.1 x10E3/uL	0.0-0.2 x10E3/uL	BN
Immature Granulocytes	0 %		BN
Immature Grans (Abs)	0.0 x10E3/uL	0.0-0.1 x10E3/uL	BN

Lab Name: LabCorp Burlington (BN)
Address: 1447 York Court
 Burlington, NC 27215-3361

Director: William F Hancock
Phone #: 8007624344

History and Physical

Patient Name:	Jennie Cox	Visit Date:	November 10, 2014
Patient ID:	55780	Provider:	Jennifer T. Ellis, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main St Simpsonville, SC 296813237
		Location Phone:	(864) 963-1548

Chief Complaint

- Comprehensive Exam
- Pt declines flu vaccine.
- Pt declines to discuss smoking cessation.

labs in emr
vision checked yearly
last pap done 12/8/2011
needs order for mammogram

History Of Present Illness

Jennie C. Cox is a 62 year old White female who presents for her annual comprehensive exam . It has been 1 year since her last check up. She is due for the following health maintenance items: DRE, EKG, fasting labs, hemoccult testing, mammogram, pap smear, urinalysis, and visual exam.

Exercise History

She does not exercise regularly but is very active.

Dietary Habits

She provided the following examples for meals on an average day. A typical breakfast might consists of some or all of the following: fast food biscuit or breakfast sandwich. Lunch is usually comprised of some or all of the following: fruit and some vegetables. Some examples of typical supper food would be some or all of the following: fast food. She does not eat desert very often. Typical beverages consumed throughout the day include coffee and regular sodas. She regularly consumes sugar-sweetened beverages. On a typical day she might consume one sweet drink. She does not drink alcohol.

Tobacco History

She uses cigarettes 2 pack/s per day.

Current Medical Problems Followed by Us

She is followed by us for hyperlipidemia and an anxiety disorder. The patient's mixed lipid levels have been poorly controlled with diet alone and are detailed in the laboratory reports. The anxiety disorder has been essentially unchanged since the last visit and waxing and waning in severity.

Jennie C. Cox is a 62 year old White female who presents for her annual exam. She is a GRAVIDA PARA who underwent a TAH/BSO 25 years ago for menorrhagia

Since her last visit, there have been no significant changes in her health history.

She has no current complaints.

The patient is not taking HRT medication. She is having no vasomotor symptoms.
She has not had a recent mammogram. A screening mammogram has been ordered.
She does not perform self breast exams.
The patient has no maternal family history of breast cancer.
She is currently single.

cvs moonville 2990234

Past Medical History

Disease Name	Date Onset	Notes
Abdominal Radiologic Abnormality	3/5/08	see CT report- L adrenal gland abnormality
Anxiety Disorder	--	--
Bone Infection	2001	Dr. devault- I & D ? R hamstring insertion/ infection. a/w overuse unloading hand truck. infxn noted upon re-attachment of hamstring per pt?
Hypercholesterolemia	11/26/2010	h/o given. willing to work on diet/ exercise. re check 4 mos. Did

Insomnia	--	not tolerate simvastatin- felt "sick," maiaise
Irritable Bowel Syndrome	2004-2007	-- w/u by GI Assoc- for IBS- Hartley- upper GI, small bowe series, U/S, HIDA Scan 2004-2007
Joint Pain	--	--
Low Back Pain	--	? HNP L5/s1

Past Surgical History

Procedure Name	Date	Notes
Adenoidectomy	--	--
Appendectomy	? at time of ooph	--
Colonoscopy	8/16/04	int/ext hemorrhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after with emesis)
EGD	10/04	mild erythema
hystw/ooph	age 20s/ 1990s	hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery
jaw surgery	5/2012- multiple	Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr CObb- oral surgeon, Dr Ridgill prosthetic orthodontist
Lysis of adhesions	surgerie 1990s	bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Biouin and May
Tonsillectomy	--	--

Medication List

Name	Date Started	Instructions
alprazolam oral tablet 0.5 mg	10/17/2014	take 1 tablet (0.5 mg) by oral route 3 times per day
Restoril oral capsule 30 mg	10/17/2014	take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days

Allergy List

Allergen Name	Date	Reaction	Notes
Magnesium	--	--	--
Nickel	--	?metal allergy?	--
Simvastatin	--	maiaise	--
Ultram	--	--	--

Family Medical History

Disease Name	Relative/Age	Notes
Alzheimer's Disease	/	--
	Aunt/ Grandmother (maternal)/ Mother/	
	/	
DM Type II	Aunt/ Uncle/	--
	/	
Myocardial Infarction, Acute	Father/70	--

Social History

Finding	Status	Start/Stop	Quantity	Notes
Children	--	--/--	--	2 daughters
Divorced	--	--/--	--	--
Grandchildren	--	--/--	--	5 gkids- 3 girls, 2 boys; had gson oldest that lost 2008; 2 younger girls (Madison 12, Emily 7) with same mom (tammy); oldest 40 yo Sonya- with twin brother and son (17 yo) Marthew and Meghan), older brother died- Michael -was at 16 yo from MVA

Nondrinker	--	--/--	--	--
Smoker	--	--/--	2 ppd	--
Tobacco	Current every day	18/--	2 PPD	--
Truck Driver	--	--/--	--	--

Review of Systems

Constitutional

- o Denies : fatigue, fever, chills, weight loss, weight gain

Eyes

- o Denies : double vision, changes in vision, floaters

HENT

- o Denies : headaches, nose bleeding, hearing loss, tinnitus, snoring, hoarseness

Breasts

- o Denies : lumps, tenderness, nipple discharge, masses, skin changes

Cardiovascular

- o Denies : chest pain, dyspnea on exertion, orthopnea, lower extremity edema, palpitations

Respiratory

- o Admits : cough- slight recent with drainage
- o Denies : shortness of breath, hemoptysis

Gastrointestinal

- o Denies : nausea, vomiting, change in bowel habits, dysphagia, heartburn, frequent heartburn, abdominal pain, blood in stools

Genitourinary

- o Denies : urgency, frequency, dysuria, nocturia, hematuria, incontinence, decreased stream, decreased libido

Integument

- o Denies : rash, new skin lesions, changes to existing skin lesions or moles

Neurologic

- o Denies : tingling or numbness, memory difficulties, tremors

Musculoskeletal

- o Denies : joint pain, joint swelling, muscle pain

Endocrine

- o Denies : polyuria, polydipsia, cold intolerance, heat intolerance, weight gain

Psychiatric

- o Denies : anxiety, depression, difficulty sleeping

Heme-Lymph

- o Denies : easy bleeding, easy bruising, lymph node enlargement or tenderness

Allergic-Immunologic

- o Denies : sinus allergy symptoms

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
11/10/2014	10:50 AM	112/70	Sitting				88 - R		98.5	110lbs 8oz	5' 6.25"	17.7	1.53		

Physical Examination

Constitutional

- o Appearance : *thin*, well developed, alert, in no acute distress, appears about reported age

Head and Face

o Head :

- Inspection : atraumatic, normocephalic
- Palpation : no tenderness or masses present

o Face :

- Inspection : no facial lesions

Eyes

o Vision :

- Acuity : visual acuity grossly normal at distance O.U., near vision grossly intact O.U.

- o Conjunctivae : conjunctiva normal

- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally
- **Ophthalmoscopic Exam** : retinas are normal without hemorrhage or exudate, no AV crossing changes, optic disk normal with normal cup to disk ratio
- **Corneas** : no lesions present
- **Eyelids/Ocular Adnexae** : eyelid appearance normal, no erythema or lesions noted

Ears, Nose, Mouth and Throat

- **Ears** :
 - **External Ears** : appearance within normal limits, no lesions present
 - **Otoscopic Examination** : tympanic membrane appearance within normal limits bilaterally without perforations, mobility normal
 - **Hearing** : Intact to conversational voice both ears
- **Nose** :
 - **External Nose** : appearance normal
 - **Intranasal Exam** : mucosa within normal limits, no intranasal lesions present
 - **Nasopharynx** : no lesions or inflammation
- **Oral Cavity** :
 - **Oral Mucosa** : no worrisome oral lesions present
 - **Lips** : lip appearance normal
 - **Teeth** : normal dentition for age
 - **Gums** : gums pink, no lesions
 - **Tongue** : tongue appearance normal, no lesions
 - **Palate** : hard palate normal, soft palate appearance normal
- **Throat** :
 - **Oropharynx** : no inflammation or lesions present
 - **Hypopharynx** : appearance within normal limits, no erythema or lesions

Neck

- **Inspection/Palpation** : normal appearance, no masses or tenderness, trachea midline
- **Range of Motion** : cervical range of motion within normal limits
- **Thyroid** : not enlarged, no nodules, non-tender

Respiratory

- **Respiratory Effort** : breathing unlabored
- **Inspection of Chest** : normal appearance, no retractions
- **Auscultation of Lungs** : clear and equal bilaterally

Cardiovascular

- **Heart** :
 - **Auscultation of Heart** : regular rate and rhythm, no appreciable murmurs, rubs or gallops
 - **Palpation of Heart** : normal apical impulse, no cardiac thrill present
- **Peripheral Vascular System** :
 - **Carotid Arteries** : no appreciable bruits present
 - **Abdominal Aorta** : aortic pulse normal without bruits
 - **Femoral Arteries** : normal femoral pulses, no appreciable bruits
 - **Pedal Pulses** : normal dorsalis pedis and posterior tibial pulses bilaterally
 - **Extremities** : no clubbing, cyanosis or edema

Breasts

- **Inspection of Breasts** : no dimpling, retractions or other skin changes
- **Palpation of Breasts, Axillae** : no masses, tenderness or adenopathy noted on palpation

Gastrointestinal

- **Abdominal Examination** : bowel sounds positive, non-distended, no appreciable masses or tenderness
- **Liver and spleen** : no appreciable hepatomegaly present, liver nontender to palpation, spleen not palpable
- **Hernias** : no appreciable hernias present

Genitourinary

- **External Genitalia** : no inflammation, no lesions present
- **Vagina** : normal vaginal vault, no discharge present, no inflammatory lesions present, no masses present
- **Urethra** : no inflammation, no lesions
- **Bladder** : nontender to palpation
- **Cervix** : *cervix not present*, no lesions present, nontender to palpation, no discharges, no bleeding present, normal midline position
- **Uterus** : *surgically absent*, no masses present, position midline/midplane, size normal
- **Adnexa** : no tenderness or masses present on bimanual examination
- **Anus** : no inflammation or lesions present
- **Perineum** : perineum within normal limits
- **Digital Rectal Examination** : normal sphincter tone, no rectal masses present

- **Occult Blood in Stool** : Hemoccult test negative, normal appearing stool present on glove

Lymphatic

- **Neck** : no lymphadenopathy present
- **Axilla** : no lymphadenopathy present
- **Groin** : no lymphadenopathy present
- **Supraclavicular Nodes** : no supraclavicular nodes
- **Preauricular Nodes** : no preauricular nodes present

Musculoskeletal

- **Spine** :
 - **Inspection/Palpation** : no spinal tenderness, scoliosis or kyphosis present
- **Right Upper Extremity** :
 - **Inspection/Palpation** : no atrophy or deformity noted, no edema, swelling or erythema present, no ecchymosis, no tenderness to palpation
 - **Range of Motion** : full passive range of motion, full active range of motion, no joint crepitus present
- **Left Upper Extremity** :
 - **Inspection/Palpation** : no atrophy or deformity noted, no edema swelling or erythema present, no ecchymosis, no tenderness to palpation
 - **Range of Motion** : full passive range of motion, full active range of motion, no joint crepitus present
- **Right Lower Extremity** :
 - **Inspection/Palpation** : no atrophy or deformity noted, no edema, swelling, or erythema present, no ecchymosis, no tenderness to palpation
 - **Range of Motion** : range of motion normal, no joint crepitus present, no pain on motion
- **Left Lower Extremity** :
 - **Inspection/Palpation** : no atrophy or deformity noted, no edema, swelling, or erythema present, no ecchymosis, no tenderness to palpation
 - **Range of Motion** : range of motion normal, no joint crepitus present, no pain on motion

Skin and Subcutaneous Tissue

- **General Inspection** : no rashes or worrisome lesions present
- **General Palpation** : no skin or subcutaneous tissue masses present, no tenderness to palpation, skin turgor normal
- **Body Hair** : scalp palpation normal, hair normal for age, general body hair distribution normal for age
- **Digits and Nails** : no clubbing or cyanosis, normal appearing nails

Neurologic

- **Mental Status Examination** :
 - **Orientation** : grossly oriented to person, place and time
 - **Memory** : intact in that we were able to conduct the interview
- **Cranial Nerves** : cranial nerves intact and symmetric throughout
- **Motor Examination** : grossly normal
- **Reflexes** : DTR's 2 bilaterally
- **Sensation** : grossly intact
- **Gait and Station** : normal gait, able to stand without difficulty

Psychiatric

- **Judgement and Insight** : judgment and insight intact
- **Thought Processes** : rate of thoughts normal, thought content logical, abstract reasoning within normal limits
- **Mood and Affect** : mood normal, affect appropriate
- **Presence of Abnormal Thoughts** : no hallucinations, no delusions present, no psychotic thoughts

In Office Procedure Results**Urinalysis - Clinitek Status w/o Micro
(81003)**

- Albumin: N/A
- Bilirubin: Small
- Creatinine: N/A
- Glucose: Negative
- Ketone: Trace
- Leukocyte: Negative
- Nitrite: Negative
- Blood: Small
- pH: 5.5
- Protein: Negative
- Specific Gravity: 1.020
- Urobilinogen: 0.2 E.U./dL
- Albumin:Creatinine Ratio: N/A

- o Protein:Creatinine Ratio: N/A
- o Color: yellow
- o Clarity: clear

Assessment

- General Medical Exam, Adult V70.0
- Pap Smear V76.2
- Insomnia 307.40
Stable
- Anxiety Disorder 300.00
Only rare use of Xanax- q few weeks.
- Hypercholesterolemia 272.0
Did not tolerate simvastatin- felt "sick," malaise. trial low dose atorvastatin.
- Microscopic hematuria 599.72
urology for persistent hematuria. lost to FU in past. discussed risk of bladder cancer.
- Abdominal Radiologic Abnormality 793.6
see CT report- L adrenal gland abnormality- CT to review along with above.

Plan

Orders

- o ECG (12-lead electrocardiogram) (93000) - - 11/10/2014
- o Hillcrest Profile (HCFP PRO) - - 08/16/2015
 - General health panel This panel must include the following: Comp (80050) - - 08/16/2015
 - Lipoprotein, direct measurement; high density cholesterol (HDL c (83718) - - 08/16/2015
- o Urine culture (87086) - - 11/10/2014

Instructions

- o Recommend regular exercise
- o Recommend working on weight loss as we discussed
- o Recommend a heart healthy diet
- o Schedule screening mammogram
- o The labs you had drawn today should be back within 3 business days. We will call you only if there are abnormalities that we need to discuss.

Disposition

- o Return Visit Request in/on 3 months +/- 2 days (63255).

Correspondence

- o Screening Mammogram Order GHS/FHv1 (Jennie C. Cox) - 11/10/2014
- o Screening Mammogram Order GHS/FHv1 (Jennie C. Cox) - 02/16/2015

Electronically Signed by: Jennifer T. Ellis, MD -Author on February 16, 2015 09:35:19 AM

Progress Note

Patient Name: Jennie Cox
Patient ID: 55780
Sex: Female
Birthdate: August 14, 1952

Visit Date: February 16, 2015
Provider: Jennifer T. Ellis, MD
Location: Hillcrest Family Practice
Location Address: 717 SE Main St
Simpsonville, SC 296813237
Location Phone: (864) 963-1548

Chief Complaint

- f/u anxiety and medication
- declined flu shot
- pt. is still smoking- not interested in smoking cessation

History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is is currently experiencing out of control feelings and somewhat overwhelmed by keeping up with items at home . She denies difficulty concentrating, difficulty performing routine daily activities, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She is not on any therapy or diet

She does not exercise but is very active.

She is not fasting today.

alprazolam expelred- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; jaw surgery; Lysis of adhesions; Tonsillectomy

Medication List

alprazolam oral tablet 0.5 mg; Restoril oral capsule 30 mg

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems**Constitutional**

- o Denies : weight loss, weight gain, loss of appetite

HENT

- o Denies : headaches

Cardiovascular

- o Denies : chest pain, dyspnea on exertion

Respiratory

- o Denies : shortness of breath

Gastrointestinal

- o Denies : nausea, vomiting, diarrhea, abdominal pain, jaundice

Integument

- o Denies : rash, itching

Neurologic

- o Denies : tingling or numbness

Musculoskeletal

- o Denies : additional musculoskeletal symptoms except as noted in the HPI

Endocrine

- o Denies : polyuria, polydipsia, cold intolerance, heat intolerance

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L\R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
02/16/2015	08:56 AM	106/47	Sitting				82 - R		97.8	108lbs 6oz	5' 6"	17.49	1.51		

Physical Examination**Constitutional**

- o Appearance : well nourished, well developed, alert, oriented, in no acute distress

Eyes

- o Conjunctivae : conjunctiva normal
- o Sclerae : sclera white
- o Pupils and Irises : pupils equal, round, and reactive to light and accommodation bilaterally

Respiratory

- o Respiratory Effort : breathing unlabored
- o Auscultation of Lungs : normal breath sounds

Cardiovascular

- o Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- o Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Gastrointestinal

- o Abdominal Examination : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

Skin and Subcutaneous Tissue

- o General Inspection : no rashes present, no lesions present, no areas of discoloration present
- o General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- o Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- o Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- o Judgement and Insight : judgement and insight intact
- o Mood and Affect : normal, appropriate

Assessment

- Depression Stable 311
- Insomnia Stable 307.40
- Anxiety Disorder Stable 300.00
- Hypercholesterolemia Stable 272.0
has been off medicine since CPE 2011 b/c labs were normal. will call with results
- Tobacco Abuse 305.1

Plan

Medications

- alprazolam oral tablet 0.5 mg
SIG: take 1 tablet (0.5 mg) by oral route 3 times per day
DISP: (30) tablets with 2 refills
Refilled on 02/16/2015
- Restoril oral capsule 30 mg
SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days
DISP: (30) capsules with 5 refills
Refilled on 02/16/2015

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- CPX
- Return Visit Request in/on 9 months +/- 2 days (67329).

Electronically Signed by: Jennifer T. Ellis, MD -Author on February 16, 2015 09:45:41 AM

Progress Note

Patient Name: Jennie Cox
Patient ID: 55780
Sex: Female
Birthdate: August 14, 1952

Visit Date: August 24, 2015
Provider: Jennifer T. Ellis, MD
Location: Hillcrest Family Practice
Location Address: 717 SE Main St
Simpsonville, SC 296813237
Location Phone: (864) 963-1548

Chief Complaint

- Pt needs medications refilled.
- Pt declines to discuss smoking cessation.

History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She does not exercise but is very active. She is not fasting today.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; usling alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no groginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Procedure Name	Date	Notes
Adenoidectomy	--	--
Appendectomy	? at time of ooph	--
Colonoscopy	8/16/04	int/ext hemorrhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after wth emesis)
EGD	10/04	mild erythema
hystw/ooph	age 20s/ 1990s	hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery
jaw surgery	5/2012- multiple	Lower jaw crushed in accident (machine fell off truck onto her)
	surgerie	5/2012- plate, studs, screws- Dr Folwer + Dr CObb- oral surgeon, Dr Ridgill prosthetic orthodontist
Lysis of adhesions	1990s	bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Blouin

Tonsillectomy -- and May --

Medication List

alprazolam oral tablet 0.5 mg; Restoril oral capsule 30 mg

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

Constitutional

- o Denies : weight loss, weight gain, loss of appetite

HENT

- o Denies : headaches

Cardiovascular

- o Denies : chest pain, dyspnea on exertion

Respiratory

- o Denies : shortness of breath

Gastrointestinal

- o Denies : nausea, vomiting, diarrhea, abdominal pain, jaundice

Integument

- o Denies : rash, itching

Neurologic

- o Denies : tingling or numbness

Musculoskeletal

- o Denies : additional musculoskeletal symptoms except as noted in the HPI

Endocrine

- o Denies : polyuria, polydipsia, cold intolerance, heat intolerance

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L\ R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
08/24/2015	08:30 AM	103/67	Sitting				97 - R		97.8		109lbs 6oz				

Physical Examination

Constitutional

- o Appearance : well nourished, well developed, alert, oriented, in no acute distress

Eyes

- o Conjunctivae : conjunctiva normal
- o Sclerae : sclera white
- o Pupils and Irises : pupils equal, round, and reactive to light and accommodation bilaterally

Respiratory

- o Respiratory Effort : breathing unlabored
- o Auscultation of Lungs : normal breath sounds

Cardiovascular

- o Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present

- **Peripheral Vascular System :**
 - **Extremities :** no edema or cyanosis

Gastrointestinal

- **Abdominal Examination :** non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

Skin and Subcutaneous Tissue

- **General Inspection :** no rashes present, no lesions present, no areas of discoloration present
- **General Palpation :** no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- **Mental Status Examination :**
 - **Orientation :** oriented
 - **Memory :** memory intact
- **Cranial Nerves :** cranial nerves intact bilaterally

Psychiatric

- **Judgement and Insight :** judgement and insight intact
- **Mood and Affect :** normal, appropriate

Assessment

- Depression Stable 311/F32.9
- Insomnia Stable 307.40
- Anxiety Disorder Stable 300.00/F41.9
- Hypercholesterolemia Stable 272.0/E78.0
has been off medicine since CPE 2011 b/c labs were normal, will call with results
- Tobacco Abuse 305.1/Z72.0

Plan

Medications

- alprazolam oral tablet 0.5 mg
SIG: take 1 tablet (0.5 mg) by oral route 3 times per day
DISP: (30) tablets with 3 refills
Refilled on 08/24/2015
- Restoril oral capsule 30 mg
SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days
DISP: (30) capsules with 5 refills
Refilled on 08/24/2015

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- CPX
- Return Visit Request in/on 6 months +/- 2 days (76317).

Electronically Signed by: Jennifer T. Ellis, MD -Author on August 24, 2015 09:07:17 AM

Progress Note

Patient Name:	Jennie Cox	Visit Date:	March 3, 2016
Patient ID:	55780	Provider:	Jennifer T. Ellis, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main St Simpsonville, SC 296813237
		Location Phone:	(864) 963-1548

Chief Complaint

- F/U Depression
- Anxiety

History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She does not exercise but is very active. She is not fasting today.

3/2016: went from running team driving, now single since Oct 2015. Physically/ mentally wearing her out. Input unchanged from prior. Still uncomfortable to eat- teeth not lined up. Eats lots of mashed potatoes, grilled chicken, green beans. 1 meals/ day. Only ensure remainder of day.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; using alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low back pain

Past Surgical History

Procedure Name	Date	Notes
Adenoidectomy	--	--
Appendectomy	at time of ooph	--
Colonoscopy	8/16/04	int/ext hemmorhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after with emesis)
EGD	10/04	mild erythema
hystw/ooph	age 20s/ 1990s	hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery

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[Digital Signature Validated]

-0277-

jaw surgery	5/2012- multiple surgeries 1990s	Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr Cobb- oral surgeon, Dr Ridgill prosthetic orthodontist bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Biouin and May
Lysis of adhesions		
Tonsillectomy	--	--

Medication List

Name	Date Started	Instructions
alprazolam 0.5 mg oral tablet	08/24/2015	take 1 tablet (0.5 mg) by oral route 3 times per day
Restoril 30 mg oral capsule	08/24/2015	take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

Constitutional

- o Denies : weight loss, weight gain, loss of appetite

HENT

- o Denies : headaches

Cardiovascular

- o Denies : chest pain, dyspnea on exertion

Respiratory

- o Denies : shortness of breath

Gastrointestinal

- o Denies : nausea, vomiting, diarrhea, abdominal pain, jaundice

Integument

- o Denies : rash, itching

Neurologic

- o Denies : tingling or numbness

Musculoskeletal

- o Denies : additional musculoskeletal symptoms except as noted in the HPI

Endocrine

- o Denies : polyuria, polydipsia, cold intolerance, heat intolerance

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
03/03/2016	12:43 PM	104/68	Sitting				81 - R	94.8		101lbs 6oz					

Physical Examination

Constitutional

- o Appearance : well nourished, well developed, alert, oriented, in no acute distress

Eyes

- o Conjunctivae : conjunctiva normal

- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally

Respiratory

- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

Cardiovascular

- **Heart** :
 - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- **Peripheral Vascular System** :
 - **Extremities** : no edema or cyanosis

Gastrointestinal

- **Abdominal Examination** : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

Skin and Subcutaneous Tissue

- **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- **Mental Status Examination** :
 - **Orientation** : oriented
 - **Memory** : memory intact
- **Cranial Nerves** : cranial nerves intact bilaterally

Psychiatric

- **Judgement and Insight** : judgement and insight intact
- **Mood and Affect** : normal, appropriate

Assessment

- Depression Stable 311/F32.9
- Insomnia Stable 307.40/F51.9
- Anxiety Disorder Stable 300.00/F41.9
- Hypercholesterolemia Stable 272.0/E78.0
has been off medicine since CPE 2011 b/c labs were normal. will call with results
- Tobacco Abuse 305.1/Z72.0
- Weight loss 783.21/R63.4
routine cancer screening- mammo, chest CT. add remeron for appetite. will be out of work this week to see how responds to meds prior to resume driving.

Plan

Orders

- General health panel This panel must include the following: Comp (80050, 80050) - - 03/03/2016

Medications

- mirtazapine 7.5 mg oral tablet
SIG: take 1 tablets by oral route Qhs, increase to 2 tabs if tolerated after 1-2 weeks
DISP: (60) tablets with 5 refills
Prescribed on 03/03/2016
- Restoril 30 mg oral capsule
SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days
DISP: (30) capsules with 5 refills
Refilled on 03/03/2016

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- Return Visit Request in/on 1 month +/- 2 days (85474).

Correspondence

- Work/School Excuse (Pain v3.6)FHV1 (Jennie C. Cox) - 03/03/2016

Electronically Signed by: Jennifer T. Ellis, MD -Author on March 3, 2016 01:39:50 PM

Progress Note

Patient Name:	Jennie Cox	Visit Date:	March 11, 2016
Patient ID:	55780	Provider:	Jennifer T. Ellis, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main St Simpsonville, SC 296813237
		Location Phone:	(864) 963-1548

Chief Complaint

- F/U to discuss lab and CT Scan results.

History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She does not exercise but is very active. She is not fasting today.

3/11/2016: trouble chewing; throughout mouth, L side feels numb, R side primary used for chewing; still using ensure 1-3 bottles/ day.
ate more this week since home.
mammo not done yet

CVS augusta

3/2016: went from running team driving, now single since Oct 2015. Physically/ mentally wearing her out. Input unchanged from prior. Still uncomfortable to eat- teeth not lined up. Eats lots of mashed potatoes, grilled chicken, green beans. 1 meals/ day. Only ensure remainder of day.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; using alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; jaw surgery; Lysis of adhesions; Tonsillectomy

Medication List

Name	Date Started	Instructions
alprazolam 0.5 mg oral tablet	08/24/2015	take 1 tablet (0.5 mg) by oral route 3 times per day
mirtazapine 7.5 mg oral tablet	03/03/2016	take 1 tablets by oral route Qhs, increase to 2 tabs if tolerated after 1-2 weeks
Restoril 30 mg oral capsule	03/03/2016	take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Disease Name	Relative/Age	Notes
Alzheimer's Disease	/	--
	Aunt/	
	Grandmother	
	(maternal)/	
	Mother/	
DM Type II	/	--
	Aunt/	
	Uncle/	
Myocardial Infarction, Acute	/	--
	Father/70	

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

Constitutional

- o Denies : weight loss, weight gain, loss of appetite

HENT

- o Denies : headaches

Cardiovascular

- o Denies : chest pain, dyspnea on exertion

Respiratory

- o Denies : shortness of breath

Gastrointestinal

- o Denies : nausea, vomiting, diarrhea, abdominal pain, jaundice

Integument

- o Denies : rash, itching

Neurologic

- o Denies : tingling or numbness

Musculoskeletal

- o Denies : additional musculoskeletal symptoms except as noted in the HPI

Endocrine

- o Denies : polyuria, polydipsia, cold intolerance, heat intolerance

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L\R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
03/11/2016	03:53 PM	88/54	Sitting				86 - R		98.2	103lbs 8oz	5' 6"	16.71	1.48		

Physical Examination

Constitutional

- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

Eyes

- **Conjunctivae** : conjunctiva normal
- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally

Respiratory

- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

Cardiovascular

- **Heart** :
 - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- **Peripheral Vascular System** :
 - **Extremities** : no edema or cyanosis

Gastrointestinal

- **Abdominal Examination** : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

Skin and Subcutaneous Tissue

- **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- **Mental Status Examination** :
 - **Orientation** : oriented
 - **Memory** : memory intact
- **Cranial Nerves** : cranial nerves intact bilaterally

Psychiatric

- **Judgement and Insight** : judgement and insight intact
- **Mood and Affect** : normal, appropriate

Assessment

- Depression Stable 311/F32.9
- Insomnia Stable 307.40/F51.9
- Anxiety Disorder Stable 300.00/F41.9
- Hypercholesterolemia 272.0/E78.0
willing to resume statin.
- Tobacco Abuse 305.1/Z72.0
- Weight loss 783.21/R63.4
routine cancer screening- mammo, chest CT. ct normal, mammo pending. some weight gain off week - pt confident she can continue to gain weight off work x 1 more week. will refer back to surgeon.

DR Fowler

Plan

Orders

- General health panel This panel must include the following: Comp (80050, 80050, 80050) - - 06/11/2016

Medications

- atorvastatin 40 mg oral tablet
SIG: take 1/2 tablet daily, increase after 2 weeks to 1 full tablet qhs if tolerated
DISP: (30) tablets with 11 refills
Prescribed on 03/11/2016

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- CPX
- Two appointments:
- Return Visit Request in/on 3 months +/- 2 days (85862).

Correspondence

- o Work/School Excuse (Pain v3.6)FHV1 (Jennie C. Cox) - 03/11/2016

Electronically Signed by: Jennifer T. Ellis, MD -Author on March 11, 2016 05:23:25 PM

Progress Note

Patient Name: Jennie Cox
Patient ID: 55780
Sex: Female
Birthdate: August 14, 1952

Visit Date: March 22, 2016
Provider: Jennifer T. Ellis, MD
Location: Hillcrest Family Practice
Location Address: 717 SE Main St
Simpsonville, SC 296813237
Location Phone: (864) 963-1548

Chief Complaint

- F/U on Weight Loss

History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is is currently experiencing depression, insomnia, irritability, out of control feelings, fatigue, weight loss, loss of appetite, and loss of interest in pleasurable activities. The patient reports losing 25 pounds loss over the past 2 years- gradually gaining back, slowly, still difficulty eating. She denies difficulty concentrating and difficulty performing routine daily activities. She has the following issues going on that are affecting the condition: a chronic medical illness. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias.

She does not exercise but is very active.

She is not fasting today.

3/21/16: does not feel she have the energy to return to work; feels overwhelmed

Feels she cannot work because does not have the energy; reports she can do the driving; out/ in the truck, opening/ closing doors, securing the freight;

decreased endurance / strenght to maintain position

if runs to Florida, takes 10-11 hrs driving straight, get freight off, empty, hand out 5-6 hours; go to Savannah, then return to Greenville; in 7 days, take 34 hour break;

3/11/2016: trouble chewing; throughout mouth, L side feels numb, R side primary used for chewing; still using ensure 1-3 bottles/ day.
ate more this week since home.
mammo not done yet

CVS augusta

3/2016: went from running team driving, now single since Oct 2015. Physically/ mentally wearing her out. Input unchanged from prior. Still uncomfortable to eat- teeth not lined up. Eats lots of mashed potatoes, grilled chicken, green beans. 1 meals/ day. Only ensure remainder of day.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; using alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expeired- has been out x 1 month; normally uses 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/ooph; jaw surgery; Lysis of adhesions; Tonsillectomy

Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; mirtazapine 7.5 mg oral tablet; Restoril 30 mg oral capsule

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

Constitutional

- **Denies** : weight loss, weight gain, loss of appetite
- HENT**
 - **Denies** : headaches
- Cardiovascular**
 - **Denies** : chest pain, dyspnea on exertion
- Respiratory**
 - **Denies** : shortness of breath
- Gastrointestinal**
 - **Denies** : nausea, vomiting, diarrhea, abdominal pain, jaundice
- Integument**
 - **Denies** : rash, itching
- Neurologic**
 - **Denies** : tingling or numbness
- Musculoskeletal**
 - **Denies** : additional musculoskeletal symptoms except as noted in the HPI
- Endocrine**
 - **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance
- Psychiatric**
 - **Denies** : additional psychiatric symptoms except as noted in the HPI

Physical Examination

- Constitutional**
 - **Appearance** : well nourished, well developed, alert, oriented, in no acute distress
- Eyes**
 - **Conjunctivae** : conjunctiva normal
 - **Sclerae** : sclera white
 - **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally
- Respiratory**
 - **Respiratory Effort** : breathing unlabored
 - **Auscultation of Lungs** : normal breath sounds
- Cardiovascular**
 - **Heart** :
 - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
 - **Peripheral Vascular System** :
 - **Extremities** : no edema or cyanosis
- Gastrointestinal**
 - **Abdominal Examination** : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly
- Skin and Subcutaneous Tissue**
 - **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
 - **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation
- Neurologic**
 - **Mental Status Examination** :
 - **Orientation** : oriented
 - **Memory** : memory intact
 - **Cranial Nerves** : cranial nerves intact bilaterally
- Psychiatric**
 - **Judgement and Insight** : judgement and insight intact
 - **Mood and Affect** : normal, appropriate

Assessment

- Depression Worsening 311/F32.9
Suspect contributing to appetite issues / wt loss. agreeable to adding fluoxetine. feels unable to maintain current intensity of job due to lost endurance, strength with low weight.
- Insomnia Worsening 307.40/F51.9
wants to consider changing med to Lunesta- will reassess at FU.
- Anxiety Disorder Stable 300.00/F41.9
- Hypercholesterolemia 272.0/E78.0
willing to resume statin.
- Tobacco Abuse 305.1/Z72.0
- Weight loss 783.21/R63.4
routine cancer screening- mammo, chest CT. ct normal, mammo pending. some weight gain off week - pt confident she can

continue to gain weight off work x 1 more week. will refer back to surgeon.

DR Fowler

Plan

Orders

- General health panel This panel must include the following: Comp (80050, 80050, 80050, 80050) - - 03/22/2016 - - (Future Order)

Medications

- fluoxetine 20 mg oral tablet
SIG: take 1 tablet (20 mg) by oral route once daily for 30 days
DISP: (30) tablets with 11 refills
Prescribed on 03/22/2016

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- Return Visit Request in/on 2 weeks +/- 2 days (86404).

Correspondence

- Work/School Excuse (Pain v3.6)FHV1 (Jennie C. Cox) - 03/22/2016

Electronically Signed by: Jennifer T. Ellis, MD -Author on March 22, 2016 05:44:40 PM

Progress Note

Patient Name: Jennie Cox
Patient ID: 55780
Sex: Female
Birthdate: August 14, 1952

Visit Date: April 7, 2016
Provider: Jennifer T. Ellis, MD
Location: Hillcrest Family Practice
Location Address: 717 SE Main St
Simpsonville, SC 296813237
Location Phone: (864) 963-1548

Chief Complaint

- F/U to discuss Depression and Anxiety Disorder.
- Pt declines to discuss smoking cessation.

History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing better She is currently taking the following prescription medications: alprazolam 0.5 mg oral tablet, fluoxetine 20 mg oral tablet, Restoril 30 mg oral capsule, and taking Prozac and Restoril daily; no Xanax She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: anxiety, sadness, and weight loss. And she feels like the following symptoms have worsened: none have worsened. She is currently experiencing fatigue, loss of appetite, and loss of interest in pleasurable activities. She denies difficulty concentrating, difficulty performing routine daily activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: a chronic medical illness. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She does not exercise but is very active. She is not fasting today.

4/7: tried to wean out restoril. did not sleep for 3 days straight. nausea with onset of prozac, now appetite starting to return. believes she will begin to gain weight. believes she will never be able to push like she used to, does hope to return to work. before would come home, go right back out and cut the lawn. believes she was in the middle of nervous breakdown, finally coming to terms with her accident.

3/21/16: does not feel she have the energy to return to work; feels overwhelmed

Feels she cannot work because does not have the energy; reports she can do the driving; out/ in the truck, opening/ closing doors, securing the freight;

decreased endurance / strength to maintain position

if runs to Florida, takes 10-11 hrs driving straight, get freight off, empty, hand out 5-6 hours; go to Savannah, then return to Greenville; in 7 days, take 34 hour break;

3/11/2016: trouble chewing; throughout mouth, L side feels numb, R side primary used for chewing; still using ensure 1-3 bottles/ day.

ate more this week since home.

mammo not done yet

CVS augusta

3/2016: went from running team driving, now single since Oct 2015. Physically/ mentally wearing her out. Input unchanged from prior. Still uncomfortable to eat- teeth not lined up. Eats lots of mashed potatoes, grilled chicken, green beans. 1 meals/ day. Only ensure remainder of day.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; using alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expired- has been out x 1 month; normally uses 1-2 x/week- usu on Wednesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours. no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost significant amount weight

Broke jaw wired mouth shut- 5/31/2012

Past Medical History

Disease Name	Date Onset	Notes
Abdominal Radiologic Abnormality	3/5/08	see CT report- L adrenal gland abnormality
Anxiety Disorder	--	--
Bone Infection	2001	Dr. devault- I & D ? R hamstring insertion/ infection. a/w overuse unloading hand truck. infxn noted upon re-attachment of hamstring per pt?
Hypercholesterolemia	11/26/2010	h/o given. willing to work on diet/ exercise. re check 4 mos. Did not tolerate simvastatin- felt "sick," malaise
Insomnia	--	--
Irritable Bowel Syndrome	2004-2007	w/u by GI Assoc- for IBS- Hartley- upper GI, small bowel series, U/S, HIDA Scan 2004-2007
Joint Pain	--	--
Low Back Pain	--	? HNP L5/s1

Past Surgical History

Procedure Name	Date	Notes
Adenoidectomy	--	--
Appendectomy	? at time of ooph	--
Colonoscopy	8/16/04	int/ext hemorrhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after w/ emesis)
EGD	10/04	mild erythema

hystw/ooph	age 20s/ 1990s	hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery
jaw surgery	5/2012- multiple surgerie 1990s	Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr CObb- oral surgeon, Dr Ridgill prosthetic orthodontist bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Biouin and May
Lysis of adhesions		
Tonsillectomy	--	--

Medication List

Name	Date Started	Instructions
alprazolam 0.5 mg oral tablet	03/14/2016	take 1 tablet (0.5 mg) by oral route 3 times per day
atorvastatin 40 mg oral tablet	03/11/2016	take 1/2 tablet daily, increase after 2 weeks to 1 full tablet qhs if tolerated
fluoxetine 20 mg oral tablet	03/22/2016	take 1 tablet (20 mg) by oral route once daily for 30 days
mirtazapine 7.5 mg oral tablet	03/03/2016	take 1 tablets by oral route Qhs, increase to 2 tabs if tolerated after 1-2 weeks
Restoril 30 mg oral capsule	03/03/2016	take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days

Allergy List

Allergen Name	Date	Reaction	Notes
Magnesium	--	--	--
Nickel	--	?metal allergy?	--
Simvastatin	--	malaise	--
Ultram	--	--	--

Family Medical History

Disease Name	Relative/Age	Notes
Alzheimer's Disease	/	--
	Aunt/ Grandmother (maternal)/ Mother/	
DM Type II	/	--
	Aunt/ Uncle/	
Myocardial Infarction, Acute	/	--
	Father/70	

Social History

Finding	Status	Start/Stop	Quantity	Notes
Children	--	--/--	--	2 daughters
Divorced	--	--/--	--	--
Grandchildren	--	--/--	--	5 gkids- 3 girls, 2 boys; had gson oldest that lost 2008; 2 younger girls (Madison 12, Emily 7) with same mom (tammy); oldest 40 yo Sonya- with twin brother and son (17 yo) Marthew and Meghan), older brother died- Michael -was at 16 yo from MVA
Nondrinker	--	--/--	--	--
Smoker	--	--/--	2 ppd	--
Tobacco	Current every day	18/--	2 PPD	--
Truck Driver	--	--/--	--	--

Review of Systems

Constitutional

- **Denies** : weight loss, weight gain, loss of appetite

HENT

- **Denies** : headaches

Cardiovascular

- **Denies** : chest pain, dyspnea on exertion

Respiratory

- **Denies** : shortness of breath

Gastrointestinal

- **Denies** : nausea, vomiting, diarrhea, abdominal pain, jaundice

Integument

- **Denies** : rash, itching

Neurologic

- **Denies** : tingling or numbness

Musculoskeletal

- **Denies** : additional musculoskeletal symptoms except as noted in the HPI

Endocrine

- **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance

Psychiatric

- **Denies** : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L\R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
04/07/2016	02:00 PM	117/70	Sitting				75 - R		97.8	102lbs 4oz					

Physical Examination

Constitutional

- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

Eyes

- **Conjunctivae** : conjunctiva normal
- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally

Respiratory

- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

Cardiovascular

- **Heart** :
 - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- **Peripheral Vascular System** :
 - **Extremities** : no edema or cyanosis

Gastrointestinal

- **Abdominal Examination** : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

Skin and Subcutaneous Tissue

- **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- **Mental Status Examination** :
 - **Orientation** : oriented
 - **Memory** : memory intact
- **Cranial Nerves** : cranial nerves intact bilaterally

Psychiatric

- **Judgement and Insight** : judgement and insight intact
- **Mood and Affect** : normal, appropriate

Assessment

- Depression Improving 311/F32.9

Suspect contributing to appetite issues / wt loss. agreeable to adding fluoxetine. feels unable to maintain current intensity of job due to lost endurance, strength with low weight.

- Insomnia Stable 307.40/F51.9

wants to consider changing med to Lunesta- will reassess at FU.

- Anxiety Disorder Stable 300.00/F41.9

- Hypercholesterolemia 272.0/E78.0

willing to resume statin.

- Tobacco Abuse 305.1/Z72.0

- Weight loss 783.21/R63.4

routine cancer screening- mammo, chest CT. ct normal, mammo pending. some weight gain off week - pt confident she can continue to gain weight off work x 1 more week. will refer back to surgeon.

DR Fowler

- Fatigue 780.79/R53.83

Plan

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- Return Visit Request in/on 2 weeks +/- 2 days (87130).

Electronically Signed by: Jennifer T. Ellis, MD -Author on April 7, 2016 03:32:09 PM

Progress Note

Patient Name:	Jennie Cox	Visit Date:	April 22, 2016
Patient ID:	55780	Provider:	Jennifer T. Ellis, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main St Simpsonville, SC 296813237
		Location Phone:	(864) 963-1548

Chief Complaint

- F/U to discuss Depression and Anxiety.
- Pt would like to know if she should be taking both Restoril and Remeron.
- Pt declines to discuss smoking cessation.

History Of Present Illness

The patient returns for follow up of Her depression Since the last visit She has been doing better She is currently taking the following prescription medications: fluoxetine 20 mg oral tablet She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is is currently experiencing fatigue. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

Taking alprazolam 1-2 x/ week, when feeling worried about how going to get things done

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Now drives - not supposed to drive over 11hours.

Dedicated run: Left greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; jaw surgery; Lysis of adhesions; Tonsillectomy

Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; fluoxetine 20 mg oral tablet; mirtazapine 7.5 mg oral tablet; Restoril 30 mg oral capsule

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

Constitutional

- **Denies** : weight loss, weight gain, loss of appetite

HENT

- **Denies** : headaches

Neurologic

- **Denies** : tingling or numbness

Psychiatric

- **Denies** : additional psychiatric symptoms except as noted in the HPI

Physical Examination

Constitutional

- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

Respiratory

- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

Cardiovascular

- **Heart** :
 - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- **Peripheral Vascular System** :
 - **Extremities** : no edema or cyanosis

Skin and Subcutaneous Tissue

- **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- **Mental Status Examination** :
 - **Orientation** : oriented
 - **Memory** : memory intact
- **Cranial Nerves** : cranial nerves intact bilaterally

Psychiatric

- **Judgement and Insight** : judgement and insight intact
- **Mood and Affect** : normal, appropriate

Assessment

- Anxiety Disorder 300.00/F41.9
long discussion about relationship between job/ injury/ mood/ weight. believe wt loss / fatigue multifactorial. will increase prozac further to address. encouraged pt to pursue less demanding driving position.
- Weight loss 783.21/R63.4

Plan

Medications

- fluoxetine 40 mg oral capsule
SIG: take 1 capsule (40 mg) by oral route once daily in the evening for 30 days
DISP: (30) capsules with 11 refills
Adjusted on 04/22/2016

Instructions

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- Return Visit Request in/on 2 weeks +/- 2 days (87836).

Correspondence

- Work/School Excuse (Pain v3.6)FHV1 (Jennie C. Cox) - 04/22/2016

Electronically Signed by: Jennifer T. Ellis, MD -Author on April 22, 2016 03:18:28 PM



**GREENVILLE
HEALTH SYSTEM**

Millcrest Family Medicine

Robert E. Draken, MD
DEAN AG7405428 • LIC# SC18320
NPI# 1555064390

David C. Smith, MD
DEAN AS1249266 • LIC# SC18890
NPI# 1556382733

Katherine A. Egan, DNP, APRN, FNP-C
DEAN MT3239872 • LIC# SC18882
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DEAN MT3239872 • LIC# SC18882
NPI# 1081078358

717 S.E. Main St., P.O. Box 1177 • Simpsonville, SC 29681 • (864) 622-5400

Name: Jennie Cox DOB: 8/14/1952

Address: _____ Date: 9/28/2015

Imaging resistant features include safety paper with uniform background color and VOID pantograph along with refill indicator.

R Physical Therapy
Working Hardening.

Di. Body Strengthening

② Fatigue
③ Neck/neck

□ 20-49
□ 50-74
□ 75-100
□ 100-124
□ 125 and over
UNITS

□ LABEL

REFILL NR: 2

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED

APA #9
DONALD L. RIDGELL, D.M.D
UPSTATE PROSTHODONTICS, LLC
10/04/12-10/28/15

Donald L. Ridgell, D.M.D.

PRACTICE LIMITED TO PROSTHODONTICS

Date 10/4/12

For Tab

Name Jennae Cox Date of Birth 8/14/59
 Name wish to be called Jennae Marital Status DD
 Address 222 W. Chapman Rd Home Phone 864-243-1703
 City Belton State SC Zip Code 29627
 Social Security # 250-94-3648 E-Mail Address NA
 Student NA School NA Cell 864-304-2723
 Employer Palmetto State Transportation Address 1050 Park West, Greenville SC
 Occupation Truck Driver Work Phone 1-800-269-0725 Cell _____
 Name of Spouse NA Employer NA
 Person Responsible for Payment Warriors Camp Charokine Insurance
 Address Warren MT
 Family Physician Dr. Jennifer Ellis Date of Last Medical Exam 12/11
 Previous Dentist Dr. Fowler-Plaster Date of Last Dental Exam Swing - Greenville SC
 Who Referred You to This Office Dr. Cobb
 What dental problem caused you to seek treatment at this office? Explain
Accident - May 31, 2012 Broke jaw (L) Side no toothache
 Preferred Day of Appointments _____ Time _____ AM/PM

Confidential Medical History

Are you now or have you recently been under a physician's care? Reason Accident on job
Broke jaw
 Have you ever been a patient in a hospital or had any serious illness? Explain _____

Circle any of the following which you have had or suspected:

No Health Problems

Cancer or Tumors	Tuberculosis	Prolonged Bleeding	Rheumatic Fever	Severe Infections
Diabetes	Severe Infections	Heart Trouble	Frequent Thirst	Severe Headaches
Heart Murmur	Kidney/Bladder Trouble	Epilepsy	High/Low Blood Pressure	Anemia
Thyroid Disease	Chest Pain	Lung Disease	Glaucoma	Venereal Disease
Stroke	Pneumonia	Radiation Treatment	Shortness of Breath	Fainting Tendency
Asthma or Hay Fever	Blood Diseases	<u>Tonsils Removed</u>	Sinus Trouble	Liver Disease
Mental Disorders	Hepatitis or Jaundice	Slow Healing	AIDS/HIV Positive	Other

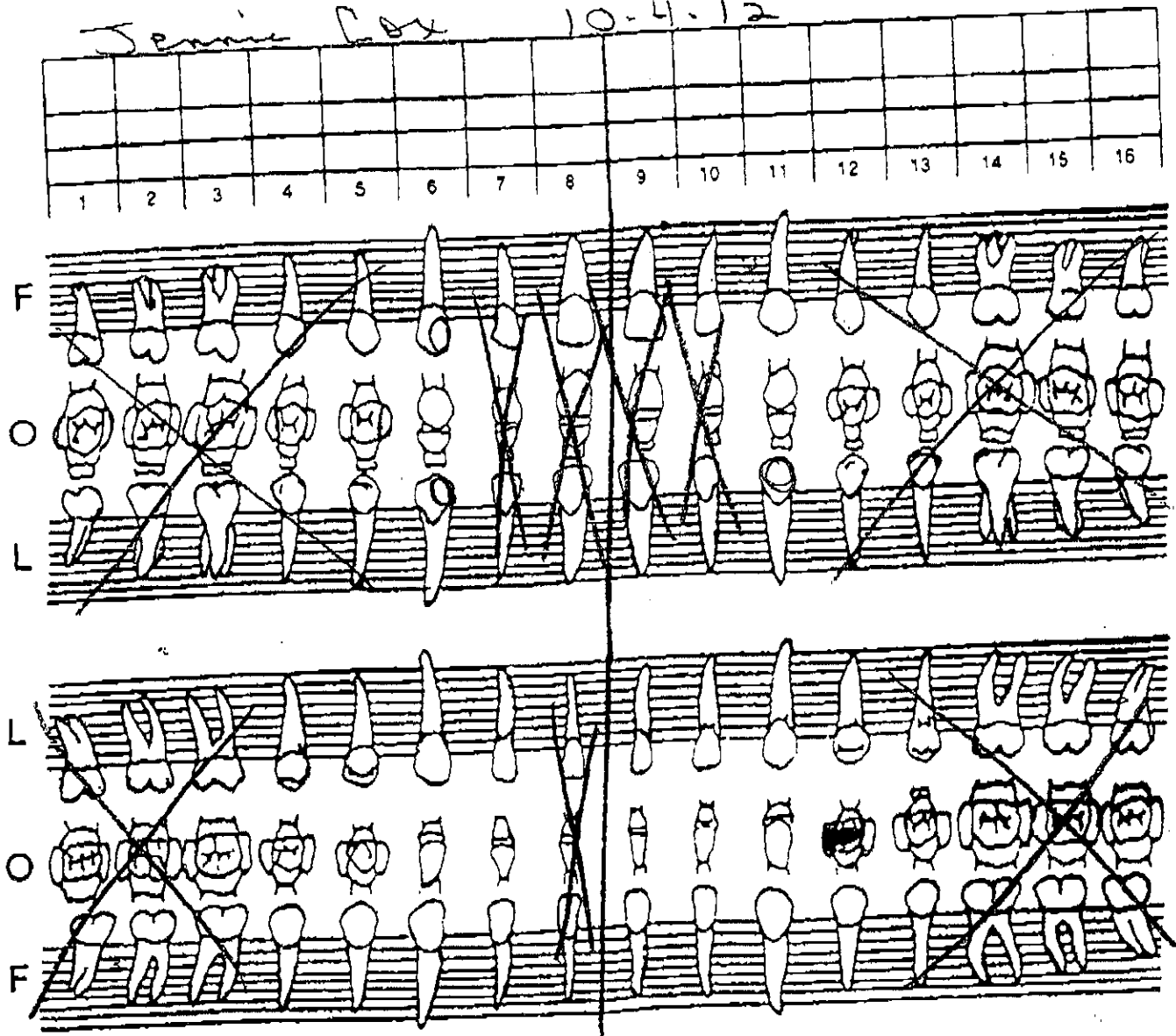
Are you taking any medications? (list) Restril - Sleep
 Medication: Dosage (mg and # per day): 30 Action: _____

Are you allergic to or suffer ill effects from: (circle) NA Lortab-nausea th
 Penicillin Codeine Nitrous Oxide Aspirin Sedatives Other

Women Only: Are you pregnant? Yes/No How many months? _____

DR 10/4/12

Jennie Cox 10-4-12



	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
1																
2																

Comments or notes:
No partials etc

Date	Tooth	
3-7	TX C/C	ad. C/ under ridge 1/C LL facial removed upper sutures - post. fixed max NA: 4 WKS
4/4		Emailed Cherokee Ins. / Mike DeCarolis to expedite payment for claims SL
1-8	C/C	pt reports w/ no actual sore spots just has to reapply fixed to lower frequently. ad. 22 + 27 Area - pt wants to wait on surg. if possible or she can gain weight. 9/1/13 Dr K said she can't wait real long or grafting will start disappearing (lost) we will see her if sore spots, or if needed or she sees Dr Cobb + they are ready for implants (lower)
1-18		prelim appts for impressions to make implant guides for Dr Cobb pt to have implant surg. 4-29-13. we will see mid June
6-20		pt reports to office after visiting Dr Cobb's office - she is now ready to have 6 implants placed on up + uncover 3 implants that were placed on lower - Cobb's made sure w/ Dr Cobb 7-17-13 then here at 1:30 Coe Soft / C - NA: 7-17-13
6/20		Sent email for /ci treatment to Mike DeCarolis.
1-17		pt reports to office after uncovering by Dr Cobb - 6 upper 5 lower Coe Soft placed on upper + lower NA: 5 left lowers in 10 days Th (FI)
1-29	1/C	FI (5 implants on ↓) w/ Fast Set Aquasil abutments, floss tied to abutments, trial gel.
	C/	upper preling done NA: 1) verification in 2) In 2 3) Jd 4) Dend 1/Ci

Donald L. Ridgell, D.M.D.

PRACTICE LIMITED TO PROSTHODONTICS

Name: Jennie Cox

Referred by: _____

Gen. Oral Health: _____

Personal: _____

Medical Alert: _____

BP _____

P _____

2013

Date	Tooth	
8-15	C	verification jig tried in - fit great - replaced healing caps
	C/	wax rim Bite & shade
		NA: TI
8/21		LM for Cherokee Ins Company to call back regarding claim status for 1c - filed 6/20/13 -
8-26	C/C	removed healing caps & tried verification jig in again - fits great - removed & did fr. In of teeth - upper teeth protruded out too far - Dr Ridgell reset them - looked better - 1 piece look great out of mouth but when placed in mouth they are too tall & "crescent moon" (☾) look - Dr Ridgell marked them & said another fr. In -
		NA: TI 1C / Just teeth after removing 30 min (healing caps not verif. jig)
8/27		Called Cherokee Ins. Company and spoke to Mike DeCarolis. asked about claim status of 6/20/13. He said a check # 416822 was mailed on 6/28/13 in the amount of \$6735.00. He will put a tracer on it and call back in 2 days. (800) 201-0450 - Workers Comp / Mike DeCarolis. Also emailed final portion of Tx. Plan DOS 8/26/13 to Mr. DeCarolis. SL
8/29		8 Tried to call Mr. DeCarolis to double check follow up on check that was supposedly issued. LM for him to call back (EFin) S
9-5	C/C	removed healing caps for In. In - (LL post. healing cap had to be replaced after difficulty in removing). In In - midline off & LL was sloping so Dr Ridgell reset them - replaced healing caps w/ topical - NA: TI ~~but~~ ~~change~~ ~~area~~

Date	Tooth	
9-16	C	removed healing caps + did another try in. Dr. Edgell moved upper teeth 6 + 8 + now lower looks good + bite is right. (we will start upper about the time lowers are done) NA: "F range Dr. Dr. on + fixed detach Del 10/14
10-14		lower + fixed tried in - fit + looks great - upper already unpacked so we will start upper after delivery of lowers - Prelim C/ NA: 1) Del 10/14 fixed 2) FI C/ fixed
10-24	C	delivered lower fixed detachable. Waxed screws - 1 permit placed, pink acrylic + A2 Herculite. Adj. Bite on Tx C/ - fit new lower. NA: FI C/ (W bar)
11-7		FI C/ W 3i Ceram attachments + Fast Set Aquasil - replaced healing caps NA: WR C/ + ref. jig to Dr. TI 3 WKS Bar TI 2 WKS <u>EIT 3.3.14</u> <u>TI</u> Del WPD
11/2	Ci	Wax Run and verification jig for bars - W: Trym -
11/9	Ci	Trym & Ci, W: Bar trym -
2014	3-3	C/ Bar In Dr. (we are issuing due to not moving for arch + upper prep up around healing caps) - topic: used NA: Del C/ Dr. Edgell said no more try ins - straight to delivery -

Donald L. Ridgell, D.M.D.

PRACTICE LIMITED TO PROSTHODONTICS

Name: Jennie Cox Referred by: _____

Gen. Oral Health: _____ Personal: _____

Medical Alert: _____ BP _____ P _____

2014 cont.

Date	Tooth	
3-17	C:	Del. denture after removing healing caps + placing Bars in - torqued screws + permit placed - adj. made to dentures to snap in - fit great - homecare kit given - NA: WPO
3-24	C:	adj. made to UR ling where metal at end of denture was rubbing tongue raw - pt said teeth were a little loose - replaced 2 (posteriors Both sides) - loose clips -
6-2	C/C:	pt reports for 3 month recheck on C - all implants doing good on top - cleaned/polished denture + pg on upper - prophyl. Over fixed due to albin - pt reports food fitting trapped under lower plates - normal occurrence - Pt. advised that replacement of flesh usually takes place ^{every} 10 yrs and cleanings are due every 6 months - NA: 6 months 1 hr appt to remove lower fixed appliance + polish/clean + adjustments -
10-23		Walk in - pt stopped by for us to check feel LL jaw - it feels like plates/screws sticking out from original surg. Payerex made - Referred to Dr. Lohr to eval/treat - Appt Mon. 10-27-14
12-8		Amox. 500mg X4D CVS 299-0231 1 month recall for cleaning - removed lower fixed + cleaned dent in ultrasonic - lower had small to moderate plaque + upper had Red spot calculus - cleaned - then no 233 replaced lower. 111 -0304-

2017 cons.

Jennie LDX

Date	Tooth	
12-8	cont	w/ white tape, fprint #18 area only, A2 + pink acrylic - upper replaced #3 area fprint. CA screening only joints clear - pt still has "knot" LL jaw area + Dr. Lohk said he could remove knot pt not sure she wants it done.
2/9		Faxed all records to The Mims Law Firm SC
4/9		Sent WC Form 14B to the Mims Law Firm SC
4/14		Faxed all records to McKay, Cauthen, Settara + Subley, PA SC
6-8		6 months recall on lower, fixed detachable - removed (5 screens) + cleaned C/C in ultrasonic - polished upper bar in mouth (pt has never brushed upper bar - what one hygiene w/ her) replaced screens, white tape - fprint #18 area - pink Triad + A2 Acrylic.
6-22	1/C	pt reports for us to remove lower fixed detachable - she will have surgery in the A.M. by Dr. Fowler. He hopes to go through LL area + hopefully release any tissue + possibly Debride any infection if there is any. pt will stay overnight - healing caps placed - we will see as needed.
6-23		Phone consult Dr. Call. Dr. Fowler asking us to remove it post op but he is not sure why. Insurance is in hospital for some reason surgery for hydrocephalus under Lt. Major Johnson. Dr. Call.
7-29	1/C	pt reports to let Dr. Kidwell look at lower to see if it is ready to have fixed detachable replaced. Dr. Fowler wants Dr. Kidwell to make the decision - we replaced lower w/ pink acrylic, A2, tape + fprint - NA. Doc for cleaning Th
10-28		Faxed ledger + copy of notes to McKay, Cauthen, Settara + Subley, PA - Copy in chart. SC



Physician's Statement

Claimant's Name: Jennie Cox

Employer's Name: Palmetto State Transportation

Physician's Name: Donald L. Ridgell, D.M.D.

Insurance Carrier: Cherokee Insurance Company

Practice/Clinic: Upstate Prosthodontics

SCWCC File No: 1206236

Preparer's Name: DONALD RIDGELL

Phone: 864 2323882

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

Date of Injury or Illness: May 31, 2012

Date of first office visit: 10/4/12

Date of last visit: 12/8/14

Diagnosis or nature of injury or illness: Missing teeth/bone of jaws from trauma

Body part(s) injured: maxilla / mandibular jaws Body part(s) affected: Teeth / maxilla / Mandible

Date of Maximum Medical Improvement: 6/12/14

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

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

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

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

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

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

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

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

Maintenance procedures annually - more expensive than natural teeth
Replac or refurbish appliances every 6-8 yrs.
Oral Surgeon visit 5yrs for radiograph / CT scan

Donald L. Ridgell
Treating Physician

4/9/15
Date

APA #10
LARRY W. COBB, D.M.D
PIEDMONT ORAL SURGERY
10/30/12-10/27/16

October 30, 2012

RE: Jennie Cox

Workers Compensation #: WC34192

To Whom It May Concern:

Mrs. Jennie Cox has had a full work up including a physical examination and CBCT evaluation to determine the treatment necessary to restore her teeth for maximum function. She has a very complicated case secondary to her normal petite size and small jaws. This has been further compromised by the very significant jaw injuries including multiple bone fractures and loss of teeth. Her remaining teeth are terminal due to the lack of bone support. These will all have to be removed. She has very minimal maxillary bone and will lose more when her teeth are removed. She will require extensive bone grafting before any definitive treatment can be achieved. Either one or both bone plates will need to be removed from the mandible before any treatment can be implemented there as well.

The following treatment will be necessary to enable restoration to as near normal function as possible.

Stage I:

Anesthesia: D9220	\$ 355.00
Surgical removal of teeth #s 4,6, and 11: D7210	\$ 645.00
Bilateral sinus lift @ \$3200.00 each side: D7940	\$6400.00

Stage I Total Charges:	\$7400.00

Stage II:

Anesthesia D9220	\$ 355.00
Surgical removal #s 21,22,26,27,28,&29 D7210	\$1290.00
Removal of superior bone plate D7997	\$ 600.00
Possible removal inferior bone plate D7997	\$ 600.00

Stage II Total Charges:	\$2845.00

Stage III:

Re-evaluate with CBCT: D0363	\$250.00
Plan implant placement with CAD/CAM surgical guide fabrication @ \$400.00 each D5982	\$800.00

Stage III Total Charges:	\$ 1050.00

Stage IV:

Placement of 6 maxillary implants: D6010	\$12,435.00
Placement of 5 mandibular implants D6010 :	\$10,485.00

Stage IV Total Charges:	\$22,920.00

Stage V:

Uncover implants and release patient for definitive prosthetic rehabilitation

Total Charges for Restoration/Implant Process:	\$34,215.00

Fees for prosthetic work will need to be obtained from Dr. Donald Ridgell

Please feel free to call our office at 864-271-9990 with any questions that you may have.

Sincerely,
Larry W. Cobb, DMD

COX, JENNIE R.
222 W. CHAPMAN ROAD

630-5004

BELTON, SC

29527

Home: (864)243-0032 Work: (800)269-0174

Age: 59 DOB: 08/14/1952

Ref: COFER, DR. W. A.

(864)877-1891

REF 121854-071
refill location # 5 (Blue)
2.4 oz
Exp 08/2017

OncoGuard®

HCNMT3

REF OG2030

LOT CMN12K1



2015-06

Manufacturer: Collagen Matrix, Inc.

OncoGuard Flex™

HCNMT3

REF OG1120

LOT HCN112M2



2014-11

Manufacturer: Collagen Matrix, Inc.

222 W. CHAPMAN ROAD

MELTON, SC

29027

Home: 18641243-1832 Work: (803)263-2174

Age : 60 DOB: 06/14/1952

Ref : ~~00587~~ M. M. H. 18641877-1891

Dr. D. P. Edgell

ID: 12345-1-044
BUTCH Casselton (P. 15-1 00mm)
2.4 m
Expt 10/04/07

OswegoGuard® BICMET®

REF OG2030

LOT CM3N12K1 2015-08

Manufacturer: Collagen Matrix, Inc.

OswegoGuard Flex™ BICMET®

REF OGF1520

LOT BCMU12M2 2016-11

Manufacturer: Collagen Matrix, Inc.

COX, JENNIE M.
222 N. CHAPMAN ROAD

34513

630-5004

BELTON, SC

29527

Home: (864)243-0032 Work: (864)267-8174

Age: 60 DOB: 06/14/1952

Ref: RIDGELL, DONALD L. (864)222-3902

REFNT410 430
2013021029
RECEIVED TUESDAY 02/10/13
11:00 AM

REFNT410 430
2013021029
RECEIVED TUESDAY 02/10/13
11:00 AM

REFNT410 430
2013021029
RECEIVED TUESDAY 02/10/13
11:00 AM

REFNT410 430
2013021029
RECEIVED TUESDAY 02/10/13
11:00 AM

REFNT410 430
2013021029
RECEIVED TUESDAY 02/10/13
11:00 AM

34513

ALLERGIC TO Magnesium Metal

FEE ESTIMATE _____ DEPOSIT _____

COMPLAINT

PURPOSE OF EXAM

have 3-D scan

LOCAL ☐

GENERAL ☐

DATE

7-17-13 NPO PMW

96/60

Diazepam 5mg
Meperidine 50mg
Methohexital 110mg
Doodron 8
Ketamine 8

Phenergan 25mg X 2
Lorazepam 7.5mg X 3
Anaxil 500mg X 2
Painex ER
Bambayl 25mg

Meperidine 30mg
Phenergan 12.5mg

8 bags .5% maxw 1200000ggs
4/10 chmwr

Uncovered lower implants + placed 4x11.5 4x11.5 4x11.5 4x11.5 4x11.5 4x11.5
H/A 4/4/4 on all

Implants placed to craniomaxillary guide.
Encode healing abutments placed - sizes noted on stickers

XIFNT411 #3 BIOMET 3i™
2013030085 OSSEOTITE Tapered Certain Implant
4 X 11.5mm

XIFNT411 #11 BIOMET 3i™
2013030085 OSSEOTITE Tapered Certain Implant
4 X 11.5mm

XIFNT411 #5 BIOMET 3i™
2013030085 OSSEOTITE Tapered Certain Implant
4 X 11.5mm

XIFNT411 #12 BIOMET 3i™
2013030085 OSSEOTITE Tapered Certain Implant
4 X 11.5mm

XIFNT411 #6 BIOMET 3i™
2013030085 OSSEOTITE Tapered Certain Implant
4 X 11.5mm

XIFNT411 #14 BIOMET 3i™
2013030085 OSSEOTITE Tapered Certain Implant
4 X 11.5mm

ENCODE®
IBHA444
1124819-CN

ENCODE®
IBHA443
1101843-CN

ENCODE®
IBHA448
1124858-CN

ENCODE®
IBHA444
1124819-CN

ENCODE®
IBHA448
1124858-CN

ENCODE®
IBHA448
1090437-CN

7-29 appt

7-29-13 Pt did not come in for appt today. Off message on Farming's call phone #

7-31-13 Healing well, return in 4 months go back to work 8-12 Pt will call back for appt.

Will need 3-D Scan + coordinate uncovering @ next visit

11-13-13 @ 2

240
.0312

24513

FEE ESTIMATE _____ DEPOSIT _____

COMPLAINT

PURPOSE OF EXAM

GENERAL ☐

DATE	
11-13-13	3-D-SCAN - Healed well, all. uncovered - may complete restorative
10-27-14	3-D-SCAN - Rt knee sore bump at left inf lat. border - firm on mobil - appears to be end of plate - Rt knee pain & swelling - tried with Ascorol over the weekend - Scan shows small bump of bone over the end of the plate. If she cont to have pain we may try to remove the terminal screw + eval for small area of bone reduction.



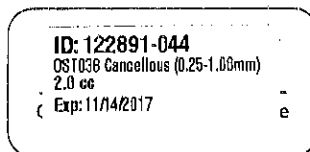
FIELD
1-31-13

ALLOGRAFT TRACKING FORM

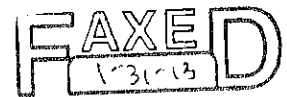
FDA Regulations and Joint Commission Standards require tissue tracking systems in all hospitals, clinics and doctor's offices using allograft for transplantation. In order to comply with these requirements, please complete ALL fields on this form and fax to (937) 222-2538.

Patient's Last Name: Cox First: Jennie MI: M
Date of Birth: 8/14/1952 Sex: F Patient ID: 34513
Hospital/ Clinic/ Doctor's Office: Piedmont Oral Surgery
Physician: Dr. Larry Cole Surgery Date: 1/31/13
Surgical Procedure: Bilateral Sinus graft
Completed by: C Johnson PA Date: 1/31/13
Comments: _____

Place peel off label or write tissue ID# in the space provided. One patient, one procedure per tracking form.



Retain this completed document with the patient's file.

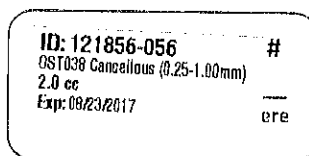


ALLOGRAFT TRACKING FORM

FDA Regulations and Joint Commission Standards require tissue tracking systems in all hospitals, clinics and doctor's offices using allograft for transplantation. In order to comply with these requirements, please complete ALL fields on this form and fax to (937) 222-2538.

Patient's Last Name: Jennie Cox First: _____ MI: M
Date of Birth: 8/14/1952 Sex: F Patient ID: 34513
Hospital/ Clinic/ Doctor's Office: Piedmont Oral Surgery
Physician: Dr. Larry Collier Surgery Date: 1/31/13
Surgical Procedure: Bilateral sinus graft
Completed by: E Johnson Date: 1/31/13
Comments: _____

Place peel off label or write tissue ID# in the space provided. One patient, one procedure per tracking form.



Retain this completed document with the patient's file.

Certificate to return to work or school

Mr.
Mrs.
Miss Jeanie Cox

has been under my care from Thurs 1/31/13 to 2/12/2013
and is able to return to work/school on Wed 2/13/2013

Remarks Oral Surgery

Dr. Larry W. Cobb Date April 1/31/13
LARRY W. COBB, D.M.D.
2-C Cleveland Court
Greenville, S.C. 29607
864-271-9990

PIEDMONT ORAL SURGERY
W. Keith Walker, DDS
Larry W. Cobb, DMD
2C Cleveland Court
Greenville, South Carolina 29607
Tel: 864-271-9990 Fax: 864-235-7959

FAXED
4-29-13

RE: Jennie Cobb

Dear Dr. Don Ridgell

I would like to take this opportunity to update you on the care of Jennie Cobb.
These are the procedures that were performed: 4/29/13

Extractions: #

Implant Placement: #

#23

XIFNT410
2013021029
OSSEOTITE Tapered Certain Implant
4 X 10mm

#23

BIOMET 3i™
2018-02

9650

#25

XIFNT410
2013021029
OSSEOTITE Tapered Certain Implant
4 X 10mm

#25

BIOMET 3i™
2018-02

0684

Healing time: 3-4 months

XIFNT410
2013021029
OSSEOTITE Tapered Certain Implant
4 X 10mm

#27

BIOMET 3i™
2018-02

0681

XIFNT410
2013021029
OSSEOTITE Tapered Certain Implant
4 X 10mm

#30

BIOMET 3i™
2018-02

0702

Follow up Appointment:

May 9th, 2013

Thank you for referring your patient to our office. The confidence of your referral is greatly appreciated.

Sincerely,

Larry W. Cobb, DMD

Larry W. Cobb, DMD

XIFNT410
2013021029
OSSEOTITE Tapered Certain Implant
4 X 10mm

#20

BIOMET 3i™
2018-02

✓

Flowers have been sent to patient from Dr. Cobb and Dr.

Ridgell

Certificate to return to work or school

Mr.
Mrs.
Miss

Jennie Cox

has been under my care from Mon Apr 29 to Fri May 2
and is able to return to work/school on Mon May 14, 2013

Remarks

Oral Surgery

Dr.

Larry W. Cobb

Date

4-29-13 April

LARRY W. COBB, D.M.D.
2-C Cleveland Court
Greenville, S.C. 29607
864-271-9990

PIEDMONT ORAL SURGERY, P.A.

W. KEITH WALKER, D.D.S.

LARRY W. COBB, D.M.D.

2 C CLEVELAND COURT

GREENVILLE, SOUTH CAROLINA 29607

**PRACTICE LIMITED
ORAL SURGERY**

**TELEPHONE
(864) 271-9990**

May 9, 2013

Attn: St. Francis Outpatient Nutrition

RE: Jennie Cox

Patient Phone number: 864-243-0032

To Whom It May Concern:

Ms. Jennie Cox has begun oral reconstructive surgery with my office after trauma which she suffered on May 12, 2012. She is a worker's compensation case. Unfortunately, she is very malnourished. The success of our treatments depends upon her ability to heal. I believe that all of our treatment may be in jeopardy if her overall nutrition does not improve. Please have a consultation with her and treat for malnourishment. She is expecting a call from your office.

Sincerely,

Larry W. Cobb, DMD

Certificate to return to work or school

Mr.
Mrs.
Miss

Jeanne Cox

has been under my care from

7-24-2012 to Present

and is able to return to work/school on

Tentative return May 20, 2013

Remarks

Ms Cox has made steady progress after her surgery but continues to be malnourished. I have referred her to ST Francis nutrition counseling.

Dr.

Larry W. Cobb

Date

5-9-2013

LARRY W. COBB, D.M.D.
2-C Cleveland Court
Greenville, S.C. 29607
864-271-9990

FAXED
7-17-13

PIEDMONT ORAL SURGERY
W. Keith Walker, DDS
Larry W. Cobb, DMD
2C Cleveland Court
Greenville, South Carolina 29607
Tel: 864-271-9990 Fax: 864-235-7959

UNCOVERY APPOINTMENT

Date: 7/17/13
To: Dr. Don Ridgell
Your patient, Jennie Cox was seen today.

RE: Implant(s) # 20, # 23, # 25, # 27 + # 30

☒ Uncovery today

☒ Surgical release scheduled on: 7/17/13

Comments:

Implants # 20, # 23, # 25, # 27 + # 30 uncovered
Certain healing abutments (straight) T SHA 44 placed
on all implants

Follow up Note:

Pt has appointment w/ Dr. Ridgell 7-17-13 @ 1:30 pm

If you have any questions, please contact our office.
It is a pleasure working with you and providing treatment for your patients.

Larry W. Cobb D.M.D.
Larry W. Cobb DMD

PIEDMONT ORAL SURGERY
W. Keith Walker, DDS
Larry W. Cobb, DMD
2C Cleveland Court
Greenville, South Carolina 29607
Tel: 864-271-9990 Fax: 864-235-7959

RE: Jennie Cox
Dear Dr. Don Ridgell

I would like to take this opportunity to update you on the care of Jennie Cox.
These are the procedures that were performed: 7/17/13

Extractions: #

Implant Placement: # 3, #5, #6, #11, #12 & #14

#3		#3		#5		#5		#6		#6	

Healing time: 4 months

Follow up Appointment:

7-29-13

Thank you for referring your patient to our office. The confidence of your referral is greatly appreciated.

Encode Healing abutments placed

ENCODE® #3

#14

ENCODE® #5

ENCODE® #6

ENCODE® #11

ENCODE® #12

ENCODE®

Sincerely,

Larry W. Cobb, DMD

Larry W. Cobb, DMD

____ Flowers have been sent to patient from Dr. Cobb and Dr. _____

LARRY W. COBB, D.M.D.
 2-C CLEVELAND COURT
 GREENVILLE, S.C. 29607
 TELEPHONE 271-9990
 PRACTICE LIMITED TO ORAL SURGERY

Jennie Cobb
July 29 AT 8:30
 IT IS IMPORTANT THAT AT LEAST 24 HOURS NOTICE
 BE GIVEN IF THIS APPOINTMENT CAN NOT BE KEPT

Certificate to return to work or school

Mr.
 Mrs.
 Miss Jennie Cobb

has been under my care from _____ to _____

and is able to return to work/school on 8-8-13

Remarks Jennie was here this AM for oral surgery.

Dr. Larry W. Cobb Date 7-17-13

LARRY W. COBB, D.M.D.
 2-C Cleveland Court
 Greenville, S.C. 29607
 864-271-9990

Certificate to return to work or schoolMr.
Mrs.
MissJennie Cox

has been under my care from _____ to _____

and is able to return to work/school on _____

Remarks Mrs Cox was also out of work onJuly 15; July 16 in preparation for oralsurgery on July 17, 2013

Dr.

Larry W. CobbDate 7-18-13LARRY W. COBB, D.M.D.
200 Cleveland Court
Greenville, S.C. 29607
864-271-8890

Attn:

Scott Justice

Certificate to return to work or school

Mr.
Mrs.
Miss

Jennie Cobb

has been under my care from _____ to _____

and is able to return to work/school on 8-12-13

Remarks Jennie does not need to
go back to work 8-12-13

Dr.

Larry W. Cobb

Date 7-31-13

LARRY W. COBB, D.M.D.
2-C Cleveland Court
Greenville, S.C. 29607
864-271-9990

Time has been reserved for:

Jennie		
On	Thurs. Aug 15	At 8:30 A.M.
Also	Mon. Aug 26	At 8:00 A.M.
Also	Thurs. Sept. 5	At 8:30 A.M.
Also	Mon. Sept. 16	At 8:30 A.M.

If unable to keep appointment, kindly give 24 hours notice.

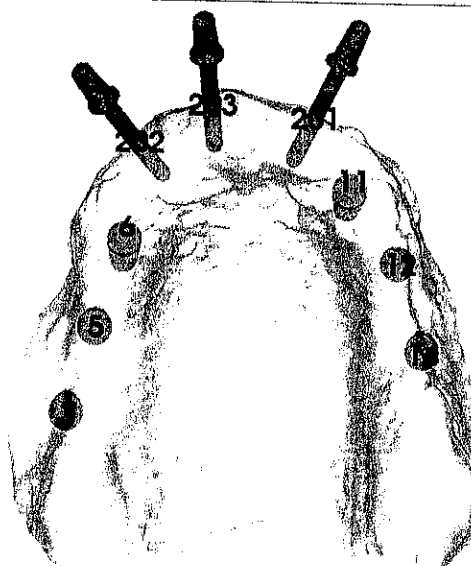
Anatomage

Guide Reference Chart – Upper Arch

Anatomage Inc.
111, N. Market St. #800
San Jose, CA 95113
www.anatomage.com
info@anatomage.com
(408)885-1474 Phone
(408)295-9766 Fax

Case Info	
Patient Name	16073 Cox, Jennie
Referring Physician	Cobb, Larry
Doctor Account	Cobb, Larry
Guide System	Biomet Navigator (Tapered)
Note	To reach desired depth, doctor will need to freehand 3mm more at sites 3, 6, 11, 12, 14. Guide may require a tissue punch at site #6 to seat properly.

Case Image - Upper Arch



Guide Fixation

Site	Manufacture / Name / Size	Drill Depth (mm)
201	(Anchor_Pin Anatomage) Ø2.00 / L14.00	15.0
202	(Anchor_Pin Anatomage) Ø2.00 / L14.00	15.0
203	(Anchor_Pin Anatomage) Ø2.00 / L14.00	15.0

Implant Plan

Site	3	5	6	11	12	14			
Implant Code	INT411	INT411	INT411	INT411	INT411	INT411			
Implant Length (mm)	11.50	11.50	11.50	11.50	11.50	11.50			
Implant Diameter (mm)	4.00	4.00	4.00	4.00	4.00	4.00			
Prolongation (mm)	8.0 (L)	5.0 (S)	8.0 (L)	8.0 (L)	8.0 (L)	8.0 (L)			

Implant Placement

Tissue Punch	4	4	4	4	4	4			
Cortical Perforator	4(L)	4(S)	4(L)	4(L)	4(L)	4(L)			
Twist Drill /Handle-Side	e / T - 4	c / T - 4	e / T - 4	e / T - 4	e / T - 4	e / T - 4			
Countersink Drill	4(L)	4(S)	4(L)	4(L)	4(L)	4(L)			
Shaping Drill ^A	3.25x11.5(L)	3.25x8.5(S)	3.25x11.5(L)	3.25x11.5(L)	3.25x11.5(L)	3.25x11.5(L)			
Shaping Drill ^A	-	3.25x11.5(S)	-	-	-	-			
Shaping Drill	4x11.5(L)	4x8.5(S)	4x11.5(L)	4x11.5(L)	4x11.5(L)	4x11.5(L)			
Shaping Drill	-	4x11.5(S)	-	-	-	-			
Tap ^A	4x11.5(L)	4x11.5(S)	4x11.5(L)	4x11.5(L)	4x11.5(L)	4x11.5(L)			
Implant Mount	4(L)	4(S)	4(L)	4(L)	4(L)	4(L)			
Bone Profiler	4	4	4	4	4	4			

Analog Placement

Analog Mount	4(L)	4(S)	4(L)	4(L)	4(L)	4(L)			
Analog Type	IILA20	IILA20	IILA20	IILA20	IILA20	IILA20			

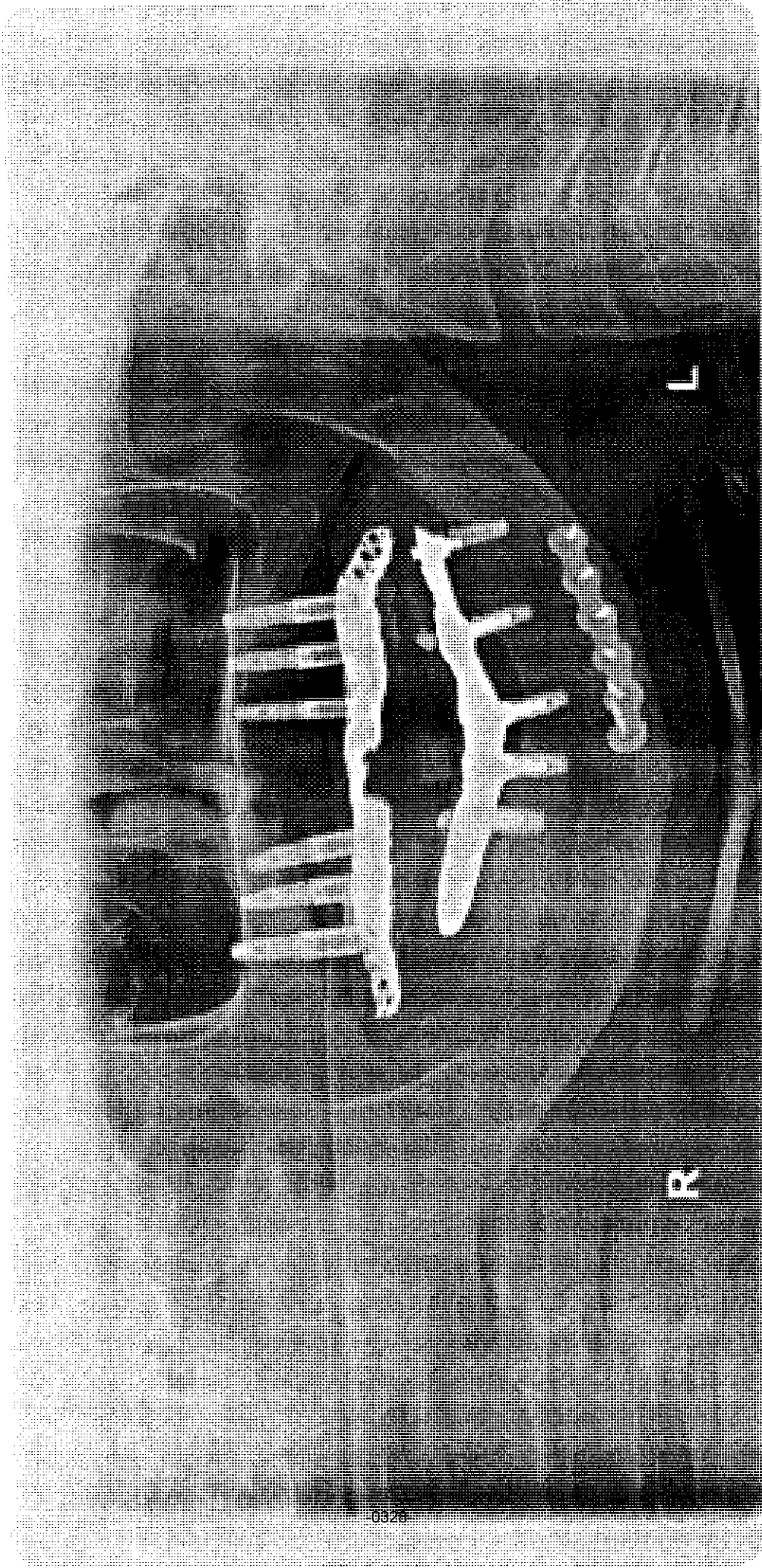
^AThese Additional Steps are Required for Dense Bone.

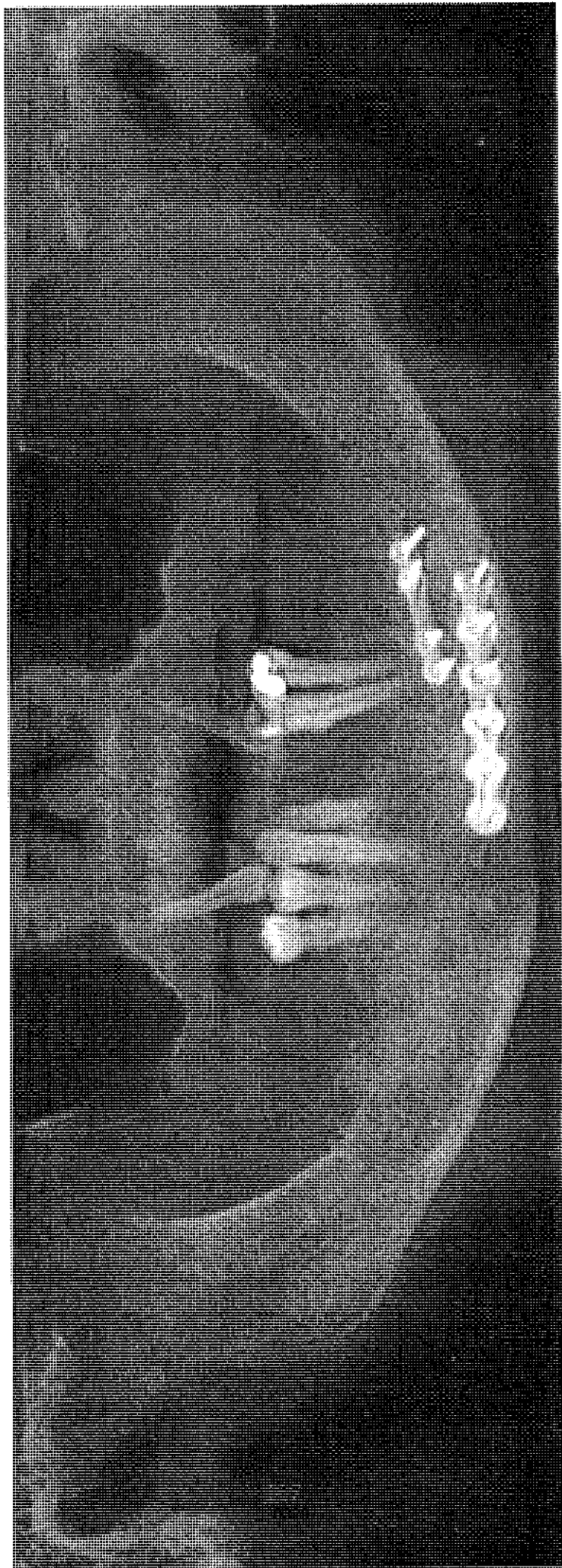
^RDesignates that the Reduction Handle Must be Used during this Step.

Case Info			Case Image: Lower Arch		
Patient Name	13376 Cox, Jennie				
Referring Physician	Cobb, Larry				
Doctor Account	Cobb, Larry				
Guide System	Blomet Navigator (Tapered)				
Note					
Guide Fixation					
Site	Manufacture / Name / Size	Drill Depth (mm)			
217	(Anchor_Pin Anatomage) Ø2.00 / L14.00	15.0			
218	(Anchor_Pin Anatomage) Ø2.00 / L14.00	15.0			
219	(Anchor_Pin Anatomage) Ø2.00 / L14.00	15.0			
Implant Plan					
Site	20	23	25	27	30
Implant Code	INT410	INT410	INT410	INT410	INT410
Implant Length (mm)	10.00	10.00	10.00	10.00	10.00
Implant Diameter (mm)	4.00	4.00	4.00	4.00	4.00
Prolongation (mm)	5.0 (S)	8.0 (L)	8.0 (L)	8.0 (L)	5.0 (S)
Implant Placement					
Tissue Punch	4	4	4	4	4
Cortical Perforator	4(S)	4(L)	4(L)	4(L)	4(S)
Twist Drill /Handle-Side	b / T - 4	d / T - 4	d / T - 4	d / T - 4	b / T - 4
Countersink Drill	4(S)	4(L)	4(L)	4(L)	4(S)
Shaping Drill	3.25x10(S)	3.25x10(L)	3.25x10(L)	3.25x10(L)	3.25x10(S)
Shaping Drill					
Shaping Drill	4x10(S)	4x10(L)	4x10(L)	4x10(L)	4x10(S)
Shaping Drill	-	-	-	-	-
Tap	4x10(S)	4x10(L)	4x10(L)	4x10(L)	4x10(S)
Implant Mount	4(S)	4(L)	4(L)	4(L)	4(S)
Bone Profiler	4	4	4	4	4
Analog Placement					
Analog Mount	4(S)	4(L)	4(L)	4(L)	4(S)
Analog Type	IILA20	IILA20	IILA20	IILA20	IILA20

^These Additional Steps are Required for Dense Bone.

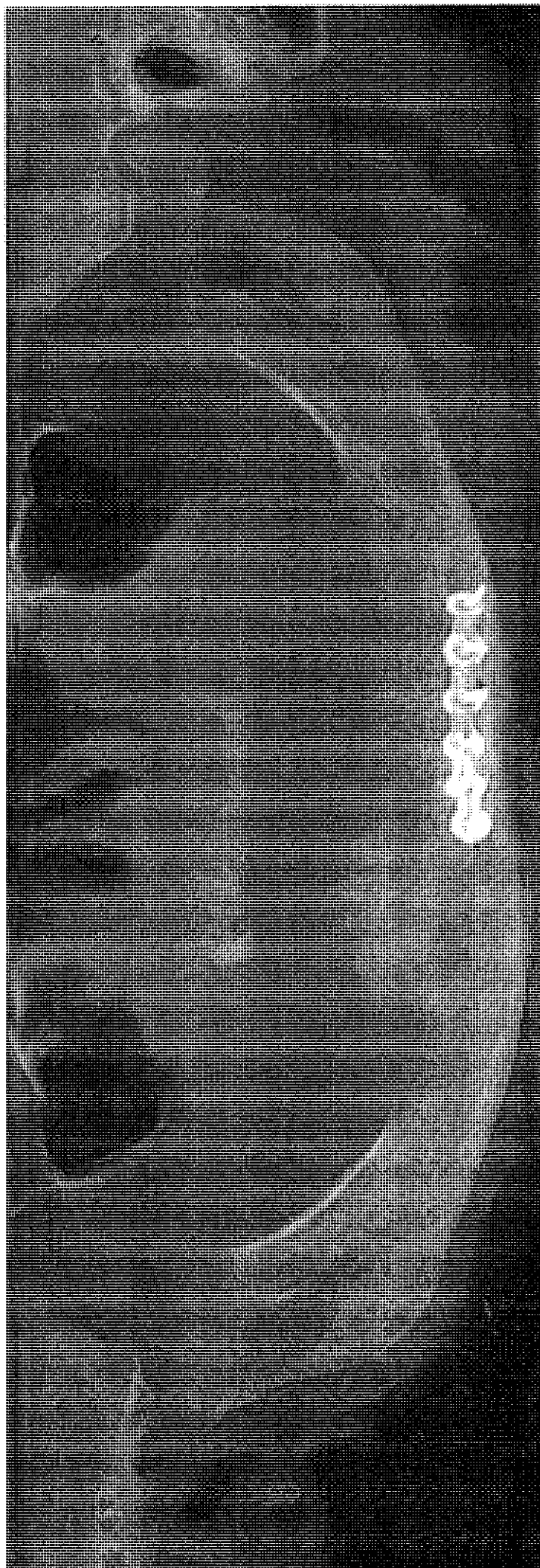
*R Designates that the Reduction Handle Must be Used during this Step.

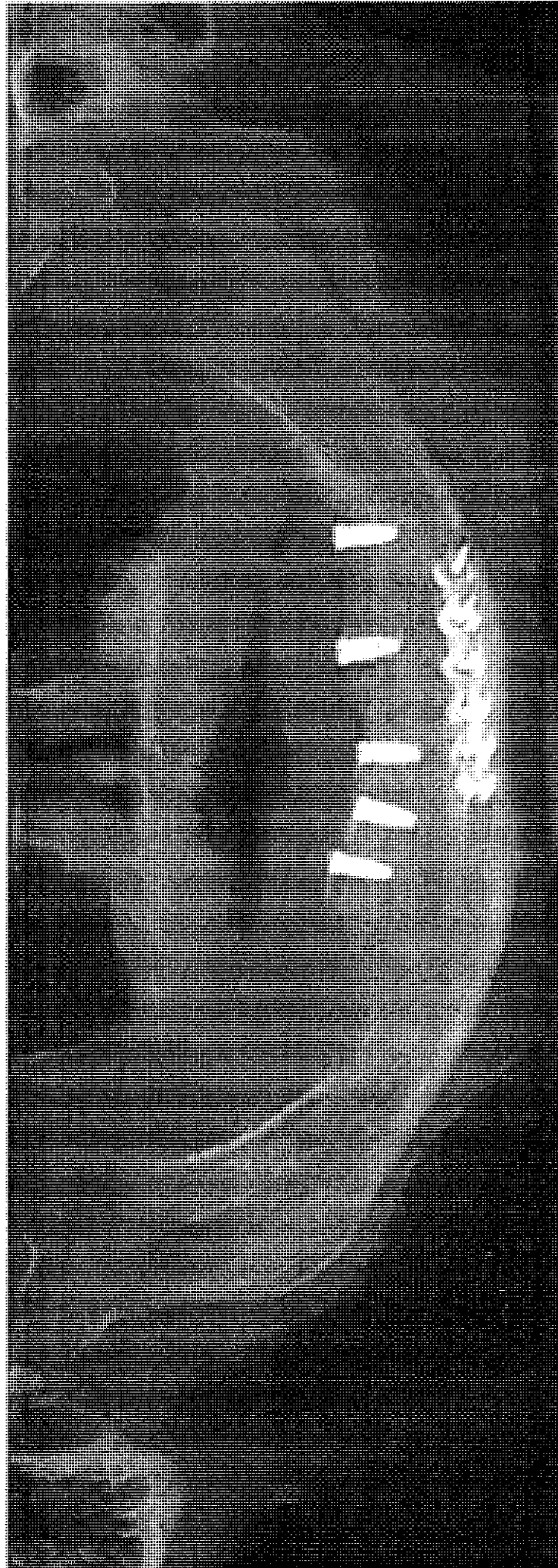


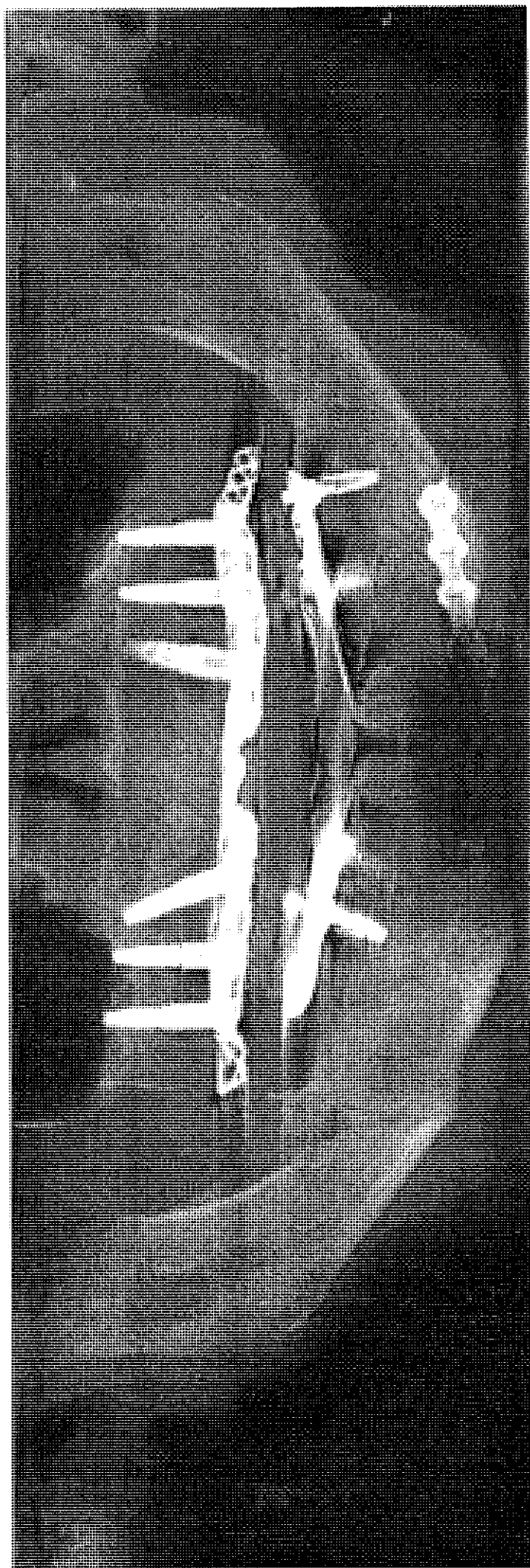














Physician's Statement

Claimant's Name: Jennie Cox
Physician's Name: Larry W. Cobb, D.M.D.
Practice/Clinic: Piedmont Oral Surgery, P.A.
Preparer's Name: Larry W. Cobb, D.M.D.
Phone: 864-271-9990

Employer's Name: Palmetto State Transportation
Insurance Carrier: Cherokee Insurance Company
SCWCC File No: 1206236

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

Date of Injury or Illness: May 31, 2012

Date of first office visit: 7/24/2012 Date of last visit: 4/27/2015

Diagnosis or nature of injury or illness: Multiple jaw fractures with fractured and avulsed teeth.

Body part(s) injured: Mandible / Maxilla, teeth Body part(s) affected: Mandible / Maxilla, teeth

Date of **Maximum Medical Improvement**: 4/27/2015

Based on the **AMA Guidelines**, the claimant has sustained a 25 % medical impairment to Jaws, teeth, soft tissue injured body part(s) and a _____ % medical impairment to _____ other affected body part(s).

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

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

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

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

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

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

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

She will need prosthetic maintenance and replacement sometime in her life time. Her prosthodontist will make this determination.

Larry W. Cobb, D.M.D.
Treating Physician

4/29/2015
Date

PIEDMONT ORAL SURGERY, P.A.

W. KEITH WALKER, D.D.S.

LARRY W. COBB, D.M.D.

2 C CLEVELAND COURT

GREENVILLE, SOUTH CAROLINA 29607

**PRACTICE LIMITED
ORAL SURGERY**

**TELEPHONE
(864) 271-9990**

April 30, 2015

To Whom It May Concern:

it is my opinion that Jennie Cox has reached her maximum medical improvement from her severe maxillofacial injuries. She has sustained some permanent disabilities form these injuries. Using the American Association of Oral and Maxillofacial Surgeons guidelines to the evaluation of impairment of the oral and maxillofacial region the determination of disability is as follows:

Masticatory dysfunction:

15%- diet limited to soft or semi solid foods- 85% of normal function

Impairment of Craniomandibular Articulation:

Interincisal Range of Motion- 30mm 4% impairment

Lateral excursion Range of Motion- 5 to 6 mm 3% impairment

Facial Disorder- Scar 2%

Nerve Disorder- Permanent numbness of lower lip and chin on the left side 1%

Her total whole person disability of 25%

Larry W. Cobb, DMD

PIEDMONT ORAL SURGERY, P.A.

W. KEITH WALKER, D.D.S.

LARRY W. COBB, D.M.D.

2 C CLEVELAND COURT

GREENVILLE, SOUTH CAROLINA 29607

**PRACTICE LIMITED
ORAL SURGERY**

**TELEPHONE
(864) 271-9990**

October 27, 2106

Re: Jennie Cox

To Whom It May Concern:

I am not familiar with the therapy that Ms. Cox has stated she is receiving. My recommendation is that she receives the accepted standard of physical therapy for maxillofacial neuromuscular rehabilitation.

Larry W. Cobb, DMD

A handwritten signature in cursive script that reads "Larry W. Cobb, DMD". The signature is written in black ink and is positioned below the typed name.

APA #11
WILLIAM A. COFER, D.M.D
04/14/16

**WILLIAM A. COFER, D.M.D.**

215 W. Poinsett St.

Greer, SC 29650

(864) 877-1891

4-14-16

Re: Jenny Cox

Jenny Cox presents with the complaint that she has a hard time chewing and eating her food. She has existing upper and lower dentures supported by implants on both arches due to a work related accident four years ago. The existing upper and lower dentures fit well and the bite is very functional. I believe the reason she is having difficulties chewing and eating is due to the numbness on the left side of her lower jaw. She has had a loss of sensation since her accident. She has no real proprioception due to the numbness thus she has difficulties chewing on the left side.

Unfortunately, it is unlikely that she will regain any meaningful sensation due to her accident.

If I may be of any further assistance please contact me.

Sincerely,
Dr. William A. Cofer

APA #12
WALTER GRADY, DO
MEDICAL GROUP OF THE CAROLINAS-
ORTHOPEDIC SURGERY-EASTSIDE
07/21/16

Medical Group of the Carolinas - Orthopedic Surgery - Eastside
 480 Floyd Road Spartanburg, SC 29307-1518
 864-582-2115 Fax: 864-582-2117

July 25, 2016
 Page 1
 Office Visit

JENNIE COX
 Female DOB: 08/14/1952

545141

Home: (864)243-0032

07/21/2016 - Office Visit: IME- LEFT SHOULDER
 Provider: Walter Grady DO
 Location of Care: Medical Group of the Carolinas - Orthopedic Surgery - Eastside
 Status: ON HOLD DOCUMENT. Contents are preliminary

Visit Type: IME Initial

History of Present Illness:
 INDEPENDENT MEDICAL EVALUATION ONLY

Attorney: Julette Mims

Area of focus: Left shoulder..

Employer at time of accident: Palmetto State Transportation..

Job description when injured: 18 wheeler truck driver..

Current employment: Unemployed..

Date of injury: 5/31/2012..

Description of injury: Patient reports that a machine rolled off of the truck and hit her. She reports that she lost consciousness as she hit her head. Apparently her head and face took a lot of the impact of the fall. She apparently had facial and jaw surgeries.. She also injured her left shoulder in the fall..

Date of surgery: Not applicable..

Chief complaint: Left shoulder weakness with some associated tingling in the left upper extremity. No pain but popping reportedly as it pertains to her left shoulder..

Past medical history: Noncontributory..

Current medications: Restoril and lorazepam..

Allergies to medications: Magnesium..

Past surgical history: Jaw surgery as described above and multiple abdominal surgeries.

Family history: Both parents are deceased..

Social history: Patient smokes however she does not consume alcohol products..

Injury history: Patient indicates that she has not received any prior treatment in regards to the above-noted problem and she has never filed a Workmen's Compensation claim for similar injury prior to this claim.

Physical Exam

Extremities: Left shoulder Examination:

Inspection reveals symmetrical deltoid and pec major atrophy bilateral shoulders..

Palpation: Tenderness is only noted in the region of the rhomboid muscle left posterior scapula. Crepitation on range of motion excursion is noted left shoulder..

Medical Group of the Carolinas - Orthopedic Surgery - Eastside

480 Floyd Road Spartanburg, SC 29307-1518

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July 25, 2016

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Office Visit

JENNIE COX

Female DOB: 08/14/1952

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PROM Testing Left Shoulder:

Flexion is 138°, extension 60°, abduction 134°, adduction 24°, internal rotation 90°, and external rotation is 90°..

Strength Testing L - Shoulder:

Flexion strength is 3/5, extension strength 5 out of 5, abduction strength 3/5, adduction strength 3+ out of 5, and internal and external rotation strength 5 out of 5...

Grip strength measurement:

30 kg of grip is noted on the right and 22 kg on the left at the number to position on the dynamometer.

Provocative testing: Negative.

Stability testing: Negative..

Neurocirculatory status: Intact.

MRI report: The study dated 7/6/12 from Innervision reveals mild DJD AC joint and mild rotator cuff tendinopathy involving the supraspinatus and infraspinatus tendons left shoulder. No rotator cuff tear is noted..

Records review: A complete records review is accomplished. The MRI result was considered in the treatment regimen rendered at GHS. The patient was deemed to be at MMI and a 6% impairment rating was given relative to her left shoulder on the date of 10 614.

Allergies or Adverse Reactions (verified):

1) Magnesium (Magnesium) (Moderate)

Impression & Recommendations:

- (1) MRI left shoulder 7- 6-12 consistent with mild DJD AC joint
- (2) MRI left shoulder 7- 6-12 consistent with mild tendinopathy supraspinatus and infraspinatus tendons..
- (3) Clinical exam 7- 21-16 left shoulder consistent with subacromial bursitis..
- (4) Clinical exam consistent with muscle weakness left shoulder as specified above
- (5) Rhomboid mild fasciitis left shoulder

Plan:

Recommend continued NSAID treatment and home exercise program. Recommend follow up with shoulder surgeon for evaluation and treatment if symptoms continue. Fresh MRI consideration at the discretion of the shoulder surgeon..

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July 25, 2016
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Office Visit

JENNIE COX
Female DOB: 08/14/1952

545141

Home: (864)243-0032

Causation: It is my current medical opinion within a reasonable degree of medical certainty that there is a causal relationship relative to this patient's noted on-the-job injury and her current medical condition..

Impairment rating calculation:

The patient is at maximum medical improvement. Her impairment rating relative to her left upper extremity is 17%. Her left shoulder impairment rating is 28%. Her whole person impairment rating is 10%..

Medical questionnaire: The medical questionnaire is accomplished on Mrs. Jenny Cox. It is scanned into the chart for review..

Physical capacities evaluation form: This form is accomplished and completed on Mrs. Janie Cox. It is scanned into the chart and available for review.

Medications Added to Medication List This Visit:

- 1) Restoril 15 Mg Caps (Temazepam)
- 2) Lorazepam 2 Mg Tabs (Lorazepam)

<u>MEDICAL QUESTIONNAIRE</u>	<u>Yes</u>	<u>No</u>
for Jennie Cox		
1. In your medical opinion, does Ms. Cox need additional medical treatment for her work related injury?	✓	
3. What is Ms. Cox's Medical Impairment Rating according to AMA guidelines? 28 % to the Claimant		
Additional Comments: 28% TO Left Shoulder And 10% Whole person		

I, Walter Grady, DO, certify to a reasonable degree of medical certainty that the above statements are my expert medical opinions.

Dated: 7-2-8-16

Dr. Walter Grady

Walter Grady, DO
480 Floyd Road
Spartanburg, SC 29307

PHYSICAL CAPACITIES EVALUATION

(For Physician's Use)

Name of Claimant: Jennie Cox

Address of Claimant: 222 West Chapman Road
Belton, SC 29627

Social Security Number: ***-**-3648

IMPORTANT: PLEASE COMPLETE THE FOLLOWING ITEMS BASED ON YOUR CLINICAL EVALUATION OF THE CLAIMANT AND OTHER TEST RESULTS. ANY ITEM THAT YOU DO NOT BELIEVE YOU CAN ANSWER SHOULD BE MARKED N/A (NOT ANSWERABLE).

Occasionally: Up to 1/3 of an Eight hour shift.
Frequently: Between 1/3 and 2/3 of an Eight hour shift.
Continuously: For a Full Eight hour shift.

I. In an 8 hour work day the Claimant should be able to:

(A) SIT a total of 8 hrs. _____ mins. of which may be done at any one time without interruption.

(B) STAND a total of 8 hrs. _____ mins. of which may be done any one time without interruption.

(C) WALK a total of 8 hrs. _____ mins. of which may be done any one time without interruption.

NOTE: Total need not equal 8 hours if the Claimant does not have sufficient capacity

II. Considering your clinical findings only, the Claimant should be able to LIFT/CARRY.

	<u>Never</u>	<u>Occasionally</u> (0% to 33% of the time)	<u>Frequently</u> (34% to 64%)
Up to 5 lbs	_____	_____	<u>✓</u>
6 to 10 lbs.	_____	<u>✓</u>	_____
11 to 20 lbs.	<u>✓</u>	_____	_____
21 to 25 lbs.	<u>✓</u>	_____	_____
26 to 50 lbs.	<u>✓</u>	_____	_____
51 to 100 lbs.	<u>✓</u>	_____	_____

III. The Claimant should be able to use his extremities for repetitive actions such as

	<u>Neither</u>	<u>Left</u>	<u>Right</u>	<u>Both</u>
A. Hands/arms simple grasping	_____	_____	_____	<u>✓</u>
handling	_____	_____	_____	<u>✓</u>
pushing & pulling	_____	_____	<u>✓</u>	_____
reaching outward	_____	_____	<u>✓</u>	_____
overhead reach	_____	_____	<u>✓</u>	_____
B. Legs/feet operating foot/	_____	_____	_____	<u>✓</u>
Leg controls	_____	_____	_____	<u>✓</u>

IV. The Claimant should be able to:

	<u>Never</u>	<u>Slightly</u> (function limited)	<u>Moderately</u> (seriously limited)	<u>Severely</u> (No useful ability)
A. Climb	☒	☐	☐	☐
B. Bend	☐	☒	☐	☐
C. Squat/Stoop	☐	☒	☐	☐
D. Kneel	☐	☒	☐	☐
E. Crouch/Crawl	☒	☐	☐	☐
F. Hands above shoulder level	☒	☐	☐	☐
G. Twist from side to side	☐	☐	☒	☐

V. The Claimant may be exposed to the following working conditions:

	<u>Never</u>	<u>Slightly</u> (function limited)	<u>Moderately</u> (seriously limited)	<u>Severely</u> (No useful ability)
A. Unprotected heights	☒	☐	☐	☐
B. Moving machinery	☒	☐	☐	☐
C. Noise and vibrations	☐	☒	☐	☐
D. Extreme temperatures	☐	☒	☐	☐
E. Dust, fumes & gases	☐	☒	☐	☐

VI. Has Claimant's current level of function lasted, or is it expected to last for twelve (12) months or more? Yes ☒ No ☐

VII. The following space may be used for any further comments re: the physical capacities of the Claimant.

VIII. Does Claimant's condition(s) cause pain which would be likely to affect his ability to concentrate? Yes ☒ No ☐IX. Could the Claimant maintain an acceptable attendance record at a competitive, 40-hour per week job? No ☒ Possibly ☐ Yes ☐X. Does Claimant's condition have facets which would require breaks or rest periods during the day: Examples- nausea, diarrhea, pain, etc. Yes ☒ No ☐
Specify how long and how frequently a rest is needed:

patient has significant pain

XI. Does any of the medication taken by the Claimant have known side effects and/or require additional limitations on his activity: Yes ☒ No ☐

Specify:

Drowsiness

XII. According to the AMA guidelines, what is the Claimant's impairment rating?

28 %

XIII. Please comment on the Claimant's ability to return to work:

Patient is unable to return to work
at this time.

THE ABOVE OPINIONS ARE HELD WITH A REASONABLE DEGREE OF CERTIANTY BASED ON GENERALLY ACCEPTED STANDARDS IN MY PROFESSION.

Date: 7-28-16

Dr. Walter Grady

Walter Grady, D.O.
480 Floyd Road
Spartanburg, SC 29307

APA #13
ROBERT E. BRABHAM, PH.D.
PSYCHOLOGICAL AND TRAINING SERVICES, PA
08/05/16

PSYCHOLOGICAL AND TRAINING SERVICES, P.A.

920 St. Andrews Rd., Columbia, SC 29210

bobnorabrabham@att.net

PH: 803-731-0588 Fax: 803-731-0589

ROBERT E. BRABHAM, PH.D

LICENSED PSYCHOLOGIST

MASTER'S IN REHABILITATION COUNSELING

CERTIFIED LIFE CARE PLANNER

ROB BRABHAM JR., MRC

NORA HEAPE, RN, BA

AMYE HAWKINS, ADM. ASST.

BETH BURNETT, BA, ED

PSYCHOLOGICAL and VOCATIONAL EVALUATION

Name: Jennie C. Cox

ID Number: xxx-xx-3648

Date of Birth: 8-14-52

Age at Evaluation: 63

Date of Evaluation: 8-5-16

Date of Report: 8-8-16

Referral and Background Information: Ms. Cox is a 63-year-old former CDL Driver for Palmetto State Transport, for whom she had worked for about 11 years. However, she has worked as a CDL Driver since 1985.

She was referred by her attorney, Ms. Juliette Brown Mims, for an independent psychological and vocational evaluation to determine vocational implications, and earnings issues, if any, related to limitations resulting from on-the-job injuries she sustained on 5-31-12. This evaluation took place at the office of her attorney, in Greer, SC. No one else was present during the evaluation.

Ms. Cox indicated that she was a Co-Driver and drove from Greenville, SC to Brownsville, TX, with a stop in Atlanta, GA. She sustained on-the-job injuries when she was stopped in Atlanta, and had moved cargo, which was on wheels, to the back of the truck. She indicated that, somehow, the load of cargo fell over, and landed on her. In that process, she fell onto the deck area of the trailer. She indicated that there was "blood everywhere" at the scene.

She has no great recall of the actual events of the accident, but has been told that her co-worker lifted the cargo off of her, and turned her over, to assist with breathing. EMS was called to the scene, and she was initially taken to nearby Grady Hospital. She was later transferred to Greenville, SC, for treatment, in order to be closer to home.

To her credit, Ms. Cox tried to return to work, and actually drove a one-week "run." However, she was "exhausted" while doing so, and since that time, she has been unable to return to any gainful employment whatsoever, as a result of her on-the-job injuries on 5-31-12.

She was married twice, but has been divorced since 1995. She has two adult daughters.

Ms. Cox arrived promptly for this evaluation and drove herself to the appointment. She drives about daily, usually locally only, for only about 30 minutes maximum at a time. She indicated that she must vastly limit her driving due to "exhaustion", as well as to neck and shoulder pain. She contrasted her limited ability to drive now with her ability to drive for "thousands of miles" in the past.

Her general appearance, hygiene and personal grooming were good. She had a pleasant general demeanor, but appeared obviously depressed and sad during the evaluation. She is 5' 6" in height, and weighs only about 103 pounds, a loss of about 15-20 pounds since her injuries, due, in her opinion, to ongoing dental issues. As will be noted, as a direct result of her on-the-job injuries, she eventually required dental surgery and lost all of her teeth, upper and lower, in that process. She wears glasses for reading. She has hearing loss in her left ear since her on-the-job injury, a result of broken facial bones near her ear. She does not require the use of any assistive device for mobility or stability.

At the time of this evaluation she was not receiving any income. As a result of her loss of employment, she is undergoing financial hardship at this time. She indicated that she has nearly depleted her modest savings. Fortunately, her company paid for her dental work, and still pays her health insurance coverage, even though she is not receiving any income from them.

Sources of Information:

Medical Records from:

Grady Hospital
Greenville Health System

University Medical Group
Innervision MRI
Jennifer Ellis, MD
ProAxis Physical Therapy
Larry Cobb, DMD
Donald Ridgell, DMD
William Cofer, DMD

James Fowler, III, MD
Brian Svazas, MD
Stacy Newsom, MD
Christopher Sidden, MD

Psychological Testing and Evaluation Results:

Wechsler Adult Intelligence Scale – Fourth Edition
Wide Range Achievement Test – Revision 4
Beck Depression Inventory – II
Diagnostic Screening for Anxiety
Clinical Interview and Behavioral Observations
Mental Status Examination

Activities of Daily Living: She lives in alone in a single-family house. She has about 15 acres of land, and indicated that she previously enjoyed caring for her own lawn. However, following her injuries, even using a riding lawn mower worsened her neck and shoulder pain, and now, she must rely on assistance of family and friends for lawn care.

On most days, she gets up at about 8 AM and is able to handle her personal grooming and toilet needs without assistance. She indicated that she avoids taking prescription medication as much as possible, due to her concern about addiction of those medications. She does not get dressed to leave the house about two days per week.

She still attempts to perform as many light chores as possible around the home, but even then, she requires frequent breaks when doing so. She shops alone, but requires items to be packaged for ease of carrying.

Despite her efforts to do so, she is not able to sustain much activity, due to pain. She indicated that she can walk with her grandchildren "for a few minutes at a time", albeit at a slow and deliberate pace.

In a typical 8-hour day she indicates she must spend about 2-3 hours of the day reclining/resting on the sofa as a result of her physical limitations and pain. She watches television to pass the time. She takes daytime naps of about an hour, something she "never" did prior to her injuries. The inability to remain in an upright position for a full 8-hour day even with sit/stand options clearly prevents her ability to sustain gainful employment at this time.

In a 5-day work week she indicated that she would be unable to remain at any job for a full 8-hour workday due to pain problems associated with medical conditions that resulted from her on-the-job injuries, resulting in her need to be absent more days than not. This would of course greatly exceed the number of days available for personal/sick leave in an average job in South Carolina, about 1-day per month.

She has developed major problems with sleep following her injuries. She returns to bed at about 9 PM but has problems falling asleep. She estimated that she gets only about five hours of non-restorative sleep, usually in short increments, often interrupted by pain. Once awake, she has difficulty returning to sleep. She indicated that she essentially "lies there" for an extended period of time, and worries about her finances. She indicated that she has a history of "some mild sleep issues", but none of such significance as to interfere with her CDL work.

As a direct result of her on-the-job injuries she is now able to participate in far fewer social or leisure activities than was the case prior to her injuries. She mostly stays home now. She also admits that she has inadequate patience and is easily irritated at times, despite her efforts to the contrary. She indicated that her relationships with friends, family and others have also changed as a result of her medical conditions. Her social circle has dwindled, which adds to the depression she is experiencing.

She noted she could no longer attend as many school activities of her grandchildren, work in her yard, go camping, ride horses, travel, or ride rides at amusement parks, all activities she enjoyed prior to her on-the-job injuries.

She noted she has difficulty concentrating and sustaining attention to complete nearly any tasks. The overall quality of her life has clearly been greatly diminished by her injuries.

Educational Background: She graduated from Woodmont High School in 1970. She attended TEC, but did not graduate. She obtained her Truck Driver's Class "A" license in 1985, and has worked in that capacity thereafter.

Work History: Ms. Cox has a quite stable work history as a CDL Driver. She indicated that, as a child, she was one of nine children, and she did not even have shoes for school. As a result, she was "determined" to provide for her children. She indicated that she was one of the first women truck drivers in the United States, a source of pride for her.

At the time of her on-the-job injuries, she was working as a Team Driver for Palmetto State Transport, for whom she had worked for the past 11 years. She earned \$60,000-\$70,000 annually, plus fringe benefits, by her report.

Work as a CDL Driver is defined by The Dictionary of Occupational Titles as Semi-skilled and Medium in physical demands. In her job duties, she was required to lift, bend, stoop, and reach on a regular basis as part of her essential job duties. She has never held an "office job" or a Sedentary position, and has no readily transferrable skills to lesser physically strenuous alternative jobs.

Prior truck driving experience included about six years for US Food Service. She indicated that she left that position for better working conditions with Palmetto State Transport.

She insisted that in her employment she had no personnel or performance problems. She enjoyed her co-workers, her colleagues and got along well with her supervisors.

Ms. Cox indicated that she had no prior injuries. She described herself as being in good health at the time of her injuries. She was only prescribed Xanax, related to the recent death of her grandson, at age 16 in a car crash. Thus, it is reasonable to conclude that it is the on-the-job injury in May 2012, which began her medical problems which have been the basis for her inability to maintain gainful employment.

Medical Problems: The medical aspects of her injury are documented in other reports, and will not be addressed in great detail herein. However, several more recent medical references have vocational significance and are noted accordingly.

On 5-31-12, Grady Hospital indicated, "...unloading a truck at loading dock...heavy machine fell on her back...caused her to fall on the floor face first...was pinned beneath the equipment...missing some upper and lower teeth...left shoulder and scapula pain...right sided lower rib pain...comminuted fracture of the mandible...transfer to Greenville..."

Also on 5-31-12, Atlanta American Medical Response of Georgia indicated, "...transfer to Greenville Memorial Hospital...closer to home...fractured jaw...heavy equipment fell on her...pain in face..."

On 6-1-12, Dr. James Fowler, III, GHS, performed surgery. Records indicated, "...bilateral subcondylar mandible fracture...left body comminuted mandible fracture...avulsed maxillary and mandibular teeth...maxillomandibular fixation with screws...open reduction and internal fixation left body mandible fracture...dental tooth extraction..."

On 6-12-12, Dr. Newsom indicated, "...mandibular fracture...chest wall pain...left shoulder pain...possible rotator cuff injury...Lortab...deep breathing exercises...*sedentary work...no lifting more than five pounds...no operating commercial motor vehicle...*"

On 6-29-15, Dr. Fowler indicated, "...post-op from removal of mandibular plates and screws...denture anchors remain in place...no dentures for one month...*remain out of work...*"

On 7-6-12, Dr. Christopher Sidden, Innervision MRI, indicated, "...MRI left shoulder...degenerative changes...mild tendinopathy in the supra and infraspinatus tendons..."

On 7-17-12, Dr. Stacy Newsom, University Medical Group, indicated, "...left shoulder discomfort...left chest pain...right-sided posterior back pain...significant injury that caused fractured mandible and loss of some teeth...*Sedentary work...no lifting over 5 pounds...no operating commercial vehicle...*"

On 8-7-12, Dr. Newsom indicated, "...weakness in shoulder...physical therapy...*lift, push, pull no more than 15 pounds occasionally...no operating commercial vehicle...*"

On 8-28-12, Dr. Jennifer Ellis noted, "...*Depression...insomnia...getting worse...loss of appetite...loss of interest in pleasurable activities...Anxiety Disorder...Alprazolam...*"

On 9-27-12, Ms. Cox began physical therapy at ProAxis Therapy.

On 10-26-12, GHS Center for Health and Occupational Services indicated, "...*no lifting more than 25 pounds...no operating commercial motor vehicle...*"

On 10-30-12, Larry Cobb, DMD, noted, "...*very complicated case...further compromised by very significant jaw injuries...remaining teeth are terminal due to lack of bone support...all will have to be removed...has very minimal maxillary bone and will lose more when her teeth are removed...will require extensive bone grafting...*"

On 11-5-12, Dr. Fowler indicated, "...is scheduled for dental restoration...nutrition has been affected...having to work to get enough nutrition in...recommend softer food diet..."

On 11-9-12, GHS Center for Health and Occupational Services indicated, "...return to full duty...residual symptoms...at MMI...2% impairment to left shoulder..."

On 5-9-13, Larry Cobb, DMD, indicated, "...*very malnourished...success of our treatments depends upon her ability heal...all of our treatment may be in jeopardy if her overall nutrition does not improve...*"

On 7-15-13, Dr. Ellis indicated, "...doing about the same...fatigue...*25 pound weight loss...loss of appetite...tries to eat but it hurts...*"

On 4-14-14, Dr. Ellis noted, "...out of control feelings...overwhelmed by keeping up with items at home..."

On 10-6-14, Dr. Brian Svazas, GHS, indicated, "...re-evaluation of left shoulder...residual difficulties in left shoulder...sore after long truck runs...difficulties with left ear...intermittent hearing diminution... complaints in left scapular border are likely related to previous injury to shoulder...physical therapy...fit for duty as truck driver...at MMI...6% impairment...may need ongoing therapy for shoulder going forward..."

On 4-8-15, Dr. Svazas indicated, "...at MMI...6% impairment to left shoulder...return to work without restrictions...will need future physical therapy..."

On 4-9-15, Donald Ridgell, DMD, noted, "...at MMI...can work without restriction...will need maintenance procedures annually...replace or refurbish appliances every 6-8 years...oral surgeon visits every 5 years..."

On 4-30-15, Dr. Cobb noted, "...can work without restriction...at MMI from severe maxillofacial injuries...*permanent disabilities from these injuries...total whole person disability of 25%...will need prosthetic maintenance and replacement...*"

On 10-12-15, Dr. Fowler indicated, "...numbness over chin and left lower lip...may be permanent..."

On 3-3-16, Dr. Ellis noted, "...has lost significant weight...*Depression...Insomnia...Anxiety Disorder...will be out of work this week to see how she responds to meds prior to resuming driving...*"

On 3-22-16, Dr. Ellis noted, "...*depression and insomnia...irritability...fatigue...still difficulty with eating...difficulty concentrating...difficulty performing routine ADLs...does not have energy to return to work...feels overwhelmed...decreased endurance...depression worsening...contributing to appetite issues...add Fluoxetine...insomnia worsening...Lunesta...*"

On 4-14-16, Dr. William Cofer indicated, "...has a hard time chewing and eating...existing upper and lower dentures supported by implants on both arches...work-related accident four years ago...numbness on left side of lower jaw...unlikely she will regain any meaningful sensation..."

On 4-22-16, Dr. Ellis indicated, "...*encouraged to pursue less demanding driving position...*"

At the time of this evaluation, Ms. Cox is prescribed Wellbutrin and Restoril for her medical conditions worsened by her on-the-job injuries. As noted previously, she avoids taking prescription pain medications as much as possible, due to her concern about addiction of such medications. However, the absence of treatment for pain does not equate to the absence of pain.

References to pain in records exist over an extended period of time. When asked to describe her pain, she indicated that since her on-the-job injuries she experiences pain at a level 8 on a 10-point scale, 7-days per week. *She is never pain free.* She noted that nearly any daily activity exacerbates her neck and shoulder pain. Her pain is best relieved by resting and avoiding activity.

Mental Status Evaluation: She was well oriented to all spheres, and neither demonstrated nor reported any hallucinations or delusional thought processes. As noted previously, she has been prescribed Xanax related to the death of her grandson. However, she noted no other mental health history of such significance as to interfere with her work or other key activities at the time.

She described, and medical records confirm, clinically significant symptoms sufficient to confirm the continued presence of a level of depression. Her depressive symptoms include a considerable loss of interest or pleasure which is nearly always present. This includes social withdrawal even from family activities; significant reduction in previous levels of sexual interest or desire; decreased energy, tiredness and fatigue out of proportion to actual activity; impaired ability to concentrate; and is easily distracted with memory difficulties.

These symptoms have clearly resulted in significant distress/impairment in social, occupational, and other important areas of functioning. These symptoms are not better described by any other general medical condition and there is no evidence of any substance abuse which would cause these same symptoms. In spite of her depression, she denies any suicidal attempts or plans at this time.

It is worthy to note that considerable recent research evidence, as published in various pain management journals, indicates that the vast majority of individuals who experience pain for more than a year can be expected to develop significant clinical depression. Ms. Cox continues to experience pain, now four years following her on-the-job injuries. Thus, it is not surprising that she also continues to experience a level of depression.

Ms. Cox also described considerable anxiety that she is continuing to experience as a direct result of the on-the-job injuries received in May 2012. This includes awareness as to her future medical prognosis. Her anxiety is worsened by the realization that in spite of full and careful compliance with all recommended medical treatments and allied services, the hoped-for significant improvement simply has not occurred.

In assessing Ms. Cox's symptoms of pain, there are medically determinable impairments that provide a reasonable basis for her reports of severe pain. Records confirm the intensity, persistence, and/or functionally limiting effects of the pain and/or other symptoms. Based on determinable medical evidence, all of these aspects are well established, and support a diagnosis of a pain disorder.

She does not use illegal drugs and does not consume alcohol. She smokes 1½-packs of cigarettes a day. We discussed the correlation between cigarette smoking and pain, and she was urged to stop smoking.

Psychological Test Results: She appeared to cooperate and to give optimal effort during this evaluation. Thus these results are believed to be valid indicators of her current levels of functioning.

On the Wechsler Adult Intelligence Test – Fourth Edition, she obtained a Full Scale IQ score of 85. Relative to examinees of comparable age, she is currently functioning within the "low average" range of intelligence on this standardized measure of intellectual ability. This would be consistent with her age and educational history, albeit 45 years ago.

On the Wide Range Achievement Test – Revision 4, her Reading Standard Score is an 8.1 grade level score, her Arithmetic Standard Score is only a 4.8 grade level score, and her Spelling Standard Score is only a 7.7 grade level score. Her academic skills are not sufficient for use in work settings in which such skills would be essential.

Her responses to the items on the Beck Depression Inventory-II, included as part of this evaluation, confirm that she is experiencing a level of depression. She indicated that she does not wish to be referred for additional mental health services, however helpful such services might be for her.

Diagnoses: After observing her during this evaluation, and from careful review of records of past behavior and levels of functioning, she is clearly manifesting signs and symptoms consistent with the requirements to establish and/or maintain several diagnoses. She is continuing to experience major pain episodes and references to pain exist in several medical records over an extended period of time. She is also anxious about her future, especially since she realizes that her past work is no longer an option for her, an anxiety-provoking thought for someone at the age of 63. Finally, her multiple losses, personal, financial, social and leisure, all have led to a level of depression.

Therefore the following diagnoses apply, in keeping with all diagnostic requirements for each:

307.89 Pain Disorder

296.32 Major Depressive Disorder, Recurrent Episode, Moderate Severity

300.02 Generalized Anxiety Disorder

These medical/mental conditions are in addition to her other physical medical problems that are well documented in her files.

Vocational Opinion and Rationale: Several factors must be considered in reaching a vocational opinion. They include her age of 63, already defined as "approaching retirement age", a negative factor; her high school graduate educational background would be positive, but is offset by her lower than might have been expected academic scores; her stable work history would be positive but is offset by her inability to perform any work on a sustained basis; due consideration must also be afforded to the pain that she experiences on a daily basis which requires that she spend 2-3 hours per day "resting or reclining"; and her depression and anxiety also interfere with her ability to maintain sufficient attention and concentration, which becomes a negative factor.

Taking all of these factors into consideration, it is my opinion, to a high degree of professional certainty, based on more than fifty years of vocational rehabilitation and psychology experience, that she must be expected to permanently remain, unable to engage in full-time gainful, competitive employment as a result of her medical conditions resulting from her on-the-job injuries in May 2012.

The rationale for my opinion is essentially based on the following observations:

Credibility: She appeared credible in her description of her limitations and remaining functional capacities. As a result of the combination of her limitations and restrictions, she cannot complete significant tasks or activities on a regular, sustained basis.

It is noted that the information provided during this interview was highly consistent with information reported in other reports. This provided additional confirmation that the responses and description of events and circumstances were candid, were not feigned or exaggerated, and do not appear to represent any symptom magnification.

It is not reasonable to suggest that someone with a stable work history, who is her own sole source of income, would suddenly feign or fake an inability to work, and by doing so, subject herself to the financial hardship she is currently experiencing.

In determining the credibility of Ms. Cox's statements, I have considered the entire case record, including the subjective medical evidence, her own statements about symptoms, statements and other information provided by treating or examining physicians and allied medical personnel about the symptoms and how they affect her. I have also taken into consideration her statements about the intensity and persistence of pain and other symptoms regarding the effect the symptoms have on her ability to work. This is the position and rationale used in several disability adjudication processes, and is one that I follow as well.

Pain Factors and Attendance Implications: She continues to experience significant pain at such levels as to interfere with her ability to sustain physical activity. Her cognitive deficits would also cause difficulty in her ability to pay attention to job tasks and job duties for hours each week, on average. The inability to maintain concentration and persistence interferes with the ability to meet production expectation for even unskilled jobs.

Social Security Considerations: Based on the evidence in her files, and following the guidelines as noted in the Psychiatric Review Technique, SSA Form 2506-BK, she likely meets the requirements of a 12.04 Affective Disorder.

As to the Affective Disorder, her depressive syndrome is characterized by (1) loss of interest in almost all activities, as noted by her withdrawal from social and recreational activities; (2) sleep disturbance; (3) decreased energy, as evidenced by the need to "rest" for hours of typical days; (4) and difficulty concentrating.

She also likely meets the "B" Criteria of the Listings as evidenced by her current "Marked" restriction in activities of daily living; her "Marked" difficulties in maintaining social functioning as evidenced by her withdrawal from nearly all such activities; and her "Marked" difficulties in maintaining concentration and persistence to even simple chores.

She was assessed with limitations in the following abilities: to understand and carry out instructions; maintain attention and concentration; respond appropriately to coworkers, supervisors and the general public; adhere to work schedule and complete tasks in a timely fashion and withstand the stresses and pressures associated with most work settings.

The combination of her limited academic skills, and her multiple physical and psychiatric conditions clearly results in an inability to sustain gainful employment. Additionally, she is 63 years of age, defined as "approaching retirement age"; her previous work as a CDL Driver is so specific that it provides no readily transferrable skills; and various medical records confirm that she is restricted to no more than light, if not sedentary, work. As a result of this combination of factors, she may well meet Social Security requirements for approval of disability benefits.

Summary and Conclusions: Based on all the evidence as described above, consistent with observations during this evaluation and various reports in her file, she would be unable to effectively perform the essential duties in any gainful work activity. It is also clear that the unfortunate combination of factors and characteristics she now faces are directly related to the injuries she sustained while working.

As noted in multiple records, Ms. Cox is unable to maintain any position for more than a brief period of time, less than thirty minutes, and has to frequently change positions. She also is unable to perform any physically strenuous activity. Further, Ms. Cox is also unable to handle any type of work that would require close attention to detail, attention, concentration, persistence or pace. As a result, she would clearly be incapable of performing any type of work that would exist in significant numbers in the regional or local economy. Directly as a result of her on-the-job injuries the only services she could perform are so limited in quality, dependability, or quantity that no reasonably stable market for them exists.

No employer could reasonably be expected to tolerate and accommodate her need for extended breaks, need to lie down throughout the day, and general lack of productivity. Clearly, her limitations eliminate her return to gainful employment on a full time basis.

The opinions noted in this report are offered within a reasonable degree of psychological certainty, based on more than 50 years of vocational rehabilitation and psychology experience. Thank you for the opportunity to work with you in this matter. If you have any questions, or if I could address additional issues, please do not hesitate to contact me.

A handwritten signature in black ink, appearing to read "Robert E. Brabham". The signature is fluid and cursive, with a long horizontal line extending from the end.

Robert E. Brabham, Ph.D.
Licensed Psychologist (SC #77)
Master's in Rehabilitation Counseling

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206236

JENNIE COX,
Employee
Claimant,

vs.

PALMETTO STATE
TRANSPORTATION,
Employer

AND

CHEROKEE INSURANCE COMPANY,
Carrier

Defendants.

APA SUBMISSIONS

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APA #26
Life Center Health
08/17/06-10/21/16

Name: Jennie Cox

Date: 8-17-16

Exercise	Pos	Sets x Reps	Weight
Airdyne		3:00	
Chest Press		2x12	35
Bicep Curl		2x12	8
Leg Press	9	2x15	120
Chest Fly		2x12	5
Hammer Curl		2x12	8
Step up		2x8	Body

Notes: _____

Date: 8-19-16

Exercise	Pos	Sets x Reps	Weight
Airdyne		3:00	
TRX Row		2x15	
Tricep Pushdown		2x12	17.5
TRX Squat		2x15	
Reverse Fly		2x12	5
Tricep Kickback		2x10	5
TRX Reverse Lunge		2x10	
Plank		2x:10s	
Toe Touches		20	

Notes: 113.6 lbs

Date: 8-22-16

Exercise	Pos	Sets x Reps	Weight
Row		250m	Level 5
Bicep curl		2x12	8
Leg Press		2x15	120
Chest Press-Ball		2x10	8
Tricep pushdown		2x12	15
Leg Extension		2x12	10
Low Row		2x15	20
Heel Touches		20	
Reverse Crunch		10-12	

Notes: 114.2 lbs

Date: 8-31-16

Exercise	Pos	Sets x Reps	Weight
Row		3:00	Level 5
Chest Press		2x12	25
Squat w/Ball		2x15	Body
TRX Row		2x15	Body
Shoulder Press		2x10	5
Step up		2x10	Body
Sit up		10	
Flutter Kicks		20	

Notes: _____

Name: Jennie Cox

Date: 9-7-16

Exercise	Pos	Sets x Reps	Weight
Airdyne		3:00	
Incline chest Press		2x12	5
Bent over Row		2x15	5
Sit to stand		2x12	Body
Bicep curl		2x12	8
Leg Press		2x15	120
Russian Twist		:20s	8
Plank		2x10s	

Notes: _____

Date: 9-9-16

Exercise	Pos	Sets x Reps	Weight
Walk Track		10 Min	
TRX Reverse Lunge		2x10	Body
TRX Chest Press		2x10	Body
Shoulder Press		2x10	5
Tricep Pushdown		2x12	20
Bicep curl (21)		21	5
Crunches		15	
Leg Raises		10	

Notes: _____

Date: 9-14-16

Exercise	Pos	Sets x Reps	Weight
Row		250M	Level 6
Tricep Dips		2x12	Body
Chest Fly on Ball		2x12	5
Step ups		2x10	5
Skull crushers		2x10	20
Chest press on Ball		2x12	8
leg Extension		2x12	15
Woodchops		2x10	5
Elevated crunch		2x15	
Sit up		12	

Notes: _____

Date: 9-16-16

Exercise	Pos	Sets x Reps	Weight
Airdyne		2:00	
TRX Courtesy Lunge		2x10	Body
Low Row		2x15	25-30
Bicep Curl		2x15	8
Wall sits		:20s	Body
Lat Pulldown		2x12	20
Crunch machine		2x20	40
Flutter Kicks		:20	
Plank		2x:15s	

Notes: _____

Name: Jennie Cox

Date: 9-21-16

Exercise	Pos	Sets x Reps	Weight
Kettlebell Swing		2x15	12
Chest Press		2x12	25
Sit to Stand		2x12	5
Tricep Kickback		2x10	5
Pull over		2x10	10
Front Raises		2x10	5
Toe Touches		20	
Heel Touches		20	
Side Bends		15	15

Notes: _____

Date: ~~9-21-16~~ 10-3-16

Exercise	Pos	Sets x Reps	Weight
Sled Push		40 yds	
Push ups		2x8	Body
Hammer curl		2x12	8
Leg Press - Plated		2x12	Leg
Incline chest fly		2x15	5
Barbell curl		2x10-12	20
Elevated crunch		2x15	
Crunches		20	

Notes: *Plated leg press is much harder than selectorizer, so weight will look less. *Sled weighs 85 pounds with no added weight.

Date: 10-5-16

Exercise	Pos	Sets x Reps	Weight
Walk Treadmill		5 min	
Shoulder Press		2x12	
Walking Lunges		2x20	
Tricep Pushdown		2x12	
Reverse Fly		2x10	
Leg Extension		2x12-15	
Superman Hold		:20s	
V-Sit Hold		:20s	

Notes: _____

Date: 10-12-16

Exercise	Pos	Sets x Reps	Weight
Row		300m	Level 6
TRX Squats		2x20	Body
Lat Pulldown		2x15	25
Bicep curl (21)		21	8
Leg Press - Plated		2x12	60
Bent over Row		2x15	20
Push ups		2x8	Body
Crunch machine		2x20	45
Plank		2x15s	

Notes: _____

Name: Jennie Cox

Date: 10-14-16

Exercise	Pos	Sets x Reps	Weight
Sted		40 yds	10
Squat Press		2x 12	8
Bench press		2x 12	30
Tricep Dips		2x 12	Body
Leg Extension		2x 15	15
Leg Curl		2x 10	10
cable chest press		2x 12	7.5
Sit ups		12	
Heel Touches		25	
Side Bends		15	12

Notes: _____

Date: 10-19-16

Exercise	Pos	Sets x Reps	Weight
Airdyne		5 min	
Walking Lunges		2x 12	10
Bicep curl		2x 10	5
Low Row		2x 15	45
Squat w/ Ball		2x 15	65
Tricep pushdown		2x 20	Body
Chest Press on Ball		2x 10	Body
Bicycle crunch		2x 20	~~10~~
Reverse crunch		2x 15	~~10~~
Superman Hold	:30s	~~2000s~~	Body

Notes: _____

Date: 10-21-16

Exercise	Pos	Sets x Reps	Weight
WALK TRACK		5 min	
Sit to Stand		2x 12	10
Lateral Raise		2x 10	5
Hip Adduction		2x 15	45
Hip Abduction		2x 15	65
TRX Row		2x 20	Body
Push ups		2x 10	Body
crunch machine		2x 20	45
cable Twist		2x 15	10
decline Sit up		2x 5	Body

Notes: _____

Date: _____

Exercise	Pos	Sets x Reps	Weight

Notes: _____

Fitness Test	9/30/2016	10-21-16		
3-min Step Up	128 bpm	144 bpm		
Push-up	12	15		
Sit-up	25	30		
1 Rep Max - Bench	401b	451b		
Leg Press Max	701b: Free Motion	901b: Free Motion		
	117.2 lbs	120.1		

10-19-16 → 119.7

APA #27
CORA Rehabilitation Clinics
10/24/16-12/19/16

**PHYSICAL RECONDITIONING/
WORK CONDITIONING
EVALUATION**

TODAY'S DATE: 10/24/16

FPT: Greenville

Name: Jennie Cox		SS#: 250-94-3648		Sex: Female	Age: 64
Date Admitted to Program: 2/16/2016	Date of Injury: 05/31/2016	Projected Program D/C Date: 6 weeks		First Date Lost Time: 10/24/2016	
Diagnosis: Generalized deconditioning/weakness		Type of Injury: Multiple Body Parts	Ins. Adjuster: Align		
Employer: Palmetto State	Referral Source: Align		Carrier/Claim #:		
Physician:	WCCCC: Cassandra Alewine		PDC: medium-Heavy		
Work Status: Not working	Occupation: Truck Driver		Dominant Hand: Right		

PATIENT MEDICAL/ INJURY HISTORY	05/31/2016- Pt is a truck driver. A machine came off of the back of the trailer and fell on her. She has little memory of the accident, all she remembers is opening her eyes, seeing blood and trying to get up but couldn't due to the machine being on top of her. She bruised her lungs, broke her jaw/teeth, and injured primarily the L side. Pt reports having very little energy and strength (noted difficulty getting enough nutrition due to jaw/teeth sx) with her primary limitations being endurance and strength.

MUSCULOSKELETAL ASSESSMENT	STRENGTH: R: ankle: PF 3+/5, DF 4/5, Inv/Ev 4/5 R: knee: FI 4/5, Ex 3+/5 R: hip: FI 3+/5, abd 3/5, Ex 3/5 L ankle: PF 3+/5, DF 4/5, Inv/Ev 4/5 L knee: Flex 4/5, Ext 3+/5 L hip: flex 3+/5, abd 3+/5, ext 3+/5 ROM: R ankle: WFL R: knee: WFL R: hip: WFL L ankle: WFL, inv WFL, ev WFL L knee: WFL grossly L hip: WFL grossly OTHER: B HS: 90/90 L 55 deg knee fl, R 30 deg knee fl

BEHAVIORAL	Validity Testing: Client passed 3 of 5 validity tests indicating maximal effort. Waddell's: N/A FPI: Functional: % Pain: 0/10

COGNITIVE STATUS	Client is alert, oriented and able to safely follow directions

FUNCTIONAL STATUS	See Attached

PHYSICAL DEMAND	Job Required: medium/heavy	Current: light	Goal: heavy

CARDIOVASCULAR	Pre-Test: HR: 104 BP: 120/80	Post-Test: HR: 84 BP: 120/80

BARRIERS	

FACILITATORS	Moderate motivation

TODAY'S DATE: 12/5/16

FPT: Greenville

Name: Jennie Cox		SS#: XXX-XX-3648		Sex: Female	Age: 64
Date Admitted to Program: 2/16/16	Date of Injury: 5/31/16	Projected Program D/C Date: 6 weeks		First Date Lost Time: 10/24/16	
Diagnosis: Generalized Deconditioning/weakness		Type of Injury: Multiple body parts		Ins. Adjuster: Align	
Employer: Palmetto State		Referral Source: Align		Carrier/Claim #:	
Physician:		WCCCC: Cassandra Alewine		PDC: Medium-heavy	
Work Status: not working		Occupation: Truck Driver		Dominant Hand: Right	

PARTICIPATION IN PROGRAM	Attendance: Good	Patient has attended 15 of 17 scheduled visits.	Comments: Pt cancelled 2 appts due to illness
	Motivation: Good		

MUSCULOSKELETAL ASSESSMENT	STRENGTH:	CURRENT R ankle: PF 4+/5, DF 5/5, Inv/Ev 5/5 L ankle: PF 4+/5, DF 5/5, Inv/Ev 5/5 R hip: Fl 4/5, abd 4/5, Ext 4/5 L hip: Fl 4/5, abd 4/5, Ext 4/5 R knee: Fl 4+/5, Ext 4/5 L knee: Fl 4+/5, Ext 4/5	IMPORTANT GAINS Generalized knee strength gains overall through the lower body
	ROM:	n/a	
	OTHER:		

FUNCTIONAL STATUS	Sec Attached

PHYSICAL DEMAND	Job Required: medium-heavy	Current: medium	Goal: heavy

CARDIOVASCULAR	Pre-Test:	HR: NT	BP: NT	Post-Test:	HR: NT	BP: NT

JOB AVAILABILITY	Modified job duty available? No	Modified duty required PDC:

TRANSFERRABLE SKILLS	

SUMMARY	Pt has been progressing well in terms of her overall strength per objective measurements. She has been steadily increasing her weights and walking time on the treadmill and is able to independently perform her exercise routine with rest breaks. Pt continues to have difficulty with heavier lifting activities, repetitively, due to weakness and neck/back discomfort that would benefit from her continuing her WC program. Remaining goals she has not met lifting/carrying 50# on frequent basis, push/pull 100# on frequent basis, perform 6+ hours of work simulation without symptom increase, and perform 50# push/pull on frequent basis. She has been progressing towards all goals unmet at this time.

GOALS	50% OF SHORT/LONG TERM GOALS MET	
	New goals (if applicable):	1. 2.

COMPLICATIONS/ BARRIERS:	Pt continues to have neck pain and UE shoulder pain with heavier lifting constantly, therefore she has not increased her weights with floor to waist box lifting. She has been able to increase her repetitions and was able to perform 20# box lift and carry with RPE of 8/10 today.	
REASONABLE ACCOMODATIONS		
RECOMMENDATIONS	☐ Refer to physician. Please advise. ☐ FCE to determine safe RTW status (to be completed at D/C) ☒ Continue program ☐ Discharge:	☐ Discharge: % goals met ☐ Discharge: Instructed in HEP ☐ Discharge: Poor Compliance ☐ Discharge: Meet job requirements
FREQUENCY/DURATION	3 X PER WEEK FOR 2 WEEKS	

X

Physician Signature
, DPT

Therapist Signature: Tyler Geib, PT

Data Collected with the assistance of: Carrie Manges, Regional
Work Comp Coordinator, PTA

FUNCTIONAL TESTS

Name: Jennie Cox

SS#: XXX-XX-3648

Date: 12/5/16

MATERIAL HANDLING

	Job Requirement	Initial Eval Date: 10/24/16	Progress Report Date: 12/5/16	Progress Report Date:	Heart Rate	Comments
Client can lift:						
Floor to Waist	50 lbs Occasional	24 lbs Occasional	10lbs constant	lbs		
Floor to Waist	50 lbs Constant	24 lbs Constant	10lbs Constant	lbs		
Vertical push/pull Frequent	50 lbs Frequent	40 lbs Frequent	50lbs occasional	lbs		
Other:	lbs	lbs	lbs	lbs		
Client can:						
Carry 50 ft.	50 lbs Occasional	19 lbs Frequent	20 lbs occasional	lbs		
Push: dynamic	100 lbs Occasional	50 lbs Frequent	30 lbs constant	lbs		
Pull: dynamic	100 lbs Occasional	50 lbs Frequent	30 lbs constant	lbs		

NON-MATERIAL HANDLING

	Job Requirement	Initial Eval Date: 10/24/16	Progress Report Date: 12/5/16	Progress Report Date:	Heart Rate	Comments
Client Can:						
Walk	Frequently	Occasionally	Constant			
Sit	Occasionally	Constantly	Constantly			
Stand	Constantly	Frequently	Constantly			
Alternately sit/stand	Occasionally	Occasionally	Occasionally			
Balance 25 ft.	Frequently	N/A	N/A			
Crawl 25 ft.	Occasionally					
Reach above shoulder height	Constantly	Constantly	Constantly			
Kneel	Occasionally	Occasionally	Occasionally			
Bend	Occasionally	Occasionally	Frequently			
Squat	Frequently	Frequently	Frequently			
Ladder climb	Occasionally	Occasionally	N/T			
Stair climb	Occasionally	Occasionally	Occasionally			
FUNCTIONAL MOVEMENT						
Left foot	Constantly	Occasionally	Constantly			
Right foot	Constantly	Constantly	Constantly			
Other:						

	thus far, at this time I feel an FCE recommendation to determine safe return to work status would be most appropriate.								
GOALS	80% OF SHORT/LONG TERM GOALS MET								
	New goals (if applicable): 1. 2.								
COMPLICATIONS/ BARRIERS:	Please see summary report for possible complications with progress								
REASONABLE ACCOMODATIONS									
RECOMMENDATIONS	<table border="1"> <tr> <td>☐ Refer to physician, Please advise.</td><td>☒ Discharge: 80 % goals met</td></tr> <tr> <td>☒ FCE to determine safe RTW status (to be completed at D/C)</td><td>☐ Discharge: Instructed in HEP</td></tr> <tr> <td>☐ Continue program</td><td>☐ Discharge: Poor Compliance</td></tr> <tr> <td>☐ Discharge:</td><td>☐ Discharge: Meet job requirements</td></tr> </table>	☐ Refer to physician, Please advise.	☒ Discharge: 80 % goals met	☒ FCE to determine safe RTW status (to be completed at D/C)	☐ Discharge: Instructed in HEP	☐ Continue program	☐ Discharge: Poor Compliance	☐ Discharge:	☐ Discharge: Meet job requirements
☐ Refer to physician, Please advise.	☒ Discharge: 80 % goals met								
☒ FCE to determine safe RTW status (to be completed at D/C)	☐ Discharge: Instructed in HEP								
☐ Continue program	☐ Discharge: Poor Compliance								
☐ Discharge:	☐ Discharge: Meet job requirements								
FREQUENCY/DURATION	Discharge with recommended FCE to determine return to work status								

X

Physician Signature
, DPT

Therapist Signature: Tyler Geib, PT

Data Collected with the assistance of: Carrie Manges, Regional
Work Comp Coordinator, PTA

TODAY'S DATE: 12/19/16

FPT: Greenville

Name: Jennie Cox		SS#: XXX-XX-3648		Sex: Female	Age: 64
Date Admitted to Program: 2/16/16	Date of Injury: 5/31/16	Projected Program D/C Date: 6 weeks		First Date Lost Time: 10/24/16	
Diagnosis: Generalized Deconditioning/weakness		Type of Injury: Multiple body parts	Ins. Adjuster: Align		
Employer: Palmetto State		Referral Source: Align	Carrier/Claim #:		
Physician:		WCCCC: Cassandra Alewine	PDC: Medium-heavy		
Work Status: not working		Occupation: Truck Driver	Dominant Hand: Right		

PARTICIPATION IN PROGRAM	Attendance: Good	Patient has attended 20 of 22 scheduled visits.	Comments: Pt cancelled 2 appts due to illness
	Motivation: Good		

MUSCULOSKELETAL ASSESSMENT	CURRENT		IMPORTANT GAINS Generalized knee strength gains overall through the lower body	
	STRENGTH:	R ankle: PF 5/5, DF 5/5, Inv/Ev 5/5 L ankle: PF 5/5, DF 5/5, Inv/Ev 5/5 R hip: Fl 4+/5, abd 4/5, Ext 4/5 L hip: Fl 4+/5, abd 4/5, Ext 4/5 R knee: Fl 5/5, Ext 4+/5 L knee: Fl 5/5, Ext 4+/5		
		ROM:		n/a
		OTHER:		

FUNCTIONAL STATUS	See Attached

PHYSICAL DEMAND	Job Required: medium-heavy	Current: medium	Goal: heavy

CARDIOVASCULAR	Pre-Test:	HR: NT	BP: NT	Post-Test:	HR: NT	BP: NT

JOB AVAILABILITY	Modified job duty available? No	Modified duty required PDC:

TRANSFERRABLE SKILLS	

SUMMARY	Pt did well with her work comp program and performed all required activities during sessions. She demonstrated improvements in all LE muscle grades per objective measurements. She did continue to have reports of pain and discomfort with lifting and heavier push/pull activity in the cervical and shoulder musculature that limited her overall progression towards her heavier PDC goals. She did have a high fear factor as well due to concerns over pain with heavier activities that could have led to some self-limiting with strenuous activities to include push/pulling as well as lifting activity; however she does have an extensive surgical and trauma history in the cervical region and mandible that would explain her inability to increase strengthening due to strain of the upper quadrant musculature. We did attempt to progress resistance with functional lifting and sled push/pull simulation, however this did increase her pain levels in the L cervical region with RPE levels of 8-9/10, therefore we did not perform higher level strength training. I did educate her on cervical stretching to perform daily to improve soft tissue constraints to improve mobility and reduce her pain reports with future activity. Based off her progress



FIRST
PHYSICAL THERAPY
CORA Rehabilitation Clinics

FUNCTIONAL TESTS

Name: Jennie Cox

SS#: XXX-XX-3648

Date: 12/19/16

MATERIAL HANDLING

	Job Requirement	Initial Eval Date: 10/24/16	Progress Report Date: 12/5/16	Progress Report Date: 12/19/16	Heart Rate	Comments
Client can lift:						
Floor to Waist	50 lbs Occasional	24 lbs Occasional	10lbs constant	30 lbs occasional		
Floor to Waist	50 lbs Constant	24 lbs Constant	10lbs Constant	10 lbs constant		
Vertical push/pull Frequent	50 lbs Frequent	40 lbs Frequent	50lbs occasional	50 lbs Frequent		
Other:	lbs	lbs	lbs	lbs		
Client can:						
Carry 50 ft.	50 lbs Occasional	19 lbs Frequent	20 lbs occasional	20 lbs occasional		
Push: dynamic	100 lbs Occasional	50 lbs Frequent	30 lbs constant	30 lbs Constant		
Pull: dynamic	100 lbs Occasional	50 lbs Frequent	30 lbs constant	30 lbs constant		

NON-MATERIAL HANDLING

	Job Requirement	Initial Eval Date: 10/24/16	Progress Report Date: 12/5/16	Progress Report Date: 12/19/16	Heart Rate	Comments
Client Can:						
Walk	Frequently	Occasionally	Constant	Constantly		
Sit	Occasionally	Constantly	Constantly	Constantly		
Stand	Constantly	Frequently	Constantly	Constantly		
Alternately sit/stand	Occasionally	Occasionally	Occasionally	Occasionally		

Revised 7/16/08

Balance 25 ft.	Frequently	N/A	N/A	N/A	
Crawl 25 ft.	Occasionally				
Reach above shoulder height	Constantly	Constantly	Constantly	Constantly	
Kneel	Occasionally	Occasionally	Occasionally	Occasionally	
Bend	Occasionally	Occasionally	Frequently	Frequently	
Squat	Frequently	Frequently	Frequently	Frequently	
Ladder climb	Occasionally	Occasionally	N/T	N/T	
Stair climb	Occasionally	Occasionally	Occasionally	Frequently	
FUNCTIONAL MOVEMENT					
Left foot	Constantly	Occasionally	Constantly	Constantly	
Right foot	Constantly	Constantly	Constantly	Constantly	
Other:					

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206236

JENNIE COX,
Employee
Claimant,

vs.

PALMETTO STATE
TRANSPORTATION,
Employer

AND

CHEROKEE INSURANCE COMPANY,
Carrier

Defendants.

APA SUBMISSIONS

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APA #28
Robert E. Brabham, PH.D.
07/16/18

PSYCHOLOGICAL AND TRAINING SERVICES, P.A.

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ROBERT E. BRABHAM, PH.D

LICENSED PSYCHOLOGIST

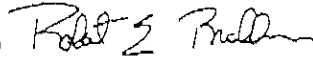
MASTER'S IN REHABILITATION COUNSELING

ROB BRABHAM JR., MRC

NORA HEAPE, RN, BA

AMYE HAWKINS, ADM. ASST.

BETH BURNETT, BA, EC

To: Juliette Brown Mims**From:** Robert Brabham, PhD**Date:** July 16, 2018**RE:** Jennie Cox DOB 8-14-52

Thank you for the highly critical critique of my report in this matter. In reading my own language, I would have to agree that I was unclear as to her last date of employment, and I apologize for that mistake. The bottom line remains that she has not been able to work since June 2016, now more than two years ago.

I cannot question or explain why other records do not cover the same topics as do my reports. However, I do take exception to the comment that I am not qualified to establish any basis for the fatigue Ms. Cox has experienced since her injuries. As a matter of fact, fatigue, out of proportion to actual exertional efforts, is not an unusual reaction to the type of injury that Ms. Cox experienced. It is, in fact, one of the most common symptoms associated with pain lasting an extended period of time, as well as depression. In that regard, I am legally and professional qualified to render such an opinion.

As to my finding of depression, the fact that there was a pre-existing history exacerbated by the death of a family member does not change the fact that any pre-existing depression only served to exacerbate the quite-obvious depression she has experienced since loss of employment in 2016. I would respectfully point out that Ms. Cox had worked for many years, as pointed out by the defense attorney of record. In fact, I think it is to her credit that, in spite of that background, she had been able to maintain employment, as they pointed out.

I would also respectfully point out that there is extensive literature correlating the relationship between pain and depression. I was not mistakenly reporting her reports of pain, as she was quite clear in that regard. I would also respectfully point out that, somewhat by definition, pain remains a subjective symptom, best identified by the individual.

As to the fact that she has not sought treatment for depression, that is not an uncommon response. Individuals are often hesitant to request the need for such services. I would also respectfully disagree that it is improper for me to use the terms "it is reasonable for me to conclude"...that is, indeed, a very professional and proper term.

The comment that her reports were "self-serving" must be weighed against the credibility of her comments. It remains my professional opinion that consistency in reporting by an individual is entirely different from "self-serving." Indeed, I am quite careful to inquire as to the consistency of reports and am careful to point out consistencies when they are found.

Finally, I would respectfully suggest that many of the comments and quotes that I have made are based on her symptoms/conditions at the time of my evaluation. They were valid points at that time, and nothing pointed out in the rebuttal changes that fact. If anything, her credibility is enhanced by her efforts to continue working. Her efforts to avoid medication should not be used against her, especially in view of considerable publicity of individuals becoming addicted to such medications. Simply stated, it is my opinion that the absence of specific treatment noted by the defendants does not equate to the absence of symptoms, as noted in my report.

Again, I regret that I confused the dates as to her efforts to work and the last date of employment. The bottom line remains that she had a good work history prior to her injuries, and following the injuries, she was unable to maintain employment, with the causal effect being the on-the-job injuries noted.

If you have any further questions, please do not hesitate to contact me.

APA #34
Jennifer T. Ellis, M.D.
05/09/16-08/02/18

[Progress Note] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 1 of 3

Progress Note

Patient Name: Jennie Cox
Patient ID: 55780
Sex: Female
Birthdate: August 14, 1952

Visit Date: May 9, 2016
Provider: Jennifer T. Ellis, MD
Location: Hillcrest Family Practice
Location Address: 717 SE Main St
 Simpsonville, SC 296813237
Location Phone: (864) 522-5400

Chief Complaint

- F/U discuss weight loss.
- Pt declines to discuss smoking cessation.

History Of Present Illness

The patient returns for follow up of Her depression Since the last visit She has been doing better She is currently taking the following prescription medications: fluoxetine 20 mg oral tablet She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is currently experiencing fatigue. She denies difficulty concentrating, difficulty performing routine daily activities, Insomnia, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

5/9: chose not to increase fluoxetine, feels she is doing OK. energy level improving.

previous visit: Taking alprazolam 1-2 x/ week, when feeling worried about how going to get things done

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Now drives - not supposed to drive over 11hours.

Dedicated run: Left greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hyster/oooph; jaw surgery; Lysis of adhesions; Tonsillectomy

Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; fluoxetine 40 mg oral capsule; Restoril 30 mg oral capsule

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

[Progress Note] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 2 of 3

Constitutional

- o Denies : weight loss, weight gain, loss of appetite

HENT

- o Denies : headaches

Neurologic

- o Denies : tingling or numbness

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
05/09/2016	01:22 PM	110/80	Sitting				100 - R		97.9	107lbs 6oz					

Physical Examination**Constitutional**

- o Appearance : *thin*, well developed, alert, in no acute distress, appears about reported age

Respiratory

- o Respiratory Effort : breathing unlabored
- o Auscultation of Lungs : normal breath sounds

Cardiovascular

- o Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- o Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Skin and Subcutaneous Tissue

- o General Inspection : no rashes present, no lesions present, no areas of discoloration present
- o General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- o Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- o Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- o Judgement and Insight : judgement and insight intact
- o Mood and Affect : normal, appropriate

Assessment

- Anxiety Disorder 300.00/F41.9
long discussion about relationship between job/ injury/ mood/ weight. believe wt loss / fatigue multifactorial. attempted to increase dose encouraged pt to pursue less demanding driving position.
- Weight loss 783.21/R63.4
pt would like to regain weight up to her previous baseline of 120. advised that unable to continue to recommend out of weight without clear deadline. agrees would be reasonable to return to work if maintains current level of weight.

Plan**Instructions**

- o Patient instructed to contact physician if mood disturbance intensifies
- o Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- o Return Visit Request in/on 2 weeks +/- 2 days (88575).

Correspondence

- o Work/School Excuse (Pain v3.6)FHV1 (Jennie C. Cox) - 05/09/2016

[Digital Signature Validated]

[Progress Note] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 3 of 3

Electronically Signed by: Jennifer T. Ellis, MD -Author on May 10, 2016 05:28:27 PM

Progress Note

Patient Name:	Jennie Cox	Visit Date:	May 23, 2016
Patient ID:	55780	Provider:	Jennifer T. Ellis, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main St Simpsonville, SC 296813237
		Location Phone:	(864) 522-5400

Chief Complaint

- f/u weight gain, general health

History Of Present Illness

The patient returns for follow up of Her depression Since the last visit She has been doing better She is currently taking the following prescription medications: fluoxetine 20 mg oral tablet She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is currently experiencing fatigue. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

5/23: weight continues to improve, worn out when went to wedding over the wedding, still taking fluox, stable mood wise, energy better with her pill. mirtazapine - never discontinued, taking nightly.

5/9: chose not to increase fluoxetine, feels she is doing OK, energy level improving.

previous visit: Taking alprazolam 1-2 x/ week, when feeling worried about how going to get things done

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Now drives - not supposed to drive over 11hours.

Dedicated run: Left greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/ocoph; jaw surgery; lysis of adhesions; Tonsillectomy

Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; fluoxetine 20 mg oral capsule; Restoril 30 mg oral capsule

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

[Progress Note] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 2 of 3

Review of Systems**Constitutional**

- o Denies : weight loss, weight gain, loss of appetite

HENT

- o Denies : headaches

Neurologic

- o Denies : tingling or numbness

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	I/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
05/23/2016	04:12 PM	116/71	Sitting				86 - R		98.4	109lbs	6oz				

Physical Examination**Constitutional**

- o Appearance : *thin*, well developed, alert, in no acute distress, appears about reported age

Respiratory

- o Respiratory Effort : breathing unlabored
- o Auscultation of Lungs : normal breath sounds

Cardiovascular

- o Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- o Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Skin and Subcutaneous Tissue

- o General Inspection : no rashes present, no lesions present, no areas of discoloration present
- o General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- o Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- o Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- o Judgement and Insight : judgement and insight intact
- o Mood and Affect : normal, appropriate

Assessment

- Anxiety Disorder 300.00/F41.9
Informed by patient that has been on mirtazapine whole time. with good weight improvement, will continue. believe wt loss / fatigue multifactorial. If wt gain reverse, will increase dose prozac. encouraged pt to pursue less demanding driving position. will write note to ease back into work.
- Weight loss 783.21/R63.4
pt would like to regain weight up to her previous baseline of 120. however, may not be achievable. encouraged continued calorie supplementation.

Plan**Medications**

- o mirtazapine 7.5 mg oral tablet
SIG: take 2 tablets (15 mg) by oral route once daily at bedtime for 30 days
DISP: (60) tablets with 0 refills
Prescribed on 05/23/2016

Instructions

[Digital Signature Validated]

[Progress Note] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 3 of 3

- o Patient instructed to contact physician if mood disturbance intensifies
- o Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- o Return Visit Request in/on 2 weeks +/- 2 days (89282).

Electronically Signed by: Jennifer T. Ellis, MD -Author on May 25, 2016 10:25:04 AM

[Digital Signature Validated]

Progress Note

Patient Name:	Jennie Cox	Visit Date:	June 23, 2016
Patient ID:	55780	Provider:	Jennifer T. Ellis, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main St Simpsonville, SC 296813237
		Location Phone:	(864) 522-5400

Chief Complaint

- F/U Anxiety
- Weight Loss

History Of Present Illness

The patient returns for follow up of Her depression Since the last visit She has been doing about the same. She is currently taking no prescription medications for this- stopped them herself after last visit. She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, fatigue, insomnia, loss of appetite, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

6/23: not working. worker's comp conversations occurring. pateint reports problem with pain once started back driving. returned the week after vist, worked 3 weeks. told HR about pain from turning head / backing up etc.

5/23: weight continues to improve. worn out when went to wedding over the wedding. still taking fluox. stable mood wise. energy better with her pill. mirtazipine - never discontinued. taking nightly.

5/9: chose not to increase fluoxetine, feels she is doing OK. energy level improving.

previous visit: Taking alprazolam 1-2 x/ week, when feeling worried about how going to get things done

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Now drives - not supposed to drive over 11hours.

Dedicated run: Left greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low back pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; jaw surgery; Lysis of adhesions; Tonsillectomy

Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; fluoxetine 20 mg oral capsule; mirtazapine 7.5 mg oral tablet; Restoril 30 mg oral capsule

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

[Progress Note] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 2 of 3

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems**Constitutional**

- o Denies : weight loss, weight gain, loss of appetite

HENT

- o Denies : headaches

Neurologic

- o Denies : tingling or numbness

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
06/23/2016	10:07 AM	104/69	Sitting				95 - R		96.5	108lbs 2oz	5' 6"	17.45	1.51		

Physical Examination**Constitutional**

- o Appearance : *thin*, well developed, alert, In no acute distress, appears about reported age

Respiratory

- o Respiratory Effort : breathing unlabored
- o Auscultation of Lungs : normal breath sounds

Cardiovascular

- o Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- o Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Skin and Subcutaneous Tissue

- o General Inspection : no rashes present, no lesions present, no areas of discoloration present
- o General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- o Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- o Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- o Judgement and Insight : judgement and insight intact
- o Mood and Affect : normal, appropriate

Assessment

- Anxiety Disorder 300.00/F41.9
pt stopped med since last visit. reports feeling no different. watch. (see previous note for recs prior to d/cin) encouraged pt to pursue less demanding driving position. however, no further work excuses provided.
- Weight loss 783.21/R63.4
pt would like to regain weight up to her previous baseline of 120. however, may not be achievable. encouraged continued calorie supplementation.

Plan**Instructions**

- o Patient instructed to contact physician if mood disturbance intensifies
- o Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for

[Digital Signature Validated]

[Progress Note] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 3 of 3

herself and/or dependents

Disposition

- o Call or Return if symptoms worsen or persist.

Correspondence

- o Work/School Excuse (Paln v3.6)FHv1 (Jennie C. Cox) - 06/23/2016
- o Light Duty Note (Revised)FHv2 (Jennie C. Cox) - 06/23/2016

Electronically Signed by: Jennifer T. Ellis, MD -Author on June 23, 2016 11:08:59 AM

[Digital Signature Validated]

Progress Note

Patient Name:	Jennie Cox	Visit Date:	September 20, 2016
Patient ID:	55780	Provider:	Jennifer T. Ellis, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main St Simpsonville, SC 296813237
		Location Phone:	(864) 522-5400

Chief Complaint

- f/u weight loss and exercise

History Of Present Illness

The patient returns for follow up of Her depression Since the last visit She has been doing better She is currently taking no prescription medications for this. She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, fatigue, insomnia, loss of appetite, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

9/20: Has been going to Life Center, seeing personal trainer. Needs a note that needs personal training needed to help her gain weight. Has been attending for over a month. Convinced it is helping her a lot. PT directing her on use of the machines. Has been going Wed and Fridays with the personal trainer- 30 min ute each session. Trying to do the weights and exercise balls.

Sees her daughter periodically q few weeks/ once per month;

Grits/ fruit/ burgers/ chicken.

Taking Restoril nightly, alprazolam once daily.

Still talking to workers comp

Pt reports she has contacted workers comp about missed work. Her attorney spoke with her about

6/23: not working. worker's comp conversations occurring. pateint reports problem with pain once started back driving. returned the week after vist, worked 3 weeks. told HR about pain from turning head / backing up etc.

5/23: weight continues to improve. worn out when went to wedding over the wedding. still taking fluox. stable mood wise. energy better with her pill. mirtazipine - never discontinued. taking nightly.

5/9: chose not to increase fluoxetine, feels she is doing OK. energy level improving.

previous visit: Taking alprazolam 1-2 x/ week, when feeling worried about how going to get things done

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Now drives - not supposed to drive over 11hours.

Dedicated run: Left greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

Past Medical History

Disease Name	Date Onset	Notes
Abdominal Radiologic Abnormality	3/5/08	see CT report- L adrenal gland abnormality
Anxiety disorder	---	---
Bone Infection	2001	Dr. devault- I & D ? R hamstring Insertion/ Infection. a/w overuse unloading hand truck. Infxn noted upon re-attachment

[Digital Signature Validated]

[Progress Note] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 2 of 4

Hypercholesterolemia	11/26/2010	of hamstring per pt? h/o given. willing to work on diet/ exercise. re check 4 mos. Did not tolerate simvastatin- felt "sick," malaise
Insomnia	--	--
Irritable Bowel Syndrome	2004-2007	w/u by GI Assoc- for IBS- Hartley- upper GI, small bowe series, U/S, HIDA Scan 2004-2007
Joint Pain	--	--
Low back pain	--	? HNP L5/s1

Past Surgical History

Procedure Name	Date	Notes
Adenoidectomy	--	--
Appendectomy	? at time of ooph	--
Colonoscopy	8/16/04	int/ext hemorrhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after with emesis)
EGD	10/04	mild erythema
hystw/ooph	age 20s/ 1990s	hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery
jaw surgery	5/2012- multiple	Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr Cobb- oral surgeon, Dr Ridgill prosthetic orthodontist
Lysis of adhesions	surgeries 1990s	bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Blouin and May
Tonsillectomy	--	--

Medication List

Name	Date Started	Instructions
alprazolam 0.5 mg oral tablet	08/30/2016	take 1 tablet (0.5 mg) by oral route 3 times per day
Restoril 30 mg oral capsule	08/30/2016	take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days

Allergy List

Allergen Name	Date	Reaction	Notes
Magnesium	--	--	--
Nickel	--	?metal allergy?	--
simvastatin	--	malaise	--
Ultram	--	--	--

Family Medical History

Disease Name	Relative/Age	Notes
Alzheimer's Disease	/	--
	Aunt/ Grandmother (maternal)/ Mother/	
DM Type II	/	--
	Aunt/ Uncle/	
Myocardial Infarction, Acute	/	--
	Father/70	

Social History

Finding	Status	Start/Stop	Quantity	Notes
Children	--	--/--	--	2 daughters
Divorced	--	--/--	--	--
Grandchildren	--	--/--	--	5 gkids- 3 girls, 2 boys; had gson oldest that lost 2008; 2 younger girls (Madison 12, Emily 7) with same mom (tammy); oldest 40 yo

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[Progress Note] [Jennie Cox] [55780]

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Sonya- with twin brother and son (17 yo)
 Marthow and Meghan), older brother died-
 Michael -was at 16 yo from MVA

Nondrinker	--	--/--	--	--
Smoker	--	--/--	2 ppd	--
Tobacco	Current every day	18/--	2 PPD	--
Truck Driver	--	--/--	--	--

Review of Systems

Constitutional

- o **Denies** : weight loss, weight gain, loss of appetite

HENT

- o **Denies** : headaches

Neurologic

- o **Denies** : tingling or numbness

Psychiatric

- o **Denies** : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HI	BMI kg/m ²	BSA m ²	O2 Sat	HC
09/20/2016	12:48 PM	130/88	Sitting				121 - R		98.2		1.161bs 6oz				

Physical Examination

Constitutional

- o **Appearance** : *thin*, well developed, alert, in no acute distress, appears about reported age

Respiratory

- o **Respiratory Effort** : breathing unlabored
- o **Auscultation of Lungs** : normal breath sounds

Cardiovascular

- o **Heart** :
 - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- o **Peripheral Vascular System** :
 - **Extremities** : no edema or cyanosis

Skin and Subcutaneous Tissue

- o **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- o **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- o **Mental Status Examination** :
 - **Orientation** : oriented
 - **Memory** : memory intact
- o **Cranial Nerves** : cranial nerves intact bilaterally

Psychiatric

- o **Judgement and Insight** : judgement and insight intact
- o **Mood and Affect** : normal, appropriate

Assessment

- Anxiety Disorder 300.00/F41.9
 pt stopped med x few months. mood appears stable. monitor.
- Hypercholesterolemia 272.0/E78.0
- Weight loss 783.21/R63.4
 has regained weight - striving to reach previous baseline of 120. encouraged continued calorie supplementation/ resistance and endurance training.

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Plan**Instructions**

- o Patient instructed to contact physician if mood disturbance intensifies
- o Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- o CPX

Correspondence

- o Work/School Excuse (Pain v3.6)FHV1 (Jennie C. Cox) - 09/20/2016

Electronically Signed by: Jennifer T. Ellis, MD -Author on September 20, 2016 01:38:46 PM

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LabCorp - Lab - General Lab

Specimen #: 328-076-2309-0 Report Status: Final Results

Patient Information:

Name: Cox, Jennie C PatientID: 55780 Sex: F DOB: 08/14/1952
 Address: 222 W Chapman Road Phone #: (864)243-0032 SSN: ###-##-3648
 Belton, SC 29627-

Date of Specimen: 11/23/2016 11:09 Date Received: 11/23/2016 00:00 Specimen Source:

Date Reported: 11/24/2016 07:39 Physician: ELLIS, J Information:

Test Name	Result	Flags	Reference Range	Lab

Comments: Fasting=Y

CMP12+LP+6AC+CBC/D/Pit+TSH+Fer

Glucose, Serum	85 mg/dL		65-99 mg/dL	BN
Uric Acid, Serum	6.4 mg/dL		2.5-7.1 mg/dL	BN
Therapeutic target for gout patients: <6.0				
BUN	18 mg/dL		8-27 mg/dL	BN
Creatinine, Serum	1.01 mg/dL	H	0.57-1.00 mg/dL	BN
eGFR If NonAfricn Am	59 mL/min/1.73	L	>59 mL/min/1.73	BN
eGFR If Africn Am	68 mL/min/1.73		>59 mL/min/1.73	BN
Sodium, Serum	138 mmol/L		136-144 mmol/L	BN
Potassium, Serum	4.9 mmol/L		3.5-5.2 mmol/L	BN
Chloride, Serum	100 mmol/L		97-106 mmol/L	BN
Calcium, Serum	9.8 mg/dL		8.7-10.3 mg/dL	BN
Phosphorus, Serum	3.6 mg/dL		2.5-4.5 mg/dL	BN
Protein, Total, Serum	7.3 g/dL		6.0-8.5 g/dL	BN
Albumin, Serum	4.6 g/dL		3.6-4.8 g/dL	BN
Globulin, Total	2.7 g/dL		1.5-4.5 g/dL	BN
Bilirubin, Total	0.3 mg/dL		0.0-1.2 mg/dL	BN
Alkaline Phosphatase, S	97 IU/L		39-117 IU/L	BN
LDH	184 IU/L		119-226 IU/L	BN
AST (SGOT)	23 IU/L		0-40 IU/L	BN
ALT (SGPT)	13 IU/L		0-32 IU/L	BN
GGT	13 IU/L		0-60 IU/L	BN
Iron, Serum	67 ug/dL		27-139 ug/dL	BN
Ferritin, Serum	49 ng/mL		15-150 ng/mL	BN
Cholesterol, Total	258 mg/dL	H	100-199 mg/dL	BN
Triglycerides	179 mg/dL	H	0-149 mg/dL	BN
HDL Cholesterol	56 mg/dL		>39 mg/dL	BN
LDL Cholesterol Calc	166 mg/dL	H	0-99 mg/dL	BN
T. Chol/HDL Ratio	4.6 ratio units	H	0.0-4.4 ratio units	BN

T. Chol/HDL Ratio

	Men	Women
1/2 Avg. Risk	3.4	3.3
Avg. Risk	5.0	4.4
2X Avg. Risk	9.6	7.1
3X Avg. Risk	23.4	11.0

Estimated CHD Risk 1.1 times avg. H 0.0-1.0 times avg. BN

T. Chol/HDL Ratio

	Men	Women
1/2 Avg. Risk	3.4	3.3
Avg. Risk	5.0	4.4
2X Avg. Risk	9.6	7.1
3X Avg. Risk	23.4	11.0

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

TSH 1.730 uIU/mL 0.450-4.500 uIU/mL BN

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[LabCorp - Lab - General Lab] [Cox, Jennie C] [55780]

[Date Printed:8/3/2018] Page 2 of 2

WBC	6.4 x10E3/uL	3.4-10.8 x10E3/uL	BN
RBC	4.74 x10E6/uL	3.77-5.28 x10E6/uL	BN
Hemoglobin	15.4 g/dL	11.1-15.9 g/dL	BN
Hematocrit	43.6 %	34.0-46.6 %	BN
MCV	92 fL	79-97 fL	BN
MCH	32.5 pg	26.6-33.0 pg	BN
MCHC	35.3 g/dL	31.5-35.7 g/dL	BN
RDW	12.5 %	12.3-15.4 %	BN
Platelets	323 x10E3/uL	150-379 x10E3/uL	BN
Neutrophils	63 %		BN
Lymphs	27 %		BN
Monocytes	6 %		BN
Eos	3 %		BN
Basos	1 %		BN
Neutrophils (Absolute)	4.0 x10E3/uL	1.4-7.0 x10E3/uL	BN
Lymphs (Absolute)	1.7 x10E3/uL	0.7-3.1 x10E3/uL	BN
Monocytes(Absolute)	0.4 x10E3/uL	0.1-0.9 x10E3/uL	BN
Eos (Absolute)	0.2 x10E3/uL	0.0-0.4 x10E3/uL	BN
Baso (Absolute)	0.1 x10E3/uL	0.0-0.2 x10E3/uL	BN
Immature Granulocytes	0 %		BN
Immature Grans (Abs)	0.0 x10E3/uL	0.0-0.1 x10E3/uL	BN

Lab Name: LabCorp Burlington (BN)
Address: 1447 York Court
 Burlington, NC 27215-3361

Director: William F Hancock
Phone #: 8007624344

[Digital Signature Validated]

History and Physical

Patient Name:	Jennie Cox	Visit Date:	November 23, 2016
Patient ID:	55780	Provider:	Jennifer T. Cills, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main St Simpsonville, SC 295813237
		Location Phone:	(864) 522-5400

Chief Complaint

- Comprehensive exam
- Pt declines flu and tetanus vaccines.
- Pt declines to discuss smoking cessation.

labs drawn this morning
vision checked yearly
pt needs pelvic exam
pt needs mammogram

History Of Present Illness

Jennie C. Cox is a 64 year old Caucasian/White female who presents for her annual comprehensive exam . It has been 1 year since her last check up. She is due for the following health maintenance items: DRE, EKG, fasting labs, hemocult testing, mammogram, pap smear, urinalysis, and visual exam.

Exercise History

She does not exercise regularly but is very active.

Dietary Habits

She provided the following examples for meals on an average day. A typical breakfast might consists of some or all of the following: usu Ensure. Lunch is usually comprised of some or all of the following: snacks of chicken, veges. Some examples of typical supper food would be some or all of the following: a home cooked meal of a meat and three and chicken/ potatoes/ veges. She does not eat desert very often. Typical beverages consumed throughout the day include coffee and sweet tea. She regularly consumes sugar-sweetened beverages. On a typical day she might consume two sweet drinks. She does not drink alcohol.

Tobacco History

She uses cigarettes 1 pack/s per day.

Current Medical Problems Followed by Us

She is followed by us for hyperlipidemia and an anxiety disorder. The patient's mixed lipid levels have been poorly controlled with diet alone and are detailed in the laboratory reports. The anxiety disorder has been essentially unchanged since the last visit and waxing and waning in severity.

Jennie C. Cox is a 64 year old Caucasian/White female who presents for her annual exam. She is a GRAVIDA PARA who underwent a TAH/BSO 25 years ago for menorrhagia

Since her last visit, there have been no significant changes in her health history.

She has no current complaints.

The patient is not taking HRT medication. She is having no vasomotor symptoms.
She has not had a recent mammogram. A screening mammogram has been ordered.
She does not perform self breast exams.
The patient has no maternal family history of breast cancer.
She is currently single.

[History and Physical] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 2 of 7

went through PT. ordered 20 sessions, has been approx 1/2 way through. strengthening program- lifting boxes, near Patewood

2012/13- jaw surgeries. back to work 2013. back out of work 10/2015.

In/ out

has been out since June 2016 this round.

Initial eval L arm - 4.5 yrs ago

cvs moonville 2990234

Past Medical History

Disease Name	Date Onset	Notes
Abdominal Radiologic Abnormality	3/5/08	see CT report- L adrenal gland abnormality
Anxiety disorder	--	--
Bone Infection	2001	Dr. devault- I & D R hamstring insertion/ Infection. a/w overuse unloading hand truck. Infxn noted upon re-attachment of hamstring per pt
Hypercholesterolemia	11/26/2010	h/o given. willing to work on diet/ exercise. re check 4 mos. Did not tolerate simvastatin- felt "sick," malaise
Insomnia	--	--
Irritable Bowel Syndrome	2004-2007	w/u by GI Assoc- for IBS- Hartley- upper GI, small bowe series, U/S, HIDA Scan 2004-2007
Joint Pain	--	--
Low back pain	--	HNP L5/S1

Past Surgical History

Procedure Name	Date	Notes
Adenoidectomy	--	--
Appendectomy	at time of ooph	--
Colonoscopy	8/16/04	int/ext hemorrhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after wth emesis)
EGD	10/04	mild erythema
hystw/ooph	age 20s/ 1990s	hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery
jaw surgery	5/2012- multiple surgeries	Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr COBB- oral surgeon, Dr Ridgill prosthetic orthodontist
Lysis of adhesions	1990s	bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Biouin and May
Tonsillectomy	--	--

Medication List

Name	Date Started	Instructions
alprazolam 0.5 mg oral tablet	08/30/2016	take 1 tablet (0.5 mg) by oral route 3 times per day
Restoril 30 mg oral capsule	08/30/2016	take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days

Allergy List

Allergen Name	Date	Reaction	Notes
Magnesium	--	--	--
Nickel	--	metal allergy	--
simvastatin	--	malaise	--

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[History and Physical] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 3 of 7

Ultram

-- --

Family Medical History

Disease Name	Relative/Age	Notes
Alzheimer's Disease	/	--
	Aunt/ Grandmother (maternal)/ Mother/	
DM Type II	/	--
	Aunt/ Uncle/	
Myocardial Infarction, Acute	/	--
	Father/70	

Social History

Finding	Status	Start/Stop	Quantity	Notes
Children	---	--/--	--	2 daughters
Divorced	--	--/--	--	--
Grandchildren	--	--/--	--	5 gkids- 3 girls, 2 boys; had gson oldest that lost 2008; 2 younger girls (Madison 12, Emily 7) with same mom (Tammy); oldest 40 yo Sonya- with twin brother and son (17 yo) Marthow and Meghan), older brother died- Michael -was at 16 yo from MVA
Nondrinker	--	--/--	--	--
Smoker	--	--/--	2 ppd	--
Tobacco	Current every day	18/---	2 PPD	--
Truck Driver	--	--/--	--	--

Review of Systems**Constitutional**

- o **Admits** : tired very easily;
- o **Denies** : fever, chills, weight loss, weight gain

Eyes

- o **Denies** : double vision, changes in vision, floaters

HENT

- o **Admits** : painful to chew, cannot open mouth wide, unable to bite down
- o **Denies** : headaches, nose bleeding, hearing loss, tinnitus, snoring, hoarseness

Breasts

- o **Denies** : lumps, tenderness, nipple discharge, masses, skin changes

Cardiovascular

- o **Denies** : chest pain, dyspnea on exertion, orthopnea, lower extremity edema, palpitations

Respiratory

- o **Denies** : shortness of breath, cough, hemoptysis

Gastrointestinal

- o **Denies** : nausea, vomiting, change in bowel habits, dysphagia, heartburn, frequent heartburn, abdominal pain, blood in stools

Genitourinary

- o **Denies** : urgency, frequency, dysuria, nocturia, hematuria, incontinence, decreased stream, decreased libido

Integument

- o **Denies** : rash, new skin lesions, changes to existing skin lesions or moles

Neurologic

- o **Denies** : tingling or numbness, memory difficulties, tremors

Musculoskeletal

- o **Admits** : shoulder pain after PT
- o **Denies** : joint pain, joint swelling, muscle pain

Endocrine

- o **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance, weight gain

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Psychiatric

- o **Admits** : believes mood reasonable; does worry about finances; girls provide strength/ supportive, gklds
- o **Denies** : anxiety, depression, difficulty sleeping

Heme-Lymph

- o **Denies** : easy bleeding, easy bruising, lymph node enlargement or tenderness

Allergic-Immunologic

- o **Denies** : sinus allergy symptoms

Physical Examination**Constitutional**

- o **Appearance** : *thin*, well developed, alert, in no acute distress, appears about reported age

Head and Face

- o **Head** :
 - **Inspection** : atraumatic, normocephalic
 - **Palpation** : no tenderness or masses present
- o **Face** :
 - **Inspection** : no facial lesions

Eyes

- o **Vision** :
 - **Acuity** : visual acuity grossly normal at distance O.U., near vision grossly intact O.U.
- o **Conjunctivae** : conjunctiva normal
- o **Sclerae** : sclera white
- o **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally
- o **Ophthalmoscopic Exam** : retinas are normal without hemorrhage or exudate, no AV crossing changes, optic disk normal with normal cup to disk ratio
- o **Corneas** : no lesions present
- o **Eyelids/Ocular Adnexae** : eyelid appearance normal, no erythema or lesions noted

Ears, Nose, Mouth and Throat

- o **Ears** :
 - **External Ears** : appearance within normal limits, no lesions present
 - **Otoscopic Examination** : tympanic membrane appearance within normal limits bilaterally without perforations, mobility normal
 - **Hearing** : intact to conversational voice both ears
- o **Nose** :
 - **External Nose** : appearance normal
 - **Intranasal Exam** : mucosa within normal limits, no intranasal lesions present
 - **Nasopharynx** : no lesions or inflammation
- o **Oral Cavity** :
 - **Oral Mucosa** : no worrisome oral lesions present
 - **Lips** : lip appearance normal
 - **Teeth** : normal dentition for age
 - **Gums** : gums pink, no lesions
 - **Tongue** : tongue appearance normal, no lesions
 - **Palate** : hard palate normal, soft palate appearance normal
- o **Throat** :
 - **Oropharynx** : no inflammation or lesions present
 - **Hypopharynx** : appearance within normal limits, no erythema or lesions

Neck

- o **Inspection/Palpation** : normal appearance, no masses or tenderness, trachea midline
- o **Range of Motion** : cervical range of motion within normal limits
- o **Thyroid** : not enlarged, no nodules, non-tender

Respiratory

- o **Respiratory Effort** : breathing unlabored
- o **Inspection of Chest** : normal appearance, no retractions
- o **Auscultation of Lungs** : clear and equal bilaterally

Cardiovascular

- o **Heart** :
 - **Auscultation of Heart** : regular rate and rhythm, no appreciable murmurs, rubs or gallops
 - **Palpation of Heart** : normal apical impulse, no cardiac thrill present
- o **Peripheral Vascular System** :
 - **Carotid Arteries** : no appreciable bruits present
 - **Abdominal Aorta** : aortic pulse normal without bruits

- **Femoral Arteries** : normal femoral pulses, no appreciable bruits
- **Pedal Pulses** : normal dorsalis pedis and posterior tibial pulses bilaterally
- **Extremities** : no clubbing, cyanosis or edema

Breasts

- **Inspection of Breasts** : no dimpling, retractions or other skin changes
- **Palpation of Breasts, Axillae** : no masses, tenderness or adenopathy noted on palpation

Gastrointestinal

- **Abdominal Examination** : bowel sounds positive, non-distended, no appreciable masses or tenderness
- **Liver and spleen** : no appreciable hepatomegaly present, liver nontender to palpation, spleen not palpable
- **Hernias** : no appreciable hernias present

Genitourinary

- **External Genitalia** : no inflammation, no lesions present
- **Vagina** : normal vaginal vault, no discharge present, no inflammatory lesions present, no masses present
- **Urethra** : no inflammation, no lesions
- **Bladder** : nontender to palpation
- **Cervix** : *cervix not present*, no lesions present, nontender to palpation, no discharges, no bleeding present, normal midline position
- **Uterus** : *surgically absent*, no masses present, position midline/midplane, size normal
- **Adnexa** : no tenderness or masses present on bimanual examination
- **Anus** : no inflammation or lesions present
- **Perineum** : perineum within normal limits
- **Digital Rectal Examination** : normal sphincter tone, no rectal masses present
- **Occult Blood in Stool** : Hemoccult test negative, normal appearing stool present on glove

Lymphatic

- **Neck** : no lymphadenopathy present
- **Axilla** : no lymphadenopathy present
- **Groin** : no lymphadenopathy present
- **Supraclavicular Nodes** : no supraclavicular nodes
- **Preauricular Nodes** : no preauricular nodes present

Musculoskeletal

- **Spine** :
 - **Inspection/Palpation** : no spinal tenderness, scoliosis or kyphosis present
- **Right Upper Extremity** :
 - **Inspection/Palpation** : no atrophy or deformity noted, no edema, swelling or erythema present, no ecchymosis, no tenderness to palpation
 - **Range of Motion** : full passive range of motion, full active range of motion, no joint crepitus present
- **Left Upper Extremity** :
 - **Inspection/Palpation** : no atrophy or deformity noted, no edema swelling or erythema present, no ecchymosis, no tenderness to palpation
 - **Range of Motion** : full passive range of motion, full active range of motion, no joint crepitus present
- **Right Lower Extremity** :
 - **Inspection/Palpation** : no atrophy or deformity noted, no edema, swelling, or erythema present, no ecchymosis, no tenderness to palpation
 - **Range of Motion** : range of motion normal, no joint crepitus present, no pain on motion
- **Left Lower Extremity** :
 - **Inspection/Palpation** : no atrophy or deformity noted, no edema, swelling, or erythema present, no ecchymosis, no tenderness to palpation
 - **Range of Motion** : range of motion normal, no joint crepitus present, no pain on motion

Skin and Subcutaneous Tissue

- **General Inspection** : no rashes or worrisome lesions present
- **General Palpation** : no skin or subcutaneous tissue masses present, no tenderness to palpation, skin turgor normal
- **Body Hair** : scalp palpation normal, hair normal for age, general body hair distribution normal for age
- **Digits and Nails** : no clubbing or cyanosis, normal appearing nails

Neurologic

- **Mental Status Examination** :
 - **Orientation** : grossly oriented to person, place and time
 - **Memory** : intact in that we were able to conduct the interview
- **Cranial Nerves** : cranial nerves intact and symmetric throughout
- **Motor Examination** : grossly normal
- **Reflexes** : DTR's 2 bilaterally
- **Sensation** : grossly intact
- **Gait and Station** : normal gait, able to stand without difficulty

[History and Physical] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 6 of 7

Psychiatric

- o **Judgement and Insight** : judgment and insight intact
- o **Thought Processes** : rate of thoughts normal, thought content logical, abstract reasoning within normal limits
- o **Mood and Affect** : mood normal, affect appropriate
- o **Presence of Abnormal Thoughts** : no hallucinations, no delusions present, no psychotic thoughts

Results**In-Office Procedures****Lab procedure****Automated urinalysis without microscopy (81003)**

- Bilirub Ur Ql Strip: neg
- Glucose Ur-sCnc: neg
- Hgb Ur Ql Strip: moderate
- Ketones Ur Ql Strip: neg
- Nitrite Ur Ql Strip: neg
- pH Ur-LsCnc: 5.5
- Prot Ur Ql Strip: neg
- Sp Gr Ur Qn: 1.020
- Urobilinogen Ur-mCnc: 0.2 E.U./dL
- WBC Est Ur Ql Strip: neg

Assessment

- Annual physical exam V70.0/Z00.00
- Anxiety disorder 300.00/F41.9
- Hypercholesterolemia 272.0/E78.00
call with labs
- General Medical Exam, Adult V70.0/Z00.00
wrote down zostavax for her to assess if covered
- Insomnia 307.40/F51.9
Stable
- Anxiety Disorder 300.00/F41.9
- Hypercholesterolemia 272.0/E78.00
Did not tolerate simvastatin- felt "sick," malaise. trial low dose atorvastatin.
- Microscopic hematuria 599.72/R31.29
urology for persistent hematuria- referred again 11/2016. did not FU in past. discussed risk of bladder cancer.
- Abdominal Radiologic Abnormality 793.6
see CT report- L adrenal gland abnormality- CT to review along with above.

Plan**Orders**

- o General health panel (80050) - V70.0/Z00.00, 300.00/F41.9, 272.0/E78.00 - 11/23/2016 - - (Standing Order 1 of 1 - occurring every 0 days)
- o ECG (12-lead electrocardiogram) (0178T, 0179T, 0180T, 93041, 93042, 93224, 93226, 93000, 93005, 93010, 93010, 93225, 93227, 93000) - - 11/23/2016
- o General health panel This panel must include the following: Comp (80050, 80050) - - 11/23/2016
- o Lipoprotein, direct measurement; high density cholesterol (HDL c (83718, 83718) - - 11/23/2016
- o Urine culture (87086, 87086) - - 11/23/2016

Instructions

- o Recommend regular exercise
- o Recommend working on weight loss as we discussed
- o Recommend a heart healthy diet
- o Schedule screening mammogram
- o The labs you had drawn today should be back within 3 business days. We will call you only if there are abnormalities that we need to discuss.

Disposition

- o Return Visit Request In/on 2 months +/- 2 days (97450).

[Digital Signature Validated]

[History and Physical] [Jennie Cox] [55780]

[Date Printed:8/3/2018] Page 7 of 7

Electronically Signed by: Jennifer T. Ellis, MD -Author on November 23, 2016 10:18:07 AM

[Digital Signature Validated]

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.



**GREENVILLE
HEALTH SYSTEM**

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 11/22/2017

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 11/22/2017

Jennifer Taylor Ellis, MD

Family Medicine

Subjective:**Chief Complaint**

Patient presents with

- Annual Exam

Welcome To Medicare, labs in emr, vision checked yearly, pt declines mammogram and pelvic exam.

HPI**Subjective**

Patient ID: Jennie C Cox is a 65 y.o. female.

The patient returns today for an Annual Wellness Visit (AWV), medication refills, and review of chronic medical problems.

Health Questionnaire

1. Do you have any difficulty managing your finances? **NO**
2. Do you have any difficulty managing your medication? **NO**
3. Do you have any difficulty getting up and down off a toilet? **NO**
4. Do you have any difficulty getting into and out of the bathtub? **NO**
5. Do you use a cane or a walker? **NO**
6. Have you fallen recently? **NO**
7. In the last 2 weeks, have you had little interest or pleasure in doing things? **NO**
8. In the last 2 weeks, have you felt down, depressed or hopeless? **NO**
9. Have you discussed with your family what you would like to have happen when you are close to death? (Living Will) **YES**
10. Overall, how would you rate your health? **good**

Health Risk Assessment/ Medicare Annual Wellness Visit, Hillcrest Family Practice completed and reviewed.

Six-Item Screener to Identify Cognitive Impairment: Passed.

Mini- Mental State Examination score if performed:

Preventive Health

Date of most recent vaccination below, or: Are all up to date? Yes

Pneumococcal Pneumovax

Pneumococcal Prevnar

Influenza

Varicella Zoster

Tetanus/Pertussis

Cancer Screening: UTD or will shedule: Yes

Mammogram

Colonoscopy

Annual LDCT (age 55-80, 30 pack year ho, currently smoke or have quit in 15 yrs)

Disease Screening: UTD, n/a or will shedule: Yes

Bone Density UTD

Eye exam UTD

Cholesterol reviewed

Diabetes reviewed

Smoking counseling n/a

High Risk Only

EKG

Hepatitis B vaccine No

Hepatitis C screening (DOB 1945-1965) Declines

HIV screening Declines

Objective:

Vitals:

Vitals:

11/22/17 1619

BP: 117/66

Pulse: (!) 95

Temp: 97.7 °F (36.5 °C)

Weight: 55.5 kg (122 lb 6.4 oz)

Height: 1.689 m (5' 6.5")

Body mass index is 19.46 kg/m².

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition. and Due to this patient's BMI, I have provided counseling regarding physical activity.

Cognitive screen performed as above.

Hearing screen performed and passed.

Visual Acuity performed and normal.

Get up and Go Test performed and passed.

My health assessment and suggested preventive care plan were reviewed with the patient today and shared decision-making with appropriate action was taken based on information obtained and the patient's wishes.

Electronically signed by Jennifer Taylor Ellis, MD at 11/22/2017 8:59 PM

Office Visit on
11/22/2017

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.



**GREENVILLE
HEALTH SYSTEM**

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 8/21/2017

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 8/21/2017

Jennifer Taylor Ellis, MD

Family Medicine

Office Visit Note

8/21/2017

Subjective:

Subjective

Jennie C Cox is a 65 y.o. female.

Chief Complaint

Patient presents with

- Medication Refill

HPI

Weight: Currently stable. Not active. Not working since June 2016. Hearing.

Anxiety: Medicine called in while I was out. Taking approx once daily. Using Restoril nights.

Hypertlipidemia: Still not interested in medicines. No regular exercise.

Review of Systems

Constitutional: Negative for fever, chills, activity change and appetite change.

Respiratory: Negative for apnea and cough.

Cardiovascular: Negative for chest pain and palpitations.

Psychiatric/Behavioral: Positive for sleep disturbance. Negative for dysphoric mood and agitation.

Objective:

BP 98/71 mmHg | Pulse 107 | Temp(Src) 98 °F (36.7 °C) | Wt 55.157 kg (121 lb 9.6 oz)

Objective

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.

Cardiovascular: Normal rate and regular rhythm.

Pulmonary/Chest: Effort normal and breath sounds normal.

Neurological: She is alert and oriented to person, place, and time.

Psychiatric: She has a normal mood and affect. Her behavior is normal. Thought content normal.

Assessment

Assessment/Plan:

Problem List Items Addressed This Visit

Other

Anxiety - Primary

Stable. No change in medicines. Recheck at QPE.

Hyperlipidemia

Insomnia

Medications

These changes are accurate as of: 8/21/17 12:10 PM. If you have any questions, ask your nurse or doctor.

Existing Medications

	Sig	Disp	Refill	Start	End

	Sig	Disp	Refill	Start	End
ALPRAZolam 0.5 mg tablet Commonly known as: XANAX	Sig: Take 1 tablet (0.5 mg) by mouth 3 (three) times a day as needed for anxiety.	Disp: 60 tablet	Refi II: 5		
CHANTIX CONTINUING MONTH BOX 1 mg tablet Generic drug: varenicline			Refi II: 0		
HYDROcodone-acetaminophen 5-325 mg per tablet Commonly known as: NORCO			Refi II: 0		
temazepam 30 mg capsule Commonly known as: RESTORIL	Sig: Take 1 capsule (30 mg) nightly.	Disp: 30 capsule	Refi II: 5		

Electronically signed by Jennifer Taylor Ellis, MD at 8/21/2017 12:43 PM

Office Visit
on
8/21/2017

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.

Assessment**Assessment/Plan:**

Tests ordered based on risk factors.

No Follow-up on file.

A portion of the information above was entered by my medical assistant. I have reviewed the documentation in detail and agree the documentation is accurate and complete.

Electronically signed by Jennifer Taylor Ellis, MD at 11/22/2017 8:59 PM

Office Visit on
11/22/2017

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.



**GREENVILLE
HEALTH SYSTEM**

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 11/22/2017

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 11/22/2017

Jennifer Taylor Ellis, MD

Family Medicine

Annual Adult Female Wellness Visit

Patient ID: Jennie C Cox is a 65 y.o. female who presents today for her Annual Wellness Visit, medication refills, and review of chronic medical problems.

Anxiety: Using Xanax 1-3 x/ day. Appealing workers comp issues. Causing lots of anxiety.

Hyperlipidemia: Reports taking medicine most of the time since call about high cholesterol. Reviewed previous labs in November 2016 her total cholesterol was 258 and her LDL was 166. Resumed after we called about labs earlier in the year/ late last year. Does not have current script- will look in Prime Suite.

LBP: None currently

The patient's Past Medical History, Past Surgical History, Family History, Social History, and Immunizations were reviewed and updated with her today.

Preventive Health:**Exercise:** none**Nutrition:** Skips bfast, lunch - steam vegetable, supper- same; Sweet tea- 1/2 gallon tea, no Etoh**PHQ 2 depression screen negative.****Immunizations:****There is no immunization history on file for this patient.****Cancer Screening: Reviewed and UTD or will schedule? Yes**

Mammogram defers

Pap Smear defers

Colonoscopy defers, agrees cologuard

Annual LDCT (age 55-80, 30 pack year ho, currently smoke or have quit in 15 yrs)

Disease Screening: Reviewed and UTD or will schedule? Yes

Eye exam Has not had done- wants to wait

Dental care UTD

Cholesterol: Reviewed

Fasting blood glucose: Reviewed

Bone Density

Smoking counseling

Hepatitis C screening (DOB 1945-1965)

HIV screening

Patient Care Team:

Jennifer Taylor Ellis, MD as PCP - General

Review of Systems**Constitutional:** Negative for activity change, appetite change, chills, fatigue, fever and unexpected weight change.**HENT:** Positive for trouble swallowing. Negative for congestion, dental problem, drooling, ear discharge, ear pain, facial swelling, hearing loss, mouth sores, nosebleeds, postnasal drip, rhinorrhea, sinus pain, sinus pressure, sneezing, sore throat, tinnitus and voice change.**Facial pain due to accident, cannot sleep on Left side of face; Mouth pain****Eyes:** Negative for photophobia, pain, discharge, redness, itching and visual disturbance.**Respiratory:** Negative for apnea, cough, chest tightness, shortness of breath and wheezing.**Cardiovascular:** Negative for chest pain, palpitations and leg swelling.**Gastrointestinal:** Negative for abdominal pain, anal bleeding, blood in stool, constipation, diarrhea, nausea and vomiting.**Endocrine:** Negative for cold intolerance, heat intolerance, polydipsia, polyphagia and polyuria.**Genitourinary:** Positive for frequency. Negative for difficulty urinating, dysuria, hematuria, urgency and vaginal bleeding.**Musculoskeletal:** Positive for arthralgias. Negative for back pain, gait problem, joint swelling and myalgias.**Skin:** Negative for rash.**Allergic/Immunologic:** Negative for immunocompromised state.

Neurological: Negative for dizziness, tremors, seizures, syncope, speech difficulty, weakness, light-headedness, numbness and headaches.
 Hematological: Negative for adenopathy. Does not bruise/bleed easily.
 Psychiatric/Behavioral: Positive for sleep disturbance (uses med nightly, sleeps 4-5 year). Negative for confusion and dysphoric mood. The patient is nervous/anxious (worried about finances).

Physical exam:

Vitals:

Vitals:

11/22/17 1619
 BP: 117/66
 Pulse: (I) 95
 Temp: 97.7 °F (36.5 °C)
 Weight: 55.5 kg (122 lb 6.4 oz)
 Height: 1.689 m (5' 6.5")

Body mass index is 19.46 kg/m².

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition. and Due to this patient's BMI, I have provided counseling regarding physical activity.

Physical Exam

Constitutional: She appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: Tympanic membrane, external ear and ear canal normal.

Left Ear: Tympanic membrane, external ear and ear canal normal.

Nose: Nose normal.

Mouth/Throat: Uvula is midline, oropharynx is clear and moist and mucous membranes are normal

Eyes: Conjunctivae, EOM and lids are normal. Pupils are equal, round, and reactive to light.

Neck: Trachea normal and normal range of motion. No JVD present. No muscular tenderness present. No thyroid mass and no thyromegaly present.

Cardiovascular: Normal rate, regular rhythm, S1 normal and S2 normal. Exam reveals no gallop. No murmur heard.

Pulses:

Carotid pulses are 2+ on the right side, and 2+ on the left side.

Femoral pulses are 2+ on the right side, and 2+ on the left side.

Dorsalis pedis pulses are 2+ on the right side, and 2+ on the left side.

Posterior tibial pulses are 2+ on the right side, and 2+ on the left side.

Pulmonary/Chest: Effort normal and breath sounds normal. She has no wheezes. She has no rales. She exhibits no mass and no deformity.

Abdominal: Soft. Normal appearance and bowel sounds are normal. She exhibits no abdominal bruit and no mass. There is no splenomegaly or hepatomegaly. There is no tenderness. No hernia. Hernia confirmed negative in the right inguinal area and confirmed negative in the left inguinal area.

Musculoskeletal: Normal range of motion.

Lymphadenopathy:

She has no cervical adenopathy.

She has no axillary adenopathy.

Right: No supraclavicular adenopathy present.

Left: No supraclavicular adenopathy present.

Neurological: She is alert. She has normal strength. No cranial nerve deficit. Gait normal.

Skin: Skin is warm and dry. No rash noted. Nails show no clubbing.

Various seborrheic keratoses on back

Psychiatric: She has a normal mood and affect. Her speech is normal and behavior is normal.

Judgment and thought content normal.

Anxiety (Primary)

Assessment & Plan:

Unchanged, encouraged SSRI.

Mixed hyperlipidemia

Assessment & Plan:

Will confirm dose of med she resumed on her own. Most recent note showed atorvastatin 40. We'll have her bring in bottle. Current lipid significant improvement compared to November 2016 Encouraged daily use. Recheck prior to Fu.

Orders:

- Lipid Panel
- Basic Metabolic Panel (BMP)(BMET)

Insomnia, unspecified type

Assessment & Plan:

Stable

Low back pain, unspecified back pain laterality, unspecified chronicity, with sciatica presence unspecified

Mandible pain

Assessment & Plan:

Chronic. Still the middle of her Worker's Comp. case.

Screen for colon cancer

- Cologuard - External

Annual physical exam

Comments:

Defer mammo, DEXA for now. Agrees to discuss at FU. Cologuard.

Orders:

- Urinalysis, Auto without Microscopic-POC

Return in about 3 months (around 2/22/2018).

Insomnia

Refill temazepam. As always advised on need to wean.

Medications

Accurate as of 2/22/18 4:41 PM. If you have any questions, ask your nurse or doctor.

Modified Medications

	Sig	Disp	Refill	Start	End
atorvastatin 20 MG tablet	Sig: Take 1 tablet (20 mg) by mouth daily.	Disp: 30 tablet	Refill: 11		
Commonly known as:					
LIPITOR					
What changed:					
• medication strength					
• how much to take					
Changed by: Jennifer Taylor Ellis, MD					

Existing Medications

	Sig	Disp	Refill	Start	End
ALPRAZolam 0.5 mg tablet	Sig: Take 1 tablet (0.5 mg) by mouth 3 (three) times a day as needed for anxiety.	Disp: 60 tablet	Refill: 5		
Commonly known as:					
XANAX					
temazepam 30 mg capsule	Sig: Take 1 capsule (30 mg) nightly.	Disp: 30 capsule	Refill: 5		
Commonly known as:					
RESTORIL					

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition. and Due to this patient's BMI, I have provided counseling regarding physical activity.

Electronically signed by Jennifer Taylor Ellis, MD at 2/22/2018 4:43 PM

Office Visit
on
2/22/2018

Existing Medications

	Sig	Disp	Refill	Start	End
ALPRAZolam 0.5 mg tablet Commonly known as: XANAX	Sig: Take 1 tablet (0.5 mg) by mouth 3 (three) times a day as needed for anxiety.	Disp: 60 tablet	Refill: 5		
atorvastatin 20 MG tablet Commonly known as: LIPITOR	Sig: Take 1 tablet (20 mg) by mouth daily.	Disp: 30 tablet	Refill: 11		
miscellaneous medication	Sig: Coenzyme Q10 100 mg Take 1 tab 1-2 x each daily as needed for muscle aches	Disp: 60	Refill: 5		
femazepam 30 mg capsule Commonly known as: RESTORIL	Sig: Take 1 capsule (30 mg) nightly.	Disp: 30 capsule	Refill: 5		

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition. and Due to this patient's BMI, I have provided counseling regarding physical activity.

Electronically signed by Jennifer Taylor Ellis, MD at 5/24/2018 11:03 AM

Office Visit
on
5/24/2018

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.



**GREENVILLE
HEALTH SYSTEM**

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 2/22/2018

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 2/22/2018

Jennifer Taylor Ellis, MD

Family Medicine

Office Visit Note

2/22/2018

Subjective:

Subjective

Jennie C Cox is a 65 y.o. female.

Chief Complaint

Patient presents with

- Anxiety
3 month f/u visit
- URI
sore throat, congestion, cough, body aches yesterday- family have the flu
- Hyperlipidemia
pt. stopped her Lipitor due to pain

Anxiety

Presents for follow-up visit. Symptoms include depressed mood, excessive worry, nervous/anxious behavior and panic. Patient reports no chest pain, confusion, decreased concentration, dizziness, feeling of choking, irritability or nausea. The severity of symptoms is mild. The quality of sleep is good. Nighttime awakenings: several.

URI

This is a new problem. The current episode started in the past 7 days. The problem has been unchanged. There has been no fever. Associated symptoms include coughing, headaches, rhinorrhea, sinus pain and a sore throat. Pertinent negatives include no chest pain, congestion, diarrhea, ear pain, nausea or vomiting. She has tried acetaminophen for the symptoms. The treatment provided mild relief.

Hyperlipidemia

This is a chronic problem. The current episode started more than 1 year ago. The problem is uncontrolled. Recent lipid tests were reviewed and are high. There are no known factors aggravating her hyperlipidemia. Associated symptoms include myalgias (L neck after last visit). Pertinent negatives include no chest pain, focal sensory loss, focal weakness or leg pain. She is currently on no antihyperlipidemic treatment. The current treatment provides mild improvement of lipids. Compliance problems include adherence to diet, adherence to exercise and medication side effects.

Was taking chol medicine at CPE 11/2017. Started after labs 11/2017. Continued after that for undetermined time. Willing to resume with Co-Q10.

1 meal/ day. Grilled chicken

Mood: As above. Still not working. Still going to court over her Worker's Comp. Using alprazolam variably. Reports not taking every day but may take another days once or twice.

Review of Systems

Constitutional: Negative for irritability.

HENT: Positive for rhinorrhea, sinus pain and sore throat. Negative for congestion and ear pain.

Respiratory: Positive for cough.

Cardiovascular: Negative for chest pain.

Gastrointestinal: Negative for diarrhea, nausea and vomiting.

Musculoskeletal: Positive for myalgias (L neck after last visit).

Neurological: Positive for headaches. Negative for dizziness and focal weakness.

Psychiatric/Behavioral: Negative for confusion and decreased concentration. The patient is nervous/anxious.

Objective:

BP 96/54 | Pulse 83 | Temp 98.6 °F (37 °C) | Wt 57 kg (125 lb 9.6 oz) | BMI 19.97 kg/m²

Objective

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion. She exhibits no edema or tenderness.

Neurological: She is alert and oriented to person, place, and time. She has normal reflexes.

Skin: Skin is warm and dry. She is not diaphoretic.

Psychiatric: She has a normal mood and affect. Her behavior is normal. Judgment and thought content normal.

Assessment

Assessment/Plan:

Problem List Items Addressed This Visit

Other

Anxiety - Primary

Advised to continue to consider SSRI. Fluoxetine 20 and 40 mg were attempted March through May 2016. At that time she was suffering with weight loss. She was taking alprazolam at that time only 1-2 times per week. In follow-up in 2016 mood appeared to be stable.

Hyperlipidemia

Agrees to resume at a lower dose and add coenzyme Q 10. Close recheck 2 months

Relevant Medications

atorvastatin (LIPITOR) 20 MG tablet

Progress Notes Encounter Date: 5/24/2018

Jennifer Taylor Ellis, MD

Family Medicine

Office Visit Note

5/24/2018

Subjective:

Subjective

Jennie C Cox is a 65 y.o. female.

Chief Complaint

Patient presents with

- Hyperlipidemia
F/U to discuss lab results.

HPI

Last visit 2/2018:

Hyperlipidemia: Agreed to resuming statin with coQ10. Was taking chol medicine at CPE 11/2017. Started after labs 11/2017. Continued after that for undetermined time. Reports has been taking since the last visit. No labs since the last visit bc Medicare not paying for labs- she is trying to work this out. Believes CoQ10 has helped avoid muscle aches.

1 meal/ day. Grilled chicken

Mood: Discussed SSRI again last visit as well as today— still not interested. Stressors include continued battles over workers comp. Still sees daughters regularly, who are both good sources of support. Symptoms are unchanged and include depressed mood, excessive worry, nervous/anxious behavior and panic. Patient reports no chest pain, confusion, decreased concentration, dizziness, feeling of choking, irritability or nausea. The severity of symptoms is mild. The quality of sleep is good. Nighttime awakenings: several. . Still not working. Still going to court over her Worker's Comp. Using alprazolam variably- similar to previous visit. Reports not taking every day but may take another days once or twice.

Review of Systems

Constitutional: Negative for activity change, appetite change, chills and fever.

Respiratory: Negative for chest tightness and shortness of breath.

Cardiovascular: Negative for chest pain and palpitations.

Gastrointestinal: Negative for abdominal pain, diarrhea and nausea.

Objective:

BP 110/72 | Temp 97.9 °F (36.6 °C) | Wt 56.9 kg (125 lb 6.4 oz) | BMI 19.94 kg/m²

ObjectivePhysical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion.

Neurological: She is alert and oriented to person, place, and time. She has normal reflexes.

Skin: Skin is warm and dry. No rash noted. She is not diaphoretic. No erythema.

Psychiatric: She has a normal mood and affect. Her behavior is normal. Judgment and thought content normal.

Assessment**Assessment/Plan:****Problem List Items Addressed This Visit**Other**Anxiety**

Continues to take alprazolam regularly temazepam at bedtime. Discussed SSRI yet again. Will be due for refills in August and can send it electronically if needed

Hyperlipidemia

Currently has an issue where Medicare is not paying for her labs or office visits. Did not get repeat labs prior to today's visit because of that. Did encourage her to continue on Lipitor and get labs prior to follow-up. However I do understand the financial limitations at this time

Return in about 3 months (around 8/24/2018).

Medications

Accurate as of 5/24/18 11:03 AM. If you have any questions, ask your nurse or doctor.



**GREENVILLE
HEALTH SYSTEM**

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681 3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 8/2/2018

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 8/2/2018

Jennifer Taylor Ellis, MD

Family Medicine

Office Visit Note

8/2/2018

Subjective:

Subjective

Jennie C Cox is a 65 y.o. female.

Chief Complaint

Patient presents with

- Follow-up
Patient Care, Paperwork

HPI

Patient presents for documentation of chronic issues for workers comp paperwork. Her sister who is a nurse practitioner was present to help fill in the history

Weight loss: Since weight has resumed normal weight, she has been able to maintain her baseline weight. However as per previous history she did have significant weight loss associated with her mandibular surgery as well as depression associated with it

A review of her treatment for the workers comp injury included: L shoulder pain and PT; treatment of mandibular fractures by oral surgeon Dr Cobb and dental implant. Dr Ridgil. Needs continued care of dental implants q 6 months. Continue mouth/ dental pain, and sholder pain.

Depression: Continues to feel regularly depressed, anxiety- most days. Needs restoril to sleep. Concentration poor, appetite poor, very nerouse, calls sister crying on the phone. Lack of interest in cleaning Poor compliance. Sister believed she tried Prozac, Wellbutrin.

Machine fell on her while on a dock. Mandibular fracture/ teeth avulsed into sinuses. Surgery with plate in place, infection, approx 6 months.

Review of Systems

Constitutional: Positive for activity change and appetite change. Negative for chills and fever.

HENT: Positive for dental problem.

Respiratory: Negative for chest tightness and shortness of breath.

Cardiovascular: Negative for chest pain and palpitations.

Gastrointestinal: Negative for abdominal pain, diarrhea and nausea.
 Psychiatric/Behavioral: Positive for agitation, dysphoric mood and sleep disturbance. The patient is nervous/anxious.

Objective:

BP 119/75 (BP Location: Left arm, Patient Position: Sitting) | Pulse 77 | Temp 98 °F (36.7 °C)
 (Oral) | Wt 56 kg (123 lb 6.4 oz) | BMI 19.62 kg/m²

Objective

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion. She exhibits no edema or tenderness.

Neurological: She is alert and oriented to person, place, and time. She has normal reflexes.

Skin: Skin is warm and dry. She is not diaphoretic.

Psychiatric: Her behavior is normal. Judgment and thought content normal. She exhibits a depressed mood.

Assessment

Assessment/Plan:

Problem List Items Addressed This Visit

Other

Anxiety - Primary

Mild episode of recurrent major depressive disorder (HCC)

Discussed the importance of prevention as we have on previous visits. Patient understands but still refuses SSRI. Sister will continue to talk with her as well

No Follow-up on file.

Medications

Accurate as of 8/2/18 5:52 PM. If you have any questions, ask your nurse or doctor.

Existing Medications

	Sig	Disp	Refill	Start	End
ALPRAZolam 0.5 mg tablet Commonly known as: XANAX	Sig: Take 1 tablet (0.5 mg) by mouth 3 (three) times a day as needed for anxiety.	Disp: 60 tablet	Refill: 5		
atorvastatin 20 MG tablet Commonly known as: LIPITOR	Sig: Take 1 tablet (20 mg) by mouth daily.	Disp: 30 tablet	Refill: 11		
miscellaneous medication	Sig: Coenzyme Q10 100 mg Take 1 tab 1-2 x each daily as needed for muscle aches	Disp: 60	Refill: 5		
temazepam 30 mg capsule Commonly known as: RESTORIL	Sig: Take 1 capsule (30 mg) nightly.	Disp: 30 capsule	Refill: 5		

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition, and Due to this patient's BMI, I have provided counseling regarding physical activity.

Electronically signed by Jennifer Taylor Ellis, MD at 8/2/2018 5:52 PM

Office Visit
on 8/2/2018

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.



**GREENVILLE
HEALTH SYSTEM**

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 5/24/2018

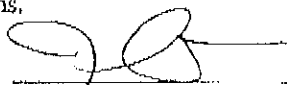
Cox, Jennie C

MRN: 971202636
Description: 65 year old female

<u>MEDICAL QUESTIONNAIRE</u>	<u>Yes</u>	<u>No</u>
for Jennie Cox		
1. It is our understanding that you are Ms. Cox's personal physician and have treated her for many years. Please state the time frame you have that you have been treating Ms. Cox. From <u>6/26/2010</u> to <u>present</u>		
2. Have you ever treated M. Cox for her work related injury of May 31, 2012 other than being authorized by the Workers' Compensation Insurance Carrier to issue a prescription for work hardening in 2016?		✓
3. In your medical opinion, does Ms. Cox need continued care relative to her injuries sustained?	✓	
4. It is our understanding that you have been treating Ms. Cox for depression prior to her work related injury. In your medical opinion, has Ms. Cox's depression worsened due to her work related accident on May 31, 2012 and if so, is that attributed to her accident?	✓	
5. In your medical opinion, has Ms. Cox's overall health deteriorated since her work related accident on May 31, 2012?	✓	
6. Did Ms. Cox complain to you relative to problems she may have had relating to her workers compensation claim of May 31, 2012?	✓	
Additional Comments:		

I, Jennifer T. Ellis, M.D., certify to a reasonable degree of medical certainty that the above statements are my expert medical opinions.

Dated: 8/2/18


Jennifer T. Ellis, M.D.
Hillcrest Family Practice
717 SE Main St
Simpsonville, SC 29681

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206236

JENNIE COX,
Employee
Claimant,

vs.

PALMETTO STATE
TRANSPORTATION,
Employer

AND

CHEROKEE INSURANCE COMPANY,
Carrier

Defendants.

APA SUBMISSIONS

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APA #28
Robert E. Brabham, PH.D.
07/16/18

PSYCHOLOGICAL AND TRAINING SERVICES, P.A.

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ROBERT E. BRABHAM, PH.D

LICENSED PSYCHOLOGIST

MASTER'S IN REHABILITATION COUNSELING

HUB BRABHAM JR., MRC

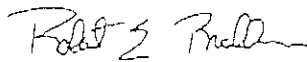
NORA HEAPE, RN, BA

AMYE HAWKINS, ADM. ASST.

BETH BURNETT, BA, EC

To: Juliette Brown Mims

From: Robert Brabham, PhD



Date: July 16, 2018

RE: Jennie Cox DOB 8-14-52

Thank you for the highly critical critique of my report in this matter. In reading my own language, I would have to agree that I was unclear as to her last date of employment, and I apologize for that mistake. The bottom line remains that she has not been able to work since June 2016, now more than two years ago.

I cannot question or explain why other records do not cover the same topics as do my reports. However, I do take exception to the comment that I am not qualified to establish any basis for the fatigue Ms. Cox has experienced since her injuries. As a matter of fact, fatigue, out of proportion to actual exertional efforts, is not an unusual reaction to the type of injury that Ms. Cox experienced. It is, in fact, one of the most common symptoms associated with pain lasting an extended period of time, as well as depression. In that regard, I am legally and professionally qualified to render an opinion.

As to my finding of depression, the fact that there was a pre-existing history exacerbated by the death of a family member does not change the fact that any pre-existing depression only served to exacerbate the quite-obvious depression she has experienced since loss of employment in 2016. I would respectfully point out that Ms. Cox had worked for many years, as pointed out by the defense attorney of record. In fact, I think it is to her credit that, in spite of that background, she had been able to maintain employment, as they pointed out.

I would also respectfully point out that there is extensive literature correlating the relationship between pain and depression. I was not mistakenly reporting her reports of pain, as she was quite clear in that regard. I would also respectfully point out that, somewhat by definition, pain remains a subjective symptom, best identified by the individual.

As to the fact that she has not sought treatment for depression, that is not an uncommon response. Individuals are often hesitant to request the need for such services. I would also respectfully disagree that it is improper for me to use the terms "it is reasonable for me to conclude"...that is, indeed, a very professional and proper term.

The comment that her reports were "self-serving" must be weighed against the credibility of her comments. It remains my professional opinion that consistency in reporting by an individual is entirely different from "self-serving." Indeed, I am quite careful to inquire as to the consistency of reports and am careful to point out consistencies when they are found.

Finally, I would respectfully suggest that many of the comments and quotes that I have made are based on her symptoms/conditions at the time of my evaluation. They were valid points at that time, and nothing pointed out in the rebuttal changes that fact. If anything, her credibility is enhanced by her efforts to continue working. Her efforts to avoid medication should not be used against her, especially in view of considerable publicity of individuals becoming addicted to such medications. Simply stated, it is my opinion that the absence of specific treatment noted by the defendants does not equate to the absence of symptoms, as noted in my report.

Again, I regret that I confused the dates as to her efforts to work and the last date of employment. The bottom line remains that she had a good work history prior to her injuries, and following the injuries, she was unable to maintain employment, with the causal effect being the on-the-job injuries noted.

If you have any further questions, please do not hesitate to contact me.

APA #34
Jennifer T. Ellis, M.D.
05/09/16-08/02/18

Progress Note

Patient Name: Jennie Cox
 Patient ID: 55780
 Sex: Female
 Birthdate: August 14, 1952

Visit Date: May 9, 2016
 Provider: Jennifer T. Ellis, MD
 Location: Hillcrest Family Practice
 Location Address: 717 SE Main St
 Simpsonville, SC 29681-3237
 Location Phone: (864) 522-5400

Chief Complaint

- F/U discuss weight loss.
- Pt declines to discuss smoking cessation.

History Of Present Illness

The patient returns for follow up of Her depression. Since the last visit She has been doing better. She is currently taking the following prescription medications: fluoxetine 20 mg oral tablet. She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is currently experiencing fatigue. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

5/9: chose not to increase fluoxetine, feels she is doing OK. energy level improving.

previous visit: Taking alprazolam 1 2 x/ week, when feeling worried about how going to get things done.

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Now drives - not supposed to drive over 11 hours.

Migrated from left Greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hyster/ooph; jaw surgery; Lysis of adhesions; Tonsillectomy

Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; fluoxetine 40 mg oral capsule; Restoril 30 mg oral capsule

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

Constitutional

- o Denies : weight loss, weight gain, loss of appetite

HENT

- o Denies : headaches

Neurologic

- o Denies : tingling or numbness

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
05/09/2016	01:22 PM	110/80	Sitting				100 - R		97.9		107lbs 6oz				

Physical Examination**Constitutional**

- o Appearance : *thin*, well developed, alert, in no acute distress, appears about reported age

Respiratory

- o Respiratory Effort : breathing unlabored
- o Auscultation of Lungs : normal breath sounds

Cardiovascular

- o Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- o Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Skin and Subcutaneous Tissue

- o General Inspection : no rashes present, no lesions present, no areas of discoloration present
- o General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- o Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- o Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- o Judgement and Insight : judgement and insight intact
- o Mood and Affect : normal, appropriate

Assessment

- Anxiety Disorder 300.00/F41.9
long discussion about relationship between job/ injury/ mood/ weight. believe wt loss / fatigue multifactorial. attempted to increase dose encouraged pt to pursue less demanding driving position.
- Weight loss 783.21/R63.4
pt would like to regain weight up to her previous baseline of 120. advised that unable to continue to recommend out of weight without clear deadline. agrees would be reasonable to return to work if maintains current level of weight.

Plan**Instructions**

- o Patient instructed to contact physician if mood disturbance intensifies
- o Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- o Return Visit Request in/on 2 weeks +/- 2 days (88575).

Correspondence

- o Work/School Excuse (Pain v3.6)FHV1 (Jennie C. Cox) - 05/09/2016

Electronically Signed by: Jennifer T. Ellis, MD -Author on May 10, 2016 05:28:27 PM

Progress Note

Patient Name: Jennie Cox
 Patient ID: 55780
 Sex: Female
 Birthdate: August 14, 1952

Visit Date: May 23, 2016
 Provider: Jennifer T. Ellis, MD
 Location: Hillcrest Family Practice
 Location Address: 717 SE Main St
 Simpsonville, SC 296813237
 Location Phone: (854) 522-5400

Chief Complaint

- f/u weight gain, general health

History Of Present Illness

The patient returns for follow up of Her depression Since the last visit She has been doing better She is currently taking the following prescription medications: fluoxetine 20 mg oral tablet She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is currently experiencing fatigue. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

5/23: weight continues to improve. worn out when went to wedding over the wedding. still taking fluox. stable mood wise. energy better with her pill. mirtazapine - never discontinued taking nightly.

5/9: chose not to increase fluoxetine, feels she is doing OK. energy level improving.

previous visit: Taking alprazolam 1-2 x/ week, when feeling worried about how going to get things done.

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Family tree - not supposed to drive over 10 hours.

Dedicated run: Left greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; CGD; hyster/coooph; jaw surgery; Cysts of adhesions; Tonsillectomy

Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; fluoxetine 20 mg oral capsule; Restoril 30 mg oral capsule

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

Constitutional

- o Denies : weight loss, weight gain, loss of appetite

HEENT

- o Denies : headaches

Neurologic

- o Denies : tingling or numbness

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	HR	Cuff Size	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
05/23/2016	04:12 PM	116/71	Sitting		86 - R		98.4		109lbs 6oz					

Physical Examination

Constitutional

- o Appearance : *Thin*, well developed, alert, in no acute distress, appears about reported age

Respiratory

- o Respiratory Effort : breathing unlabored
- o Auscultation of Lungs : normal breath sounds

Cardiovascular

- o Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- o Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Skin and Subcutaneous Tissue

- o General Inspection : no rashes present, no lesions present, no areas of discoloration present
- o General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- o Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- o Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- o Judgement and Insight : judgement and insight intact
- o Mood and Affect : normal, appropriate

Assessment

- Anxiety Disorder 300.00/F41.9

Informed by patient that has been on mirtazapine whole time, with good weight improvement, will continue. believe wt loss / fatigue multifactorial. If wt gain reverse, will increase dose prozac. encouraged pt to pursue less demanding driving position. will write note to ease back into work.

- Weight loss 783.21/R63.4

pt would like to regain weight up to her previous baseline of 120, however, may not be achievable. encouraged continued calorie supplementation.

Plan

Medications

- o mirtazapine 7.5 mg oral tablet
SIG: take 2 tablets (15 mg) by oral route once daily at bedtime for 30 days
DISP: (60) tablets with 0 refills
Prescribed on 05/23/2016

Instructions

- o Patient Instructed to contact physician if mood disturbance Intensifies
- o Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

Disposition

- o Return Visit Request in/on 2 weeks +/- 2 days (89282).

Electronically Signed by: Jennifer T. Ellis, MD -Author on May 25, 2016 10:25:04 AM

[Digital Signature Validated]

Progress Note

Patient Name: Jennie Cox
 Patient ID: 55780
 Sex: Female
 Birthdate: August 14, 1952

Visit Date: June 23, 2016
 Provider: Jennifer T. Ellis, MD
 Location: Hillcrest Family Practice
 Location Address: 717 SE Main St
 Simpsonville, SC 296813237
 Location Phone: (864) 522-5400

Chief Complaint

- F/U Anxiety
- Weight Loss

History Of Present Illness

The patient returns for follow up of Her depression Since the last visit She has been doing about the same. She is currently taking no prescription medications for this- stopped them herself after last visit. She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, fatigue, insomnia, loss of appetite, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

6/23: not working. worker's comp conversations occurring. patient reports problem with pain once started back driving. returned the week after visit, worked 3 weeks. told HR about pain from turning head / backing up etc.

5/23: weight continues to improve. worn out when went to wedding over the wedding. still taking fluox. stable mood wise. energy better with her pill. mirtazapine - never discontinued. taking nightly.

5/9: chose not to increase fluoxetine, feels she is doing OK. energy level improving.

previous visit: Taking alprazolam 1-2 x/ week, when feeling worried about how going to get things done

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Now drives - not supposed to drive over 11hours.

Dedicated run: Left greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low back pain

Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hyster/ooph; jaw surgery; Lysis of adhesions; Tonsillectomy

Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; fluoxetine 20 mg oral capsule; mirtazapine 7.5 mg oral tablet; Restoril 30 mg oral capsule

Allergy List

Magnesium; Nickel; Simvastatin; Ultram

Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

Review of Systems

Constitutional

- o Denies : weight loss, weight gain, loss of appetite

HEENT

- o Denies : headaches

Neurologic

- o Denies : tingling or numbness

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	LAR	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
06/23/2016	10:07 AM	104/69	Sitting				95 - R		96.5	108lbs 2oz	5' 6"	17.45	1.51		

Physical Examination

Constitutional

- o Appearance : *thin*, well developed, alert, in no acute distress, appears about reported age

Respiratory

- o Respiratory Effort : breathing unlabored
- o Auscultation of Lungs : normal breath sounds

Cardiovascular

- o Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- o Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Skin and Subcutaneous Tissue

- o General Inspection : no rashes present, no lesions present, no areas of discoloration present
- o General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- o Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- o Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- o Judgement and Insight : judgement and insight intact
- o Mood and Affect : normal, appropriate

Assessment

- Anxiety Disorder 300.00/F41.9
pt stopped med since last visit. reports feeling no different. watch. (see previous note for recs prior to d/cn) encouraged pt to pursue less demanding driving position. however, no further work excuses provided.
- Weight loss 783.21/R63.4
pt would like to regain weight up to her previous baseline of 120, however, may not be achievable. encouraged continued calorie supplementation.

Plan

Instructions

- o Patient instructed to contact physician if mood disturbance intensifies
- o Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for

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herself and/or dependents

Disposition

- o Call or Return if symptoms worsen or persist.

Correspondence

- o Work/School Excuse (Pain v3.6)FHV1 (Jennie C. Cox) - 06/23/2016
- o Light Duty Note (Revised)FHV2 (Jennie C. Cox) - 06/23/2016

Electronically Signed by: Jennifer T. Ellis, MD -Author on June 23, 2016 11:08:59 AM

[Digital Signature Validated]

Progress Note

Patient Name:	Jennie Cox	Visit Date:	September 20, 2016
Patient ID:	55780	Provider:	Jennifer T. Ellis, MD
Sex:	Female	Location:	Hillcrest Family Practice
Birthdate:	August 14, 1952	Location Address:	717 SE Main St Simpsonville, SC 296813237
		Location Phone:	(864) 522-5400

Chief Complaint

- f/u weight loss and exercise

History Of Present Illness

The patient returns for follow up of Her depression Since the last visit She has been doing better She is currently taking no prescription medications for this. She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, fatigue, insomnia, loss of appetite, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

9/20: Has been going to Life Center, seeing personal trainer. Needs a note that needs personal training needed to help her gain weight. Has been attending for over a month. Convinced it is helping her a lot. PT directing her on use of the machines. Has been going Wed and Fridays with the personal trainer- 30 min ute each sesioon. Trying to do the weights and exercise balls.

Sees her daughter periodically a few weeks/ once per month;

Grits/ fruit/ burgers/ chicken.

Taking Restoril nightly, alprazolam once daily.

Still talking to workers comp

Pt reports she has contacted workers comp about missed work. Her attorney spoke with her about

6/23: not working. worker's comp conversations occurring. pateint reports problem with pain once started back driving. returned the week after vist, worked 3 weeks. told HR about pain from turning head / backing up etc.

5/23: weight continues to improve. worn out when went to wedding over the wedding. still taking fluox. stable mood wise. energy better with her pill. mirtazipine - never discontinued. taking nightly.

5/9: chose not to increase fluoxetine, feels she is doing OK. energy level improving.

previous visit: Taking alprazolam 1-2 x/ week, when feeling worried about how going to get things done

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Now drives - not supposed to drive over 11 hours.

Dedicated run: Left greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

Past Medical History

Disease Name	Date Onset	Notes
Abdominal Radiologic Abnormality	3/5/08	see CT report- L adrenal gland abnormality
Anxiety disorder	--	--
Bone Infection	2001	Dr. devault- I & D ? R hamstring Insertion/ Infection. a/w overuse unloading hand truck. infxn noted upon re-attachment

Hypercholesterolemia	11/26/2010	of hamstring per pt?
Insomnia	--	h/o given. willing to work on diet/ exercise. re check 4 mos. Did not tolerate simvastatin- felt "sick," malaise
Irritable Bowel Syndrome	2004-2007	--
Joint Pain	--	w/u by GI Assoc- for IBS- Hartley- upper GI, small bowe series, U/S, HIDA Scan 2004-2007
Low back pain	--	--
	--	? HNP L5/s1

Past Surgical History

Procedure Name	Date	Notes
Adenoidectomy	--	--
Appendectomy	? at time of ooph	--
Colonoscopy	8/16/04	Int/ext hemorrhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after wth emesis)
EGD	10/04	mild erythema
hystw/ooph	age 20s/ 1990s	hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery
jaw surgery	5/2012- multiple	Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr COBB- oral surgeon, Dr Ridgill prosthetic orthodontist
Lysis of adhesions	surgeries 1990s	bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Blouin and May
Tonsillectomy	--	--

Medication List

Name	Date Started	Instructions
alprazolam 0.5 mg oral tablet	08/30/2016	take 1 tablet (0.5 mg) by oral route 3 times per day
Restoril 30 mg oral capsule	08/30/2016	take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days

Allergy List

Allergen Name	Date	Reaction	Notes
Magnesium	--	--	--
Nickel	--	?metal allergy?	--
simvastatin	--	malaise	--
Ultram	--	--	--

Family Medical History

Disease Name	Relative/Age	Notes
Alzheimer's Disease	/	--
	Aunt/ Grandmother (maternal)/ Mother/	
DM Type II	/	--
	Aunt/ Uncle/	
Myocardial Infarction, Acute	/	--
	Father/70	

Social History

Finding	Status	Start/Stop	Quantity	Notes
Children	--	--/--	--	2 daughters
Divorced	--	--/--	--	--
Grandchildren	--	--/--	--	5 gkids- 3 girls, 2 boys; had gson oldest that lost 2008; 2 younger girls (Madison 12, Emily 7) with same mom (tammy); oldest 40 yo

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Sonya- with twin brother and son (17 yo)
 Marthow and Meghan), older brother died-
 Michael -was at 16 yo from MVA

Nondrinker	--	--	--
Smoker	--	--	2 ppd
Tobacco	Current every day	18/--	2 PPD
Truck Driver	--	--	--

Review of Systems

Constitutional

- o Denies : weight loss, weight gain, loss of appetite

HEENT

- o Denies : headaches

Neurologic

- o Denies : tingling or numbness

Psychiatric

- o Denies : additional psychiatric symptoms except as noted in the HPI

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HI	BMI kg/m ²	BSA m ²	O2 Sat	Hct	
09/20/2016	12:48 PM	130/83	Sitting				121 - R		98.2		166lbs 6oz					

Physical Examination

Constitutional

- o Appearance : thin, well developed, alert, in no acute distress, appears about reported age

Respiratory

- o Respiratory Effort : breathing unlabored
- o Auscultation of Lungs : normal breath sounds

Cardiovascular

- o Heart :
 - Auscultation of Heart : regular rate and rhythm, no murmurs present
- o Peripheral Vascular System :
 - Extremities : no edema or cyanosis

Skin and Subcutaneous Tissue

- o General Inspection : no rashes present, no lesions present, no areas of discoloration present
- o General Palpation : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

Neurologic

- o Mental Status Examination :
 - Orientation : oriented
 - Memory : memory intact
- o Cranial Nerves : cranial nerves intact bilaterally

Psychiatric

- o Judgement and Insight : judgement and insight intact
- o Mood and Affect : normal, appropriate

Assessment

- Anxiety Disorder 300.00/F41.9
pt stopped med x few months, mood appears stable. monitor.
- Hypercholesterolemia 272.0/E78.0
- Weight loss 783.21/R63.4
has regained weight - striving to reach previous baseline of 120. encouraged continued calorie supplementation/ resistance and endurance training.

Plan

Instructions

- o Patient Instructed to contact physician if mood disturbance intensifies
- o Patient Instructed to seek medical help immediately if suicidal or homicidal ideation occur, or If she is unable to care for herself and/or dependents

Disposition

- o CPX

Correspondence

- o Work/School Excuse (Pain v3.6)FHV1 (Jennie C. Cox) - 09/20/2016

Electronically Signed by: Jennifer T. Ellis, MD -Author on September 20, 2016 01:38:16 PM

LabCorp - Lab - General Lab

Specimen #: 328-076-2309-0

Report Status: Final Results



Patient Information:

Name: Cox, Jennie C

Patient ID: 55780

Sex: F

DOB: 08/14/1952

Address: 222 W Chapman Road
Belton, SC 29627-

Phone #: (864)243-0032

SSN: ###-##-3648

Date of Specimen: 11/23/2016 11:09

Date Received: 11/23/2016 00:00 Specimen Source:

Date Reported: 11/24/2016 07:39

Physician: ELLIS, J

Information:

Test Name	Result	Flags	Reference Range	Lab

Comments: Fasting=Y

CMP12+LP+6AC+CBC/D/Pit+TSH+Fer

Glucose, Serum	85 mg/dL		65-99 mg/dL	BN
Uric Acid, Serum	6.4 mg/dL		2.5-7.1 mg/dL	BN
	Therapeutic target for gout patients: <6.0			
BUN	18 mg/dL		8-27 mg/dL	BN
Creatinine, Serum	1.01 mg/dL	H	0.57-1.00 mg/dL	BN
eGFR If NonAfricn Am	59 mL/min/1.73	L	>59 mL/min/1.73	BN
eGFR If Africn Am	58 mL/min/1.73		>59 mL/min/1.73	BN
Sodium, Serum	138 mmol/L		136-144 mmol/L	BN
Potassium, Serum	4.9 mmol/L		3.5-5.2 mmol/L	BN
Chloride, Serum	100 mmol/L		97-106 mmol/L	BN
Calcium, Serum	9.8 mg/dL		8.7-10.3 mg/dL	BN
Phosphorus, Serum	3.6 mg/dL		2.5-4.5 mg/dL	BN
Protein, Total, Serum	7.3 g/dL		6.0-8.5 g/dL	BN
Albumin, Serum	4.6 g/dL		3.6-4.8 g/dL	BN
Globulin, Total	2.7 g/dL		1.5-4.5 g/dL	BN
Bilirubin, Total	0.3 mg/dL		0.0-1.2 mg/dL	BN
Alkaline Phosphatase, S	97 IU/L		39-117 IU/L	BN
LDH	184 IU/L		119-226 IU/L	BN
AST (SGOT)	23 IU/L		0-40 IU/L	BN
ALT (SGPT)	13 IU/L		0-32 IU/L	BN
GGT	13 IU/L		0-60 IU/L	BN
Iron, Serum	67 ug/dL		27-139 ug/dL	BN
Ferritin, Serum	49 ng/mL		15-150 ng/mL	BN
Cholesterol, Total	258 mg/dL	H	100-199 mg/dL	BN
Triglycerides	179 mg/dL	H	0-149 mg/dL	BN
HDL Cholesterol	56 mg/dL		>39 mg/dL	BN
LDL Cholesterol Calc	166 mg/dL	H	0-99 mg/dL	BN
T. Chol/HDL Ratio	4.6 ratio units	H	0.0-4.4 ratio units	BN
T. Chol/HDL Ratio				
1/2 Avg. Risk 3.4 3.3				
Avg. Risk 5.0 4.4				
2X Avg. Risk 9.6 7.1				
3X Avg. Risk 23.4 11.0				

Estimated CHD Risk

1.1 times avg.	H	0.0-1.0 times avg.	BN
T. Chol/HDL Ratio			
1/2 Avg. Risk 3.4 3.3			
Avg. Risk 5.0 4.4			
2X Avg. Risk 9.6 7.1			
3X Avg. Risk 23.4 11.0			

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

1.730 uIU/mL

0.450-4.500 uIU/mL

BN

[Digital Signature Validated]

WBC	6.4 x10E3/uL	3.4-10.8 x10E3/uL	BN
RBC	4.74 x10E6/uL	3.77-5.28 x10E6/uL	BN
Hemoglobin	15.4 g/dL	11.1-15.9 g/dL	BN
Hematocrit	43.6 %	34.0-46.6 %	BN
MCV	92 fL	79-97 fL	BN
MCH	32.5 pg	26.6-33.0 pg	BN
MCHC	35.3 g/dL	31.5-35.7 g/dL	BN
RDW	12.5 %	12.3-15.4 %	BN
Platelets	323 x10E3/uL	150-379 x10E3/uL	BN
Neutrophils	63 %		BN
Lymphs	27 %		BN
Monocytes	6 %		BN
Eos	3 %		BN
Basos	1 %		BN
Neutrophils (Absolute)	4.0 x10E3/uL	1.4-7.0 x10E3/uL	BN
Lymphs (Absolute)	1.7 x10E3/uL	0.7-3.1 x10E3/uL	BN
Monocytes (Absolute)	0.4 x10E3/uL	0.1-0.9 x10E3/uL	BN
Eos (Absolute)	0.2 x10E3/uL	0.0-0.4 x10E3/uL	BN
Baso (Absolute)	0.1 x10E3/uL	0.0-0.2 x10E3/uL	BN
Immature Granulocytes	0 %		BN
Immature Grans (Abs)	0.0 x10E3/uL	0.0-0.1 x10E3/uL	BN

Lab Name:	LabCorp Burlington (BN)	Director:	William F Hancock
Address:	1447 York Court Burlington, NC 27215-3361	Phone #:	8007624344

History and Physical

Patient Name: Jennie Cox
Patient ID: 55780
Sex: Female
Birthdate: August 14, 1952

Visit Date: November 23, 2016
Provider: Jennifer T. Ellis, MD
Location: Hillcrest Family Practice
Location Address: 717 SE Main St
Simpsonville, SC 296813237
Location Phone: (864) 522-5400

Chief Complaint

- Comprehensive exam
- Pt declines flu and tetanus vaccines.
- Pt declines to discuss smoking cessation.

labs drawn this morning
vision checked yearly
pt needs pelvic exam
pt needs mammogram

History Of Present Illness

Jennie C. Cox is a 64 year old Caucasian/White female who presents for her annual comprehensive exam. It has been 1 year since her last check up. She is due for the following health maintenance items: DRE, EKG, fasting labs, hemocult testing, mammogram, pap smear, urinalysis, and visual exam.

Exercise History

She does not exercise regularly but is very active.

Dietary Habits

She provided the following examples for meals on an average day. A typical breakfast might consist of some or all of the following: usu Ensure. Lunch is usually comprised of some or all of the following: snacks of chicken, vege. Some examples of typical supper food would be some or all of the following: a home cooked meal of a meat and three and chicken/vegetables/vege. She does not eat desert very often. Typical beverages consumed throughout the day include coffee and iced tea. She regularly consumed sugar sweetened beverages. On a typical day she might consume two sweet drinks. She does not drink alcohol.

Tobacco History

She uses cigarettes 1 pack/s per day.

Current Medical Problems Followed by Us

She is followed by us for hyperlipidemia and an anxiety disorder. The patient's mixed lipids levels have been poorly controlled with diet alone and are detailed in the laboratory reports. The anxiety disorder has been essentially unchanged since the last visit and waxing and waning in severity.

Jennie C. Cox is a 64 year old Caucasian/White female who presents for her annual exam. She is a GRAVIDA PARA who underwent a TAH/BSO 25 years ago for menorrhagia. Since her last visit, there have been no significant changes in her health history.

She has no current complaints.

The patient is not taking HRT medication. She is having no vasomotor symptoms.
She has not had a recent mammogram. A screening mammogram has been ordered.
She does not perform self breast exams.
The patient has no maternal family history of breast cancer.
She is currently single.

went through PT. ordered 20 sessions, has been approx 1/2 way through. strengthening program- lifting boxes, near Patewood

2012/13- jaw surgeries. back to work 2013. back out of work 10/2015.
In/ out

has been out since June 2016 this round.

Initial eval L arm - 4.5 yrs ago

cvs moonville 2990234

Past Medical History

Disease Name	Date Onset	Notes
Abdominal Radiologic Abnormality	3/5/08	see CT report- L adrenal gland abnormality
Anxiety disorder	--	--
Bone Infection	2001	Dr. devault- I & D R hamstring insertion/ Infection, a/w overuse unloading hand truck. Infxn noted upon re-attachment of hamstring per pt
Hypercholesterolemia	11/26/2010	h/o given. willing to work on diet/ exercise. re check 4 mos. Did not tolerate simvastatin- felt "sick," malaise
Insomnia	--	--
Irritable Bowel Syndrome	2004-2007	w/u by GI Assoc- for IBS- Hartley- upper GI, small bowe series, U/S, HIDA Scan 2004-2007
Joint Pain	--	--
Low back pain	--	HNP L5/s1

Past Surgical History

Procedure Name	Date	Notes
Adenoidectomy	--	--
Appendectomy	at time of ooph	--
Colonoscopy	8/16/04	int/ext hemorrhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after with emesis)
EGD	10/04	mild erythema
hystw/ooph	age 20s/ 1990s	hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery
jaw surgery	5/2012- multiple	Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr COBB- oral surgeon, Dr Ridgill prosthetic orthodontist
Lysis of adhesions	surgeries 1990s	bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Bioulin and May
Tonsillectomy	--	--

Medication List

Name	Date Started	Instructions
alprazolam 0.5 mg oral tablet	08/30/2016	take 1 tablet (0.5 mg) by oral route 3 times per day
Restoril 30 mg oral capsule	08/30/2016	take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days

Allergy List

Allergen Name	Date	Reaction	Notes
Magnesium	--	--	--
Nickel	--	metal allergy	--
simvastatin	--	malaise	--

Ultram

Family Medical History

Disease Name	Relative/Age	Notes
Alzheimer's Disease	/	--
	Aunt/	
	Grandmother	
	(maternal)/	
DM Type II	Mother/	
	/	--
	Aunt/	
Myocardial Infarction, Acute	Uncle/	
	/	--
	Father/70	

Social History

Finding	Status	Start/Stop	Quantity	Notes
Children	--	--/--	--	2 daughters
Divorced	--	--/--	--	--
Grandchildren	--	--/--	--	5 gklds- 3 girls, 2 boys; had gson oldest that lost 2008; 2 younger gils (Madison 12, Emily 7) with same mom (tammy); oldest 40 yo Sonya- with twin brother and son (17 yo) Marthow and Meghan), older brother died- Michael -was at 16 yo from MVA
Nondrinker	--	/	--	--
Smoker	--	--/--	2 ppd	--
Tobacco	Current every day	18/--	2 PPD	--
Truck Driver	--	--/--	--	--

Review of Systems

- Constitutional**
- o Admits : tired very easily;
 - o Denies : fever, chills, weight loss, weight gain
- Eyes**
- o Denies : double vision, changes in vision, floaters
- HENT**
- o Admits : painful to chew, cannot open mouth wide, unable to bite down
 - o Denies : headaches, nose bleeding, hearing loss, tinnitus, snoring, hoarseness
- Breasts**
- o Denies : lumps, tenderness, nipple discharge, masses, skin changes
- Cardiovascular**
- o Denies : chest pain, dyspnea on exertion, orthopnea, lower extremity edema, palpitations
- Respiratory**
- o Denies : shortness of breath, cough, hemoptysis
- Gastrointestinal**
- o Denies : nausea, vomiting, change in bowel habits, dysphagia, heartburn, frequent heartburn, abdominal pain, blood in stools
- Genitourinary**
- o Denies : urgency, frequency, dysuria, nocturia, hematuria, incontinence, decreased stream, decreased libido
- Integument**
- o Denies : rash, new skin lesions, changes to existing skin lesions or moles
- Neurologic**
- o Denies : tingling or numbness, memory difficulties, tremors
- Musculoskeletal**
- o Admits : shoulder pain after PT
 - o Denies : joint pain, joint swelling, muscle pain
- Endocrine**
- o Denies : polyuria, polydipsia, cold intolerance, heat intolerance, weight gain

Psychiatric

- o Admits : believes mood reasonable; does worry about finances; girls provide strength/ supportive, gklds
- o Denies : anxiety, depression, difficulty sleeping

Heme-Lymph

- o Denies : easy bleeding, easy bruising, lymph node enlargement or tenderness

Allergic-Immunologic

- o Denies : sinus allergy symptoms

Physical Examination**Constitutional**

- o Appearance : *thin*, well developed, alert, in no acute distress, appears about reported age

Head and Face**o Head :**

- Inspection : atraumatic, normocephalic
- Palpation : no tenderness or masses present

o Face :

- Inspection : no facial lesions

Eyes**o Vision :**

- Acuity : visual acuity grossly normal at distance O.U., near vision grossly intact O.U.

o Conjunctivae : conjunctiva normal**o Sclerae :** sclera white**o Pupils and Irises :** pupils equal, round, and reactive to light and accommodation bilaterally**o Ophthalmoscopic Exam :** retinas are normal without hemorrhage or exudate, no AV crossing changes, optic disk normal with normal cup to disk ratio**o Corneas :** no lesions present**o Eyelids/Ocular Adnexae :** eyelid appearance normal, no erythema or lesions noted**Ears, Nose, Mouth and Throat****o Ears :**

- External Ears : appearance within normal limits, no lesions present

- Otoscopic Examination : tympanic membrane appearance within normal limits bilaterally without perforations, mobility normal

- Hearing : intact to conversational voice both ears

o Nose :

- External Nose : appearance normal

- Intranasal Exam : mucosa within normal limits, no intranasal lesions present

- Nasopharynx : no lesions or inflammation

o Oral Cavity :

- Oral Mucosa : no worrisome oral lesions present

- Lips : lip appearance normal

- Teeth : normal dentition for age

- Gums : gums pink, no lesions

- Tongue : tongue appearance normal, no lesions

- Palate : hard palate normal, soft palate appearance normal

o Throat :

- Oropharynx : no inflammation or lesions present

- Hypopharynx : appearance within normal limits, no erythema or lesions

Neck

- o Inspection/Palpation : normal appearance, no masses or tenderness, trachea midline

- o Range of Motion : cervical range of motion within normal limits

- o Thyroid : not enlarged, no nodules, non-tender

Respiratory

- o Respiratory Effort : breathing unlabored

- o Inspection of Chest : normal appearance, no retractions

- o Auscultation of Lungs : clear and equal bilaterally

Cardiovascular**o Heart :**

- Auscultation of Heart : regular rate and rhythm, no appreciable murmurs, rubs or gallops
- Palpation of Heart : normal apical impulse, no cardiac thrill present

o Peripheral Vascular System :

- Carotid Arteries : no appreciable bruits present

- Abdominal Aorta : aortic pulse normal without bruits

- Femoral Arteries : normal femoral pulses, no appreciable bruits
- Pedal Pulses : normal dorsalis pedis and posterior tibial pulses bilaterally
- Extremities : no clubbing, cyanosis or edema

Breasts

- Inspection of Breasts : no dimpling, retractions or other skin changes
- Palpation of Breasts, Axillae : no masses, tenderness or adenopathy noted on palpation

Gastrointestinal

- Abdominal Examination : bowel sounds positive, non-distended, no appreciable masses or tenderness
- Liver and spleen : no appreciable hepatomegaly present, liver nontender to palpation, spleen not palpable
- Hernias : no appreciable hernias present

Genitourinary

- External Genitalia : no inflammation, no lesions present
- Vagina : normal vaginal vault, no discharge present, no inflammatory lesions present, no masses present
- Urethra : no inflammation, no lesions
- Bladder : nontender to palpation
- Cervix : *cervix not present*, no lesions present, nontender to palpation, no discharges, no bleeding present, normal midline position
- Uterus : *surgically absent*, no masses present, position midline/midplane, size normal
- Adnexa : no tenderness or masses present on bimanual examination
- Anus : no inflammation or lesions present
- Perineum : perineum within normal limits
- Digital Rectal Examination : normal sphincter tone, no rectal masses present
- Occult Blood in Stool : Hemoccult test negative, normal appearing stool present on glove

Lymphatic

- Neck : no lymphadenopathy present
- Axilla : no lymphadenopathy present
- Groin : no lymphadenopathy present
- Supraclavicular Nodes : no supraclavicular nodes
- Preauricular Nodes : no preauricular nodes present

Musculoskeletal

- Spine :
 - Inspection/Palpation : no spinal tenderness, scoliosis or kyphosis present
- Right Upper Extremity :
 - Inspection/Palpation : no atrophy or deformity noted, no edema, swelling or erythema present, no ecchymosis, no tenderness to palpation
 - Range of Motion : full passive range of motion, full active range of motion, no joint crepitus present
- Left Upper Extremity :
 - Inspection/Palpation : no atrophy or deformity noted, no edema swelling or erythema present, no ecchymosis, no tenderness to palpation
 - Range of Motion : full passive range of motion, full active range of motion, no joint crepitus present
- Right Lower Extremity :
 - Inspection/Palpation : no atrophy or deformity noted, no edema, swelling, or erythema present, no ecchymosis, no tenderness to palpation
 - Range of Motion : range of motion normal, no joint crepitus present, no pain on motion
- Left Lower Extremity :
 - Inspection/Palpation : no atrophy or deformity noted, no edema, swelling, or erythema present, no ecchymosis, no tenderness to palpation
 - Range of Motion : range of motion normal, no joint crepitus present, no pain on motion

Skin and Subcutaneous Tissue

- General Inspection : no rashes or worrisome lesions present
- General Palpation : no skin or subcutaneous tissue masses present, no tenderness to palpation, skin turgor normal
- Body Hair : scalp palpation normal, hair normal for age, general body hair distribution normal for age
- Digits and Nails : no clubbing or cyanosis, normal appearing nails

Neurologic

- Mental Status Examination :
 - Orientation : grossly oriented to person, place and time
 - Memory : intact in that we were able to conduct the interview
- Cranial Nerves : cranial nerves intact and symmetric throughout
- Motor Examination : grossly normal
- Reflexes : DTR's 2 bilaterally
- Sensation : grossly intact
- Gait and Station : normal gait, able to stand without difficulty

Psychiatric

- o **Judgement and Insight** : Judgment and insight intact
- o **Thought Processes** : rate of thoughts normal, thought content logical, abstract reasoning within normal limits
- o **Mood and Affect** : mood normal, affect appropriate
- o **Presence of Abnormal Thoughts** : no hallucinations, no delusions present, no psychotic thoughts

Results**In-Office Procedures****Lab procedure****Automated urinalysis without microscopy (81003)**

- Bilirub Ur Ql Strip: neg
- Glucose Ur-sCnc: neg
- Hgb Ur Ql Strip: moderate
- Ketones Ur Ql Strip: neg
- Nitrite Ur Ql Strip: neg
- pH Ur-LsCnc: 5.5
- Prot Ur Ql Strip: neg
- Sp Gr Ur Qn: 1.020
- Urobilinogen Ur-mCnc: 0.2 E.U./dL
- WBC Est Ur Ql Strip: neg

Assessment

- Annual physical exam V70.0/Z00.00
- Anxiety disorder 300.00/F41.9
- Hypercholesterolemia 272.0/E78.00
call with labs
- General Medical Exam, Adult V70.0/Z00.00
wrote down zostavax for her to assess if covered
- Insomnia 307.40/F51.9
Stable
- Anxiety Disorder 300.00/F41.9
- Hypercholesterolemia 272.0/E78.00
Did not tolerate simvastatin- felt "sick," initiated trial low dose atorvastatin.
- Microscopic hematuria 599.72/R31.29
urology for persistent hematuria- referred again 11/2016. did not FU in past. discussed risk of bladder cancer
- Abdominal Radiologic Abnormality 793.6
see CT report- L adrenal gland abnormality- CT to review along with above.

Plan**Orders**

- o General health panel (80050) - V70.0/Z00.00, 300.00/F41.9, 272.0/E78.00 - 11/23/2016 -- (Standing Order 1 of 1 - occurring every 0 days)
- o ECG (12-lead electrocardiogram) (0178T, 0179T, 0180T, 93041, 93042, 93224, 93226, 93000, 93005, 93010, 93010, 93225, 93227, 93000) -- 11/23/2016
- o General health panel This panel must include the following: Comp (80050, 80050) -- 11/23/2016
- o Lipoprotein, direct measurement; high density cholesterol (HDL c (83718, 83718) -- 11/23/2016
- o Urine culture (87086, 87086) -- 11/23/2016

Instructions

- o Recommend regular exercise
- o Recommend working on weight loss as we discussed
- o Recommend a heart healthy diet
- o Schedule screening mammogram
- o The labs you had drawn today should be back within 3 business days. We will call you only if there are abnormalities that we need to discuss.

Disposition

- o Return Visit Request in/on 2 months +/- 2 days (97450).

Electronically Signed by: Jennifer T. Ellis, MD -Author on November 23, 2016 10:18:07 AM

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.



GREENVILLE
HEALTH SYSTEM

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 11/22/2017

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 11/22/2017

Jennifer Taylor Ellis, MD

Family Medicine

Subjective:

Chief Complaint

Patient presents with

- Annual Exam

Welcome To Medicare, labs in emr, vision checked yearly, pt declines mammogram and pelvic exam.

HPI

Subjective

Patient ID: Jennie C Cox is a 65 y.o. female.

The patient returns today for an Annual Wellness Visit (AWV), medication refills, and review of chronic medical problems.

Health Questionnaire

1. Do you have any difficulty managing your finances? **NO**
2. Do you have any difficulty managing your medication? **NO**
3. Do you have any difficulty getting up and down off a toilet? **NO**
4. Do you have any difficulty getting into and out of the bathtub? **NO**
5. Do you use a cane or a walker? **NO**
6. Have you fallen recently? **NO**
7. In the last 2 weeks, have you had little interest or pleasure in doing things? **NO**
8. In the last 2 weeks, have you felt down, depressed or hopeless? **NO**
9. Have you discussed with your family what you would like to have happen when you are close to death? (Living Will) **YES**
10. Overall, how would you rate your health? good

Health Risk Assessment/ Medicare Annual Wellness Visit, Hillcrest Family Practice completed and reviewed.

Six-Item Screener to Identify Cognitive Impairment: Passed.

Mini- Mental State Examination score if performed:

Preventive Health

Date of most recent vaccination below, or: Are all up to date? Yes

Pneumococcal Pneumovax

Pneumococcal Prevnar

Influenza

Varicella Zoster

Tetanus/Pertussis

Cancer Screening: UTD or will schedule: Yes

Mammogram

Colonoscopy

Annual LDCT (age 55-80, 30 pack year ho, currently smoke or have quit in 15 yrs)

Disease Screening: UTD, n/a or will schedule: Yes

Bone Density UTD

Eye exam UTD

Cholesterol reviewed

Diabetes reviewed

Smoking counseling n/a

High Risk Only

EKG

Hepatitis B vaccine No

Hepatitis C screening (DOB 1945-1965) Declines

HIV screening Declines

Objective:

Vitals:

Vitals:

11/22/17 1619

BP: 117/66

Pulse: (I) 95

Temp: 97.7 °F (36.5 °C)

Weight: 55.5 kg (122 lb 6.4 oz)

Height: 1.689 m (5' 6.5")

Body mass index is 19.46 kg/m².

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition, and Due to this patient's BMI, I have provided counseling regarding physical activity.

Cognitive screen performed as above.

Hearing screen performed and passed.

Visual Acuity performed and normal.

Get up and Go Test performed and passed.

My health assessment and suggested preventive care plan were reviewed with the patient today and shared decision-making with appropriate action was taken based on information obtained and the patient's wishes.

Electronically signed by Jennifer Taylor Ellis, MD at 11/22/2017 8:59 PM

Office Visit on
11/22/2017

Chart Review Routing History

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GREENVILLE
HEALTH SYSTEM

Hilcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 8/21/2017

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 8/21/2017

Jennifer Taylor Ellis, MD

Family Medicine

3/21/2017

Office Visit Note

Subjective:

Subjective

Jennie C Cox is a 65 y.o. female.

Chief Complaint

Patient presents with

- Medication Refill

HPI

Weight: Currently stable. Not active. Not working since June 2016. Hearing.

Anxiety: Medicine called in while I was out. Taking approx once daily. Using Restoril nights.

Hyperlipidemia: Still not interested in medicines. No regular exercise.

Review of Systems

Constitutional: Negative for fever, chills, activity change and appetite change.

Respiratory: Negative for apnea and cough.

Cardiovascular: Negative for chest pain and palpitations.

Psychiatric/Behavioral: Positive for sleep disturbance. Negative for dysphoric mood and agitation.

Objective:

BP 98/71 mmHg | Pulse 107 | Temp(Scr) 98 °F (36.7 °C) | Wt 55.157 kg (121 lb 9.6 oz)

Objective

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.

Cardiovascular: Normal rate and regular rhythm.

Pulmonary/Chest: Effort normal and breath sounds normal.

Neurological: She is alert and oriented to person, place, and time.

Psychiatric: She has a normal mood and affect. Her behavior is normal. Thought content normal.

Assessment

Assessment/Plan:

Problem List Items Addressed This Visit

Other

Anxiety - Primary

Stable. No change in medicines. Recheck at CPE.

Hyperlipidemia

Insomnia

Medications

Those changes are accurate as of: 8/21/17 12:10 PM. If you have any questions, ask your nurse or doctor.

Existing Medications

	Sig	Disp	Refill	Start	End

	Sig	Disp	Refill	Start	End
ALPRAZolam 0.5 mg tablet Commonly known as: XANAX	Sig: Take 1 tablet (0.5 mg) by mouth 3 (three) times a day as needed for anxiety.	Disp: 60 tablet	Refi II: 5		
CHANTIX CONTINUING MONTH BOX 1 mg tablet Generic drug: varenicline			Refi II: 0		
HYDROcodone- acetaminophen 5-325 mg per tablet Commonly known as: NORCO			Refi II: 0		
temazepam 30 mg capsule Commonly known as: RESTORIL	Sig: Take 1 capsule (30 mg) nightly.	Disp: 30 capsul e	Refi II: 5		

Electronically signed by Jennifer Taylor Ellis, MD at 8/21/2017 12:43 PM

Office Visit
on
8/21/2017

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.

Assessment**Assessment/Plan:**

Tests ordered based on risk factors.

No Follow-up on file.

A portion of the information above was entered by my medical assistant. I have reviewed the documentation in detail and agree the documentation is accurate and complete.

Electronically signed by Jennifer Taylor Ellis, MD at 11/22/2017 8:59 PM

Office Visit on
11/22/2017

Chart Review Routing History

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**GREENVILLE
HEALTH SYSTEM**

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 11/22/2017

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 11/22/2017

Jennifer Taylor Ellis, MD

Family Medicine

Annual Adult Female Wellness Visit

Patient ID: Jennie C Cox is a 65 y.o. female who presents today for her Annual Wellness Visit, medication refills, and review of chronic medical problems.

Anxiety: Using Xanax 1-3 x/ day. Appealing workers comp issues. Causing lots of anxiety.

Hyperlipidemia: Reports taking medicine most of the time since call about high cholesterol. Reviewed previous labs in November 2016 her total cholesterol was 258 and her LDL was 166, Resumed after we called about labs earlier in the year/ late last year. Does not have current script- will look in Prime Suite.

LBP: None currently

The patient's Past Medical History, Past Surgical History, Family History, Social History, and Immunizations were reviewed and updated with her today.

Preventive Health:

Exercise: none

Nutrition: Skips bfast, lunch - steam vegetable, supper- same; Sweet tea- 1/2 gallon tea, no Etoh

PHQ 2 depression screen negative.

Immunizations:

There is no immunization history on file for this patient.

Cancer Screening: Reviewed and UTD or will schedule? Yes

Mammogram defers

Pap Smear defers

Colonoscopy defers, agrees cologuard

Annual LDCT (age 55-80, 30 pack year ho, currently smoke or have quit in 15 yrs)

Disease Screening: Reviewed and UTD or will schedule? Yes

Eye exam Has not had done- wants to wait

Dental care UTD

Cholesterol: Reviewed

Fasting blood glucose: Reviewed

Bone Density

Smoking counseling

Hepatitis C screening (DOB 1945-1965)

HIV screening

Patient Care Team:

Jennifer Taylor Ellis, MD as PCP - General

Review of Systems

Constitutional: Negative for activity change, appetite change, chills, fatigue, fever and unexpected weight change.

HENT: Positive for trouble swallowing. Negative for congestion, dental problem, drooling, ear discharge, ear pain, facial swelling, hearing loss, mouth sores, nosebleeds, postnasal drip, rhinorrhea, sinus pain, sinus pressure, sneezing, sore throat, tinnitus and voice change.

Facial pain due to accident, cannot sleep on Left side of face; Mouth pain

Eyes: Negative for photophobia, pain, discharge, redness, itching and visual disturbance.

Respiratory: Negative for apnea, cough, chest tightness, shortness of breath and wheezing.

Cardiovascular: Negative for chest pain, palpitations and leg swelling.

Gastrointestinal: Negative for abdominal pain, anal bleeding, blood in stool, constipation, diarrhea, nausea and vomiting.

Endocrine: Negative for cold intolerance, heat intolerance, polydipsia, polyphagia and polyuria.

Genitourinary: Positive for frequency. Negative for difficulty urinating, dysuria, hematuria, urgency and vaginal bleeding.

Musculoskeletal: Positive for arthralgias. Negative for back pain, gait problem, joint swelling and myalgias.

Skin: Negative for rash.

Allergic/Immunologic: Negative for immunocompromised state.

Neurological: Negative for dizziness, tremors, seizures, syncope, speech difficulty, weakness, light-headedness, numbness and headaches.
 Hematological: Negative for adenopathy. Does not bruise/bleed easily.
 Psychiatric/Behavioral: Positive for sleep disturbance (uses med nightly, sleeps 4-5 year).
 Negative for confusion and dysphoric mood. The patient is nervous/anxious (worried about finances).

Physical exam:

Vitals:

Vitals:

11/22/17 1619
 BP: 117/66
 Pulse: (I) 95
 Temp: 97.7 °F (36.5 °C)
 Weight: 55.5 kg (122 lb 6.4 oz)
 Height: 1.689 m (5' 6.5")

Body mass index is 19.46 kg/m².

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition. and Due to this patient's BMI, I have provided counseling regarding physical activity.

Physical Exam

Constitutional: She appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: Tympanic membrane, external ear and ear canal normal.

Left Ear: Tympanic membrane, external ear and ear canal normal.

Nose: Nose normal.

Mouth/Throat: Uvula is midline, oropharynx is clear and moist and mucous membranes are normal.

Eyes: Conjunctivae, EOM and lids are normal. Pupils are equal, round, and reactive to light.

Neck: Trachea normal and normal range of motion. No JVD present. No muscular tenderness present. No thyroid mass and no thyromegaly present.

Cardiovascular: Normal rate, regular rhythm, S1 normal and S2 normal. Exam reveals no gallop. No murmur heard.

Pulses:

Carotid pulses are 2+ on the right side, and 2+ on the left side.

Femoral pulses are 2+ on the right side, and 2+ on the left side.

Dorsalis pedis pulses are 2+ on the right side, and 2+ on the left side.

Posterior tibial pulses are 2+ on the right side, and 2+ on the left side.

Pulmonary/Chest: Effort normal and breath sounds normal. She has no wheezes. She has no rales. She exhibits no mass and no deformity.

Abdominal: Soft. Normal appearance and bowel sounds are normal. She exhibits no abdominal bruit and no mass. There is no splenomegaly or hepatomegaly. There is no tenderness. No hernia. Hernia confirmed negative in the right inguinal area and confirmed negative in the left inguinal area.

Musculoskeletal: Normal range of motion.

Lymphadenopathy:

She has no cervical adenopathy.

She has no axillary adenopathy.

Right: No supraclavicular adenopathy present.

Left: No supraclavicular adenopathy present.

Neurological: She is alert. She has normal strength. No cranial nerve deficit. Gait normal.

Skin: Skin is warm and dry. No rash noted. Nails show no clubbing.

Various seborrheic keratoses on back

Psychiatric: She has a normal mood and affect. Her speech is normal and behavior is normal.

Judgment and thought content normal.

Anxiety (Primary)

Assessment & Plan:

Unchanged, encouraged SSRI.

Mixed hyperlipidemia

Assessment & Plan:

Will confirm dose of med she resumed on her own. Most recent note showed atorvastatin 40. We'll have her bring in bottle. Current lipid significant improvement compared to November 2016 Encouraged daily use. Recheck prior to Fu.

Orders:

- Lipid Panel
- Basic Metabolic Panel (BMP)(BMET)

Insomnia, unspecified type

Assessment & Plan:

Stable

Low back pain, unspecified back pain laterality, unspecified chronicity, with sciatica presence unspecified

Mandible pain

Assessment & Plan:

Chronic. Still the middle of her Worker's Comp. case.

Screen for colon cancer

- Cologuard - External

Annual physical exam

Comments:

Defer mammo, DEXA for now. Agrees to discuss at FU. Cologuard.

Orders:

- Urinalysis, Auto without Microscopic-POC

Return in about 3 months (around 2/22/2018).

Insomnia

Refill temazepam. As always advised on need to wean.

Medications

Accurate as of 2/22/18 4:41 PM. If you have any questions, ask your nurse or doctor.

Modified Medications

	Sig	Disp	Refill	Start	End
atorvastatin 20 MG tablet	Sig: Take 1 tablet (20	Disp: 30	Refill:		
Commonly known as:	mg) by mouth daily.	tablet	11		
LIPITOR					
What changed:					
	• medication strength				
	• how much to take				
Changed by: Jennifer Taylor					
Ellis, MD					

Existing Medications

	Sig	Disp	Refill	Start	End
ALPRAZolam 0.5 mg tablet	Sig: Take 1 tablet (0.5	Disp: 60	Refill:		
Commonly known as:	mg) by mouth 3 (three)	tablet	5		
XANAX	times a day as needed				
	for anxiety.				
temazepam 30 mg capsule	Sig: Take 1 capsule (30	Disp: 30	Refill:		
Commonly known as:	mg) nightly.	capsule	5		
RESTORIL					

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition. and Due to this patient's BMI, I have provided counseling regarding physical activity.

Electronically signed by Jennifer Taylor Ellis, MD at 2/22/2018 4:43 PM

Office Visit
on
2/22/2018

Existing Medications

	Sig	Disp	Refill	Start	End
ALPRAZolam 0.5 mg tablet Commonly known as: XANAX	Sig: Take 1 tablet (0.5 mg) by mouth 3 (three) times a day as needed for anxiety.	Disp: 60 tablet	Refill: 5		
atorvastatin 20 MG tablet Commonly known as: LIPITOR	Sig: Take 1 tablet (20 mg) by mouth daily.	Disp: 30 tablet	Refill: 11		
miscellaneous medication	Sig: Coenzyme Q10 100 mg Take 1 tab 1-2 x each daily as needed for muscle aches	Disp: 60	Refill: 5		
temazepam 30 mg capsule Commonly known as: RESTORIL	Sig: Take 1 capsule (30 mg) nightly.	Disp: 30 capsule	Refill: 5		

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition. and Due to this patient's BMI, I have provided counseling regarding physical activity.
Electronically signed by Jennifer Taylor Ellis, MD at 5/24/2018 11:03 AM

Office Visit
on
5/24/2018

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.



GREENVILLE
HEALTH SYSTEM

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 2/22/2018

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 2/22/2018

Jennifer Taylor Ellis, MD
Family Medicine

Office Visit Note

2/22/2018

Subjective:

Subjective

Jennie C Cox is a 65 y.o. female.

Chief Complaint

Patient presents with

- Anxiety
3 month f/u visit
- URI
sore throat, congestion, cough, body aches yesterday- family have the flu
- Hyperlipidemia
pt. stopped her Lipitor due to pain

Anxiety

Presents for follow-up visit. Symptoms include depressed mood, excessive worry, nervous/anxious behavior and panic. Patient reports no chest pain, confusion, decreased concentration, dizziness, feeling of choking, irritability or nausea. The severity of symptoms is mild. The quality of sleep is good. Nighttime awakenings: several.

URI

This is a new problem. The current episode started in the past 7 days. The problem has been unchanged. There has been no fever. Associated symptoms include coughing, headaches, rhinorrhea, sinus pain and a sore throat. Pertinent negatives include no chest pain, congestion, diarrhea, ear pain, nausea or vomiting. She has tried acetaminophen for the symptoms. The treatment provided mild relief.

Hyperlipidemia

This is a chronic problem. The current episode started more than 1 year ago. The problem is uncontrolled. Recent lipid tests were reviewed and are high. There are no known factors aggravating her hyperlipidemia. Associated symptoms include myalgias (L neck after last visit). Pertinent negatives include no chest pain, focal sensory loss, focal weakness or leg pain. She is currently on no antihyperlipidemic treatment. The current treatment provides mild improvement of lipids. Compliance problems include adherence to diet, adherence to exercise and medication side effects.

Was taking chol medicine at CPE 11/2017. Started after labs 11/2017. Continued after that for undertermined time. Willing to resume with Co-Q10.

1 meal/ day. Grilled chicken

Mood: As above. Still not working. Still going to court over her Worker's Comp. Using alprazolam variably. Reports not taking every day but may take another days once or twice.

Review of Systems

Constitutional: Negative for irritability.

HENT: Positive for rhinorrhea, sinus pain and sore throat. Negative for congestion and ear pain.

Respiratory: Positive for cough.

Cardiovascular: Negative for chest pain.

Gastrointestinal: Negative for diarrhea, nausea and vomiting.

Musculoskeletal: Positive for myalgias (L neck after last visit).

Neurological: Positive for headaches. Negative for dizziness and focal weakness.

Psychiatric/Behavioral: Negative for confusion and decreased concentration. The patient is nervous/anxious.

Objective:

BP 96/54 | Pulse 83 | Temp 98.6 °F (37 °C) | Wt 57 kg (125 lb 9.6 oz) | BMI 19.97 kg/m²

Objective

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion. She exhibits no edema or tenderness.

Neurological: She is alert and oriented to person, place, and time. She has normal reflexes.

Skin: Skin is warm and dry. She is not diaphoretic.

Psychiatric: She has a normal mood and affect. Her behavior is normal. Judgment and thought content normal.

Assessment

Assessment/Plan:

Problem List Items Addressed This Visit

Other

Anxiety - Primary

Advised to continue to consider SSRI. Fluoxetine 20 and 40 mg were attempted March through May 2016. At that time she was suffering with weight loss. She was taking alprazolam at that time only 1-2 times per week. In follow-up in 2016 mood appeared to be stable.

Hyperlipidemia

Agrees to resume at a lower dose and add coenzyme Q 10. Close recheck 2 months

Relevant Medications

atorvastatin (LIPITOR) 20 MG tablet

Progress Notes Encounter Date: 5/24/2018

Jennifer Taylor Ellis, MD

Family Medicine

Office Visit Note

5/24/2018

Subjective:

Subjective

Jennie C Cox is a 65 y.o. female.

Chief Complaint

Patient presents with

- Hyperlipidemia

F/U to discuss lab results.

HPI

Last visit 2/2018:

Hyperlipidemia: Agreed to resuming statin with coQ10. Was taking chol medicine at CPE 11/2017. Started after labs 11/2017. Continued after that for undetermined time. Reports has been taking since the last visit. No labs since the last visit bc Medicare not paying for labs- she is trying to work this out. Believes CoQ10 has helped avoid muscle aches.

1 meal/ day. Grilled chicken

Mood: Discussed SSRI again last visit as well as today- still not interested. Stressors include continued battles over workers comp. Still sees daughters regularly, who are both good sources of support. Symptoms are unchanged and include depressed mood, excessive worry, nervous/anxious behavior and panic. Patient reports no chest pain, confusion, decreased concentration, dizziness, feeling of choking, irritability or nausea. The severity of symptoms is mild. The quality of sleep is good. Nighttime awakenings: several. . Still not working. Still going to court over her Worker's Comp. Using alprazolam variably- similar to previous visit. Reports not taking every day but may take another days once or twice.

Review of Systems

Constitutional: Negative for activity change, appetite change, chills and fever.

Respiratory: Negative for chest tightness and shortness of breath.

Cardiovascular: Negative for chest pain and palpitations.

Gastrointestinal: Negative for abdominal pain, diarrhea and nausea.

Objective:

BP 110/72 | Temp 97.9 °F (36.6 °C) | Wt 56.9 kg (125 lb 6.4 oz) | BMI 19.94 kg/m²

ObjectivePhysical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion.

Neurological: She is alert and oriented to person, place, and time. She has normal reflexes.

Skin: Skin is warm and dry. No rash noted. She is not diaphoretic. No erythema.

Psychiatric: She has a normal mood and affect. Her behavior is normal. Judgment and thought content normal.

Assessment

Assessment/Plan:

Problem List Items Addressed This Visit

Anxiety

Anxiety

Continues to take alprazolam regularly temazepam at bedtime. Discussed SSRI yet again. Will be due for refills in August and can send it electronically if needed.

Hyperlipidemia

Currently has an issue where Medicare is not paying for her labs or office visits. Did not get repeat labs prior to today's visit because of that. Did encourage her to continue on Lipitor and get labs prior to follow-up. However I do understand the financial limitations at this time.

Return in about 3 months (around 8/24/2018).

Medications

Accurate as of 5/24/18 11:03 AM. If you have any questions, ask your nurse or doctor.



GREENVILLE
HEALTH SYSTEM

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681 3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 8/2/2018

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

Progress Notes Encounter Date: 8/2/2018

Jennifer Taylor Ellis, MD

Family Medicine

Office Visit Note

8/2/2018

Subjective:

Subjective

Jennie C Cox is a 65 y.o. female.

Chief Complaint

Patient presents with

- Follow-up

Patient Care, Paperwork

HPI

Patient presents for documentation of chronic issues for workers comp paperwork. Her sister who is a nurse practitioner was present to help fill in the history.

Weight loss: Since weight has resumed normal weight, she has been able to maintain her baseline weight. However as per previous history she did have significant weight loss associated with her mandibular surgery as well as depression associated with it.

A review of her treatment for the workers comp injury included: L shoulder pain and PT; treatment of mandibular fractures by oral surgeon Dr Cobb and dental implant. Dr Ridgit. Needs continued care of dental implants q 6 months. Continue mouth/ dental pain, and sholder pain.

Depression: Continues to feel regularly depressed, anxiety- most days. Needs restoril to sleep. Concentration poor, appetite poor, very nerouse, calls sister crying on the phone. Lack of interest in cleaning. Poor compliance. Sister believed she tried Prozac, Wellbutrin.

Machine fell on her while on a dock. Mandibular fracture/ teeth avulsed into sinuses. Surgery with plate in place, infection, approx 6 months.

Review of Systems

Constitutional: Positive for activity change and appetite change. Negative for chills and fever.

HENT: Positive for dental problem.

Respiratory: Negative for chest lightness and shortness of breath.

Cardiovascular: Negative for chest pain and palpitations.

Gastrointestinal: Negative for abdominal pain, diarrhea and nausea.

Psychiatric/Behavioral: Positive for agitation, dysphoric mood and sleep disturbance. The patient is nervous/anxious.

Objective:

BP 119/75 (BP Location: Left arm, Patient Position: Sitting) | Pulse 77 | Temp 98 °F (36.7 °C) (Oral) | Wt 56 kg (123 lb 6.4 oz) | BMI 19.62 kg/m²

Objective

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion. She exhibits no edema or tenderness.

Neurological: She is alert and oriented to person, place, and time. She has normal reflexes.

Skin: Skin is warm and dry. She is not diaphoretic.

Psychiatric: Her behavior is normal. Judgment and thought content normal. She exhibits a depressed mood.

Assessment

Assessment/Plan:

Problem List Items Addressed This Visit

Other

Anxiety - Primary

Mild episode of recurrent major depressive disorder (HCC)

Discussed the importance of prevention as we have on previous visits. Patient understands but still refuses SSRI. Sister will continue to talk with her as well

No Follow-up on file.

Medications

Accurate as of 8/2/18 5:52 PM. If you have any questions, ask your nurse or doctor.

Existing Medications

	Sig	Disp	Refill	Start	End
ALPRAZolam 0.5 mg tablet Commonly known as: XANAX	Sig: Take 1 tablet (0.5 mg) by mouth 3 (three) times a day as needed for anxiety.	Disp: 60 tablet	Refill: 5		
atorvastatin 20 MG tablet Commonly known as: LIPITOR	Sig: Take 1 tablet (20 mg) by mouth daily.	Disp: 30 tablet	Refill: 11		
miscellaneous medication	Sig: Coenzyme Q10 100 mg Take 1 tab 1-2 x each daily as needed for muscle aches	Disp: 60	Refill: 5		
temazepam 30 mg capsule Commonly known as: RESTORIL	Sig: Take 1 capsule (30 mg) nightly.	Disp: 30 capsule	Refill: 5		

BMI counseling: Due to this patient's BMI, I have provided counseling regarding nutrition, and Due to this patient's BMI, I have provided counseling regarding physical activity.

Electronically signed by Jennifer Taylor Ellis, MD at 8/2/2018 5:52 PM

Office Visit
on 8/2/2018

Chart Review Routing History

Routing history could not be found for this note. This is because the note has never been routed or because communication record creation was suppressed.



GREENVILLE
HEALTH SYSTEM

Hillcrest Family
Medicine
717 SE MAIN STREET
SIMPSONVILLE SC
29681-3237

Cox, Jennie C
MRN: 971202636, DOB: 8/14/1952, Sex:
F
Encounter date: 5/24/2018

Cox, Jennie C

MRN: 971202636
Description: 65 year old female

<u>MEDICAL QUESTIONNAIRE</u> for Jennie Cox	Yes	No
1. It is our understanding that you are Ms. Cox's personal physician and have treated her for many years. Please state the time frame you have that you have been treating Ms. Cox. From <u>11/26/2010</u> to <u>Present</u>		
2. Have you ever treated M. Cox for her work related injury of May 31, 2012 other than being authorized by the Workers' Compensation Insurance Carrier to issue a prescription for work hardening in 2016?		✓
3. In your medical opinion, does Ms. Cox need continued care relative to her injuries sustained?	✓	
4. It is our understanding that you have been treating Ms. Cox for depression prior to her work related injury. In your medical opinion, has Ms. Cox's depression worsened due to her work related accident on May 31, 2012 and if so, is that attributed to her accident?	✓	
5. In your medical opinion, has Ms. Cox's overall health deteriorated since her work related accident on May 31, 2012?	✓	
6. Did Ms. Cox complain to you relative to problems she may have had relating to her workers compensation claim of May 31, 2012?	✓	
Additional Comments:		

I, Jennifer T. Ellis, M.D., certify to a reasonable degree of medical certainty that the above statements are my expert medical opinions.

Dated: 8/2/18


 Jennifer T. Ellis, M.D.
 Hillcrest Family Practice
 717 SE Main St
 Simpsonville, SC 29681

APA #41
The Honorable Aisha Taylor, Commissioner
Order
05/23/17

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206236

JENNIE COX,
Employee
Claimant,

vs.

**PALMETTO STATE
TRANSPORTATION,**
Employer,

CHEROKEE INSURANCE COMPANY,
Insurance Company,

Defendants.

ORDER

HEARING: Held in Anderson, South Carolina on February 2, 2017

APPEARANCES: Claimant represented by Juliette B. Mims, Esquire, of Greer, South Carolina and Adrienne Turner, of Columbia, South Carolina

Defendants represented by Robert E. Horner, Esquire, of Columbia, South Carolina

PURPOSE OF HEARING: To determine issues set forth in Forms 50 and 51, including, Claimant's degree of disability. Whether or not Claimant was rendered totally disabled and whether or not Claimant is entitled to lifetime medicals.

AWARD: The Honorable Aisha Taylor, Commissioner

FILED:

APA SUBMISSIONS

Submissions on behalf of Claimant:

1. Grady Hospital
2. American Medical Response of Georgia
3. Greenville Memorial
4. James Fowler, M.D. of GHS Plastic Surgery & Aesthetics
5. GHS Center for Health & Occupational Services
6. Innervision MRI & Imaging
7. Proaxis Therapy
8. Jennifer T. Ellis, M.D. of Hillcrest Family Practice
9. Donald L. Ridgell, DMD of Upstate Prosthodontics, LLC
10. Larry W. Cobb, DMD
11. William A. Cofer, DMD
12. Walter Grady, D.O
13. Robert E. Brabham, Ph.D.
26. Life Center Health
27. CORA Rehabilitation Center

Submissions by Defendant:

14. Occupational Health
15. Piedmont Oral Surgery
16. Piedmont Oral Surgery questionnaire
17. Center for Health & Occupational Services
18. Impairment rating
19. Hillcrest Family Practice
20. Claimant's 2015 tax returns
21. Letter to Claimant's attorney regarding work
22. Liberty Bell Agency check log & ltr from CA
23. Duvall Group Investigation report
24. Photos
25. Deposition transcript of Claimant
26. Wage Records (submitted at hearing)

STIPULATIONS

This case came before the undersigned Commissioner in Anderson, South Carolina on February 2, 2017. At the hearing the Claimant was represented by Juliette B. Mims and Adrienne Turner; Palmetto State Transportation and its carrier, Cherokee Insurance Company, was represented by Robert E. Horner with Speed, Seta, Martin, Trivett & Stubley.

The parties stipulated as follows:

1. All parties are subject to, and bound by, the terms and conditions of the South Carolina Workers' Compensation Act ("Act").

2. Notice of the hearing was timely and properly served upon all necessary and proper parties, and the file and its contents, along with the Commissioner's notes, are made part of the record without objection.
3. There were no objections to the submission of APAs and/or exhibits.
4. The Claimant's average weekly wage is \$1,327.69, yielding a compensation rate of \$725.47.
5. That the Workers' Compensation Commission has jurisdiction over this matter and venue in Anderson County is proper as stipulated by all parties;
6. Claimant seeks benefits under the South Carolina Workers' Compensation Act based upon accidental injuries occurring on May 31, 2012, which occurred while in the course and scope of the Claimant's employment with the Defendant employer. The injury and date of injury are stipulated to and not disputed.

STATEMENT OF CASE

It is undisputed that on May 31, 2012 Claimant sustained compensable injuries by accident arising out of and in the course of her employment with Palmetto State Transportation as a CDL truck driver. The accident occurred while she was on a delivery in Georgia, when she was removing freight; a machine fell on her, causing her to fall to the ground face first knocking her unconscious. At the time of the accident, she injured her head, teeth, mandible, left shoulder, neck and facial nerves. As a result of the injuries Claimant has sustained, she has been treating for depression due to chronic pain and severe weight loss.

It is the Claimant's position that she has been rendered totally and permanently disabled as a result of the injuries in question and that she is entitled to lifetime medical care.

Palmetto State Transportation and its carrier admit that Claimant did in fact sustain injuries as a result of the above referenced accident, and that she has reached maximum medical improvement, but assert that she is entitled only to permanent partial benefits and continued medical care for her physical injuries as prescribed by Dr. Ridgell and Dr. Cobb.

The following issues are for determination by this Commissioner:

1. Has the Claimant sustained total and permanent disability due to her injuries?
2. To what extent is the Claimant entitled to additional medical care?
3. Is the Claimant entitled to further compensation?

EVIDENCE OF CASE

The Claimant testified that she is 64 years old, divorced and has two adult daughters.¹ She graduated from Woodmont High School in 1970 and attended TEC, but did not graduate. She obtained her Truck Driver's Class "A" license in 1985, and has worked in that capacity thereafter. At the time of the accident, Claimant had worked for Employer for eleven (11) years, and worked for US Food Service for six (6) years prior to that. Claimant testified that she had no prior physical injuries and was in good health at the time of her injuries. She testified that she did suffer from pre-existing depression related to the death of her grandson who was killed at age 16 in a car accident.

On May 31, 2012, Claimant was on a delivery in Georgia, when she was removing freight from her truck; a machine fell on her, causing her to fall to the ground face first knocking her unconscious. She was rushed to Grady Memorial in Georgia and then brought by EMS to Greenville Memorial Hospital with injuries to her head, face, mouth and neck, left shoulder, chest, low back and problems breathing. On June 1, 2012, James Fowler, M.D. performed extensive surgical intervention to address Claimant's injuries. Records indicated he performed a bilateral subcondylar mandible fracture, left body comminuted mandible fracture, avulsed maxillary and mandibular teeth, maxillomandibular fixation with screws, open reduction and internal fixation left body mandible fracture and dental tooth extraction.

Claimant was subsequently seen by Stacey Newsom, M.D. at the Center for Health and Occupational Services for chest wall pain and left shoulder pain. Dr. Newsome indicated chest wall contusions and left shoulder contusion with weakness and possible rotator cuff injury. Dr. Newsome instructed Claimant to continue with Lortab for pain, deep breathing exercises and imposed work restrictions limiting Claimant to sedentary work with a five (5) pound lifting restriction and prohibited her from operating commercial motor vehicle.

Claimant had a follow-up with Dr. Fowler on June 11, 2012, after which Dr. Fowler opined that Claimant was to remain in a "levered and wired occlusion for one more week." On July 5, 2012, Claimant underwent surgery to remove the IMG screws.

On July 6, 2012, Claimant underwent an MRI of the left shoulder at Innervision MRI &

¹ Facts included herein are derived from Claimant's live testimony at the hearing, Claimant's deposition testimony, which was submitted without objection, and medical histories derived from submitted APAs.

Imaging with an impression of “degenerative changes and mild tendinopathy in the suprae and infraspinatus tendons.” On July 17, 2012, Claimant returned to Innervision for an x-ray of the chest with an impression of COPD without acute findings. Claimant then returned to Dr. Newsome on July 17, 2012 to review the findings of the MRI and x-ray. Dr. Newsome’s diagnosis was chest wall contusions resolving and left shoulder contusion improving. Claimant was to continue the same restrictions with the additional restrictions ordered by Dr. Fowler.

On July 24, 2012, Claimant began treating with Larry W. Cobb, D.M.D at Piedmont Oral Surgery to discuss surgical oral restoration. Dr. Cobb noted Claimant had multiple jaw and teeth fractures and determined he would allow them to heal for an additional three months before attempting restorative procedures. Dr. Cobb also ordered a CT for September and sought preauthorization for implants and restoration.

Claimant again saw Dr. Newsome on August 7, 2012, at which point Dr. Newsome noted left shoulder weakness and tendinosis and chest wall contusion. She recommended physical therapy for strengthening prior to return to full duty. Dr. Newsome stated Claimant could return to work with restrictions of no lifting, pushing or pulling more than 15 pounds occasionally and no operating commercial motor vehicle. Claimant started physical therapy with Proaxis Therapy on August 22, 2012 for her left shoulder pain.

On August 28, 2012, Claimant went to her family doctor, Jennifer T. Ellis, M.D., for a follow-up. Dr. Ellis noted that her depression and insomnia had been getting worse since her last visit and Claimant was also experiencing loss of appetite and loss of interest in pleasurable activities since her work related injury.

On September 4, 2012 Dr. Cobb examined Claimant and stated she was healing well and scheduled a CT. The CT scan on October 3, 2012 also showed she was healing well. Dr. Cobb referred her to Donald L. Ridgell, DM.D. for his evaluation. Claimant saw Dr. Ridgell on October 4, 2012, wherein Dr. Ridgell examined Claimant and agreed with Dr. Cobb that a full mouth extraction of Claimant’s natural teeth with implant replacement was the best solution. Dr. Ridgell further noted that he would continue to work along-side Dr. Cobb for the maintenance and upkeep of the implants.

On October 30, 2012 Dr. Cobb opined that Claimant had “a full work up including a physical examination CBCT evaluation to determine the best treatment necessary to restore her teeth for maximum function. She has a very complicated case secondary to her normal petite size and small jaw. This has been further compromised by the very significant jaw injuries including

multiple bone fractures and loss of teeth. Her remaining teeth are terminal due to the lack of bone support. These will all have to be removed. She has very minimal maxillary bone and will lose more when her teeth are removed. She will require extensive bone grafting before any definitive treatment can be achieved. Either one or both bone plates will need to be removed from the mandible before any treatment can be implemented there as well.” Dr. Cobb set out the treatment in 5 stages with an estimated cost of \$34, 215.00, not including the prosthetic work to be done by Dr. Ridgell.

On November 5, 2012, Claimant saw Dr. Fowler for a follow up examination. Dr. Fowler noted that Claimant had been seen by a prosthodontist and was scheduled for dental restoration. He specifically noted that Claimant’s nutrition has been affected in that she had to work to get enough nutrition in and was eating pureed food. Dr. Fowler recommended a softer food diet and that Claimant maintain her nutrition as needed with calorie supplements including Ensure or Carnation Instant Breakfast.

Claimant was discharged from Proaxis on November 6, 2012, after completing 20 visits, to an independent home exercise program. Following her discharge from physical therapy, she returned to Dr. Newsome on November 9, 2012. Dr. Newsome opined that her left shoulder injury was at MMI with an impairment rating of the left shoulder of 2% and stated Claimant could return to work on November 9, 2012 without restrictions with regard to her left shoulder.

On January 31, 2013, Claimant began her restoration with Dr. Cobb as follows:

- a) 01/13/13 bilateral sinus graft, removal of superior bone plate and surgical removal of teeth numbers 4, 6, 11, 21, 22, 26, 27, 28, 29;
- b) 04/29/13 surgical implant placement of teeth numbers 20, 23, 25, 27, 30; and
- c) 07/17/13 surgical implant placement of teeth number 3, 5, 6, 11, 12, 14.

During the process of her oral reconstructive surgery, Dr. Cobb referred Claimant to a nutritionist. He stated that she is “very malnourished. The success of our treatment depends on her ability to heal. I believe that all of our treatment may be in jeopardy if her overall nutrition does not improve.”

On July 15, 2013, Claimant returned to Dr. Ellis for a follow-up. Dr. Ellis stated Claimant is doing “about the same.” “She is currently experiencing fatigue, weight loss of 25 pounds over the past year and loss of appetite. Claimant states she gets hungry and tries to eat but it hurts.” Dr. Ellis refilled her anxiety and insomnia medications of Alprazolam Oral 0.5 mg and Restoril Oral Capsule 30 mg.

Upon her healing from the restoration surgeries, Claimant returned to work on August 12, 2013. Claimant testified that although she did her absolute best to perform her work duties in the same manner as before the accident, she continued to have difficulties and was never able to perform her duties as well as before she was injured. Significantly, despite her commendable attempt to return to work, Claimant continued to experience pain, inability to maintain proper nutrition except through the use of nutritional supplements, and suffered from weaknesses, fatigue and inability to concentrate.

On October 6, 2014, Claimant returned to the Center for Health & Occupational Services for reevaluation of her left shoulder. Claimant was seen by Brian Svazas, M.D. and advised him that she was having some difficulties in the left shoulder with it being sore after long truck runs. Claimant also discussed difficulties with the left ear with intermittent hearing diminution. Dr. Svazas advised that he believed the complaints she had in the left scapular border were likely related to her work injury to the shoulder. He advised that physical therapy could help clear up some of the soft tissue areas. Dr. Svazas found her at MMI with a 6% left shoulder rating and opined that "she may need some ongoing therapy to this shoulder going forward."

Dr. Ridgell opined on April 9, 2015 that Claimant will need future medical care by way of "maintenance procedures annually- more expensive than natural teeth, replace or refurbish appliances every 6-8 years and oral surgeon visit in 5 years for radiograph/CT scan." Dr. Ridgell continues to see Claimant every 6 months.

Claimant last saw Dr. Cobb on April 27, 2015 where he released her to MMI with the following impairment ratings: 15%- diet limited to soft or semi solid foods, 85% of normal function, 4% interincisal range of Motion- 30mm, 3% lateral excursion range of motion 5-6mm, 2% facial disorder- scar, 1% nerve disorder- permanent numbness of lower lip and chin on left side, for a 25% whole person. He also stated that she will need prosthetic maintenance and replacement.

Claimant continued to have pain in her jaw and returned to Dr. Fowler on June 8, 2015 and again on June 15, 2015 with draining sinus to the left jaw in the region of a previous ORIF and plate and screw placement for a compound fracture of an atrophic mandible. Claimant went out of work again on June 20, 2015 due to these issues and on July 5, 2015 Dr. Fowler performed surgery for removal of the indwelling device of the mandibular bone along with removal of plate and screws, bone biopsy and bone grafting.

Dr. Fowler released her to return to work, which Claimant did in August 2015. Claimant

had a follow-up appointment with Dr. Fowler on October 12, 2015, wherein Dr. Fowler stated “she has residual numbness from the left mental nerve that may be permanent.”

In October 2015, Claimant went from running team driving to single driving.

Throughout these surgeries for her mouth, Claimant continued to see Dr. Ellis for routine follow ups and prescription refills for her depression that continued to get worse. At her appointment on March 3, 2016, Dr. Ellis noted that since Claimant has gone to single driving, it was physically and mentally wearing her out. Dr. Ellis further noted it was still uncomfortable for her to eat as her- “teeth not lined up” and that Claimant had lost a significant amount of weight as a result. Dr. Ellis took her out of work until she could gain some weight. Claimant went to her dentist, William A Cofer, D.M.D. on April 14, 2016 to get his opinion as to the pain she continues to have chewing and eating her food. Dr. Cofer opined “I believe the reason she is having difficulties chewing and eating is due to the numbness on the left side of her lower jaw. She has had a loss of sensation since her accident.....Unfortunately; it is unlikely that she will regain any meaningful sensation due her accident.” Over the next several months, Claimant was able to show good weight improvement and return to work on June 1, 2016. However, Claimant testified she did not experience a corresponding return at her pre-accident strength. In fact, Claimant indicated her lack of strength, consistent fatigue and inability to maintain concentration rendered truck driving an unsafe occupation for her to continue. She testified credibly and without challenge from the Employer that she had conveyed her concerns to her supervisor and he indicated that the company would not be comfortable accepting the liability implications stemming from her symptoms. Claimant did not receive temporary total benefits for this period of time she was out.

Claimant ran nonstop runs for a few weeks with constant pain over her entire body. On June 14, 2016 she notified the Employer that she was in too much pain, could not work and needed additional treatment.

While awaiting authorization for additional treatment from the Employer, Claimant’s attorney sent her for an Independent Medical Evaluation with Walter Grady, DO on July 21, 2016. Upon physical examination of the Claimant and review of her prior extensive medical treatment history, Dr. Grady gave Claimant an impairment rating of 17% to the left upper extremity, 28% to left shoulder impairment and 10% whole person.

Claimant’s attorney also scheduled a physiological and vocational evaluation with Robert E. Brabham, Ph.D. on August 8, 2016. Dr. Brabham has opined that “she would be unable to

effectively perform the essential duties in any gainful work activity.”

Claimant sought treatment at the Wellness Center on her own on August 17, 2016, as she was in pain and Employer had not approve physical therapy as requested. She was making progress at the Wellness Center and her primary care doctor, Dr. Ellis, opined that she should continue there. Employer eventually authorized work hardening at CORA Rehabilitation. Claimant completed treatment three (3) times a week for several hours for a total of 20 visits between October 24, 2016 and December 19, 2016 at CORA Rehabilitation. Notably, CORA’s December 19, 2016 Functional Capacity Test results indicated Claimant is not able to perform several of the minimal material handling requirements for a truck driver.

Claimant testified that she loved her job and wanted to continue working, however, due to the pain, weakness, fatigue and anxiety she experiences is not able to perform the job. As well, Claimant also remains unable to conduct her day-to-day living activities in the same manner as before her injuries.

FINDING OF FACT

1. I find that the parties of this proceeding are subject to and bound by the terms of the Title 42 of the South Carolina Code of Laws, Annotated, dealing with South Carolina Workers’ Compensation Law with Palmetto State Transportation and Cherokee Insurance Company, employer and carrier.
2. After observing the demeanor of Claimant while she testified at the hearing, the medical records, and the other exhibits in evidence, I find that the testimony of Claimant to be fully credible regarding her work injury and its effect on her current quality of life, including her inability to work.
3. I find that the Claimant sustained admitted compensable injuries by accident arising out of in the course of her employment on Mary 31, 2012, injuries to her teeth, mandible, left shoulder, neck, facial nerve and scarring to her chin.
4. I find that based upon the medical opinions of Dr. Ellison and Dr. Brabham and testimony submitted, that Claimant had preexisting depression and her injuries caused an aggravation and/or exacerbation of the preexisting condition and is therefore compensable under the Act.
5. I find that at the time of the accident, Claimant was an employee of the Palmetto State Transportation as a truck driver.

6. I find that the applicable average weekly wage of the Claimant is One Thousand Three Hundred Twenty Seven and 69/100 (\$1,327.69) Dollars, corresponding to a compensation rate of is Seven Hundred Twenty-Five and 47/100 (\$725.47) Dollars, which was stipulated by Claimant's counsel and defense counsel at the hearing.
7. I find that the Claimant has been unable to work since June 2016 and is permanently and totally disabled pursuant to S.C. Code Ann. Section 42-9-10 as a result of her combined injuries. This finding is based on the preponderance of the evidence as a whole including the medical evidence, the credible testimony of the Claimant, and the vocational assessment of Robert Brabham, Ph.D., Claimant's age, education and work history also weighed into this decision.
8. I find that the Claimant is entitled to a lump-sum payment of the commuted value of Five Hundred (500) weeks of benefits less any amounts previously paid by Defendants in the form of temporary compensation.
9. I find that Claimant is entitled to lifetime medical treatment for her work injuries pursuant to S.C. Code Ann. Section 42-15-60 including lifetime repair, replacement and/or removal of any retained hardware. Defendants are responsible for lifetime causally related medical expenses. This includes but is not necessarily limited to: her teeth, mandible, left shoulder, neck, facial nerve and depression. The depression was aggravated by her accident.
10. The Claimant is entitled to a lump-sum payment and that the settlement proceeds of Three Hundred Thousand Nine Hundred Thirty Eight and 67/100 (\$300,938.67) Dollars shall be allocated as follows:
 - (a) One Hundred Thousand Three Hundred Two and 85/100 (\$100,302.85) Dollars for attorney's fee and Three Thousand Eight Hundred Fifty Eight and 45/100 (\$3,858.45) Dollars for related litigation expenses and costs to Juliette B. Mims;
 - (b) One Hundred Ninety Six Thousand Seven Hundred Seventy Seven and 37/100 (\$196,777.37) Dollars to the Claimant in compromise settlement of disputed future lost earnings for a period of 20.90 years or 1,086.8 weeks, the life expectancy of the Claimant (DOB; 08/14/1952) at the rate of One Hundred Eighty One and 06/00 (\$181.06) Dollars per week, pursuant to §19-1-150 of the South Carolina Code of Law, as amended.

See *Utica-Mohawk vs. Orr*, 227 S.C. 226, 87 S.E.2d 589 (1955); *Sciarotta vs. Bowen*, 837 F.2d 135 (3rd Cir. 1988); *James v. Anne's Inc.*, 688 S.E.2d 562 (S.C. 2010); See also on remand: *Sciarotta vs. Secretary of H.H.S.*, 735 F. Supp. 148 (D.N.J. 1989).

CONCLUSIONS OF LAW

It is the conclusion of the Hearing Commissioner that the following and other sections of the South Carolina Code of Laws, 1976, as amended, apply in this case:

1. Section 42-1-130 defines "employee"; Section 42-1-120 defines disability; Section 42-1-360 defines "exempt businesses"; Section 42-9-10 defines "amount of compensation for total disability"; Section 42-1-100 defines "compensation"; Section 42-1-160 defines "injury" and "personal injury"; Section 42-15-60 governs medical care; and Commission Rules 67-601 through 67-615 set forth the contested case procedures.

Accordingly, as provided in the South Carolina Code of Laws, 1976, as amended, it is the determination of this Commissioner:

1. That under Section 42-1-60, the Carrier is authorized under Section 42-5-20 to insure.
2. That under Section 42-1-130, the Claimant was a covered employee at the time in question.
3. That under Section 42-1-140, the Defendant was a covered employer under the Act.
4. That under Section 42-9-30, the Claimant sustained injuries by accident arising out of and in the course of her employment resulting in an accidental injury.
5. That under Section 42-9-10, the Claimant is deemed permanently disabled.
6. That under Section 42-15-60, the Claimant is entitled to lifetime medical treatment for her work injuries.

ORDER

IT IS THEREFORE ORDERED ADJUDGED AND DECREED that Claimant is permanently and totally disabled and is entitled to Total Disability Compensation in the amount of 500 weeks. The insurance carrier previously paid 48 weeks of temporary total benefits through

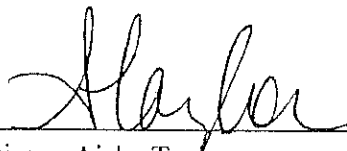
August 21, 2015; leaving 452 weeks to commute. The claimant is hereby awarded and shall be paid the commuted value of the remaining 452 weeks which equals Three Hundred Thousand Nine Hundred Thirty Eight and 67/100 (\$300,938.67) Dollars.

IT IS FURTHER ORDERED that the Employer is responsible for lifetime causally related medical expenses as outlined in the Findings hereinabove. This includes but is not necessarily limited to: her teeth, mandible, left shoulder, neck, facial nerve and depression. The depression was aggravated by her accident.

IT IS FURTHER ORDERED that Cherokee Insurance Company is and shall be the responsible carrier and shall provide coverage for the Employer with reference to this claim.

AND IT IS SO ORDERED.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION



Commissioner Aisha Taylor

CERTIFICATE OF SERVICE

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

May 23, 2017

By: Renee Smith, Administrative Assistant to Commissioner Taylor

APA #42
SC Workers' Compensation Commission
Request for Proposed Decision and Order
12/12/17

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
REQUEST FOR A PROPOSED DECISION AND ORDER

This document is not a Decision and Order. It is a request for a proposed order.
The Commissioners reserve the right to modify and/or delete any or all portions
of the submitted Decision and Order.

Jeannie Cox v Palmetto State Transport
SCWCC: 1206236
Commission Panel: Campbell, Wilkerson, Barden; Chair
Order Assigned to Commissioner: Campbell
Court Reporter – Travis McLeod– 803-252-3445

Robert Horner
Juliette B. Mims

Defendants/Appellant
Claimant/Respondent

This matter was heard before the South Carolina Workers' Compensation Full Commission Appellate Panel during the last term of Review. The Commissioners considered the matter and **Reverse and Remand** the decision and order of the Single Commissioner for a finding of permanency. Not to the Hearing Commissioner.

Mr. Horner please prepare a proposed order and submit to the Judicial Department within thirty (30) days of this notice. The proposed order shall be submitted in Word format to appeals@wcc.sc.gov and shared with each Party. Please make sure the Appellate Panel Decision and Order recites the specific Finds of Fact and Rulings of Law of the Single Commissioner's Decision and Order and reflects any comments requested by a Commissioner.

The signature page shall include a signature line for each Commissioner and the first signature should be the name of the Commissioner assigned the case as indicated above.

If you have any questions, please do not hesitate to email me at ehollmon@wcc.sc.gov or call at 803.737.5737

Judicial

Transmitted via email this 12 December 2017



Claimant's Name: Jeannie Cox Employer's Name: Palmetto State Transportation
Address: 222 W. Chapman Road Address: 1050 Park West Blvd.
City: Belton State: SC Zip: 29627 City: Greenville State: SC Zip: 29611
Home Phone: (864) 243-0032 Work Phone: () - Carrier: Cherokee Insurance Company
Preparer's Name: George Gallagher, Esquire Preparer's Phone #: (803) 748-2919

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$ 725.47 2. AWW: \$ 1327.69 Date of Injury: 5/13/2012
3. Type of injury and body part(s): ADMITTED- teeth (11 extractions with dental implants); left shoulder (contusion/soft tissue-NON SURGICAL); facial nerve; mandible; and scarring on chin; ALL OTHER INJURIES DENIED PER FULL WCC APPELLATE PANEL ORDER DATED 5/21/2018.
4. Facts in controversy:
 - a) Determination of Claimant's entitlement to PPD compensation for loss of use of scheduled injuries under § 42-9-30 and WCC R 67-1101 per Remand Order from the Full Commission; AND
 - b) Determination of Claimant's entitlement to ongoing/future medical treatment.
5. Legal Issues Involved: S.C. Code § 42-9-30 (loss of use of the shoulder and scarring) and WCC R 67-1101 (loss of use of mandible, teeth, and facial nerve); S.C. Code § 42-15-60 (B)(2); doctrine of "law of the case"- Full WCC Order dated 5/21/2018 implicitly finding MMI by remanding for determination of PPD is the law of this case; Hartzell v. Palmetto Collision LLC, 419 S.C. 87, 796 S.E.2d 145 (S.C. App., 2016) (expert medical evidence required to support order for further medical evaluation/treatment).
6. Unusual aspects: Defendants reserve right to amend their PHB and/or supplement their APA submissions in response to further clarification from the WCC regarding scope of issues for Hearing.
7. Witnesses (designate if expert):* Scott Justice and/or any other representative from the Employer/carrier with knowledge of the issues presented may be called to testify.
8. Exhibits: Full WCC Appellate Panel Order dated 5/21/2018; WCC File # 1206236; all prior APA evidentiary submissions
9. Medical evidence (Indicate report pursuant to R.67-612; deposition or appearance):
See Notice of Defense APA Submissions
10. Name, address, and specialty, if any, of the treating physician: James Fowler, M.D.- Greenville Hospital Plastic Surgery; Larry Cobb, DMD Piedmont Oral Surgery- Greenville, SC; Donald Ridgell, MD- Upstate Prosthodontics Greenville, SC; Dr. Stacy Newsome- University Medical Group; and Dr. Brian Scavase- Center for Occupational Health and Services.
11. Impairment rating(s); body part(s); physician and date of opinion: 2% to the left shoulder per Dr. Newsom dated 11/9/2012; 6% to the left shoulder per Dr. Scavas dated 4/8/2015; 7% to the mandible per Dr. Cobb dated 4/30/2015; 11 lost teeth; and 28% to the left shoulder per Dr. Grad dated 7/25/16- CLAIMANT's IME
12. I am amending my Form 50/51 in the following manner: N/A

☐ Mediation

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B. (SEE UNUSUAL ASPECTS/LEGAL ISSUES)
- ☐ b. Mediation is required pursuant to Reg. 67-1802.
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☒ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

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

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

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Juliette Mims, Esquire

address 100 E. Poinsett Street, Greer, SC 29651 on the 31st day of July, 2018 by; ☒ first class postage ☐ certified mail ☐ personal service.

Signature: [Signature]
Date of hearing: August 9, 2018 (Commissioner Beck)

Email: ggallagher@speed-seta.com
Time needed for hearing: _____

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

STATE OF SOUTH CAROLINA)
COUNTY OF GREENVILLE)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION
COMMISSION

Jennie Cox,)

WCC FILE NO: 1206236

Employee,)

vs.)

Palmetto State Transportation,)

Employer,)

and)

Cherokee Insurance Company,)

Carrier.)

NOTICE OF WITNESSES
AND WRITTEN REPORT(S) PHYSICIAN
OR OTHER EVIDENCE TO BE
INTRODUCED ON BEHALF OF
THE EMPLOYER/CARRIER

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
THE CLAIMANT'S ATTORNEY JULIETTE MIMS:

YOU ARE HEREBY NOTIFIED THAT THE employer/carrier, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended), herewith submits the following reports/physicians or other evidence on behalf of the employer/carrier, to wit:

TAB	NAME OF PHYSICIAN/OTHER	DATE OF REPORTS	NO.
29.	Occupational Health	11/9/12 – 3/10/16	387-390
30.	Piedmont Oral Surgery	1/31/13 – 4/30/15	391-398
31.	Piedmont Oral Surgery questionnaire	2/23/16	399
32.	Center for Health & Occupational Services	10/6/14 – 6/29/15	400-403
33.	Impairment rating	4/9/15 – 4/30/15	404-407

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the

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

YOU ARE FURTHER HEREBY NOTIFIED that the originals of the documents referred herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the employer/carrier.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the employer/carrier:

Scott Justice and any other representative of the employer. The Defendants reserve the right to cross-examine any expert submitted by the claimant pursuant to 1-23-330(3).



George D. Gallagher, Esquire
Speed, Seta, Martin, Trivett & Stubley, LLC
Post Office Box 11669
Columbia, South Carolina 29211
(803) 748-2919

Columbia, South Carolina
July 31, 2018

CERTIFICATE OF SERVICE

Maggie E. Rogers, states that she is a paralegal for Speed, Seta, Martin, Trivett & Stubley, with offices in Columbia, South Carolina. This is to certify that a copy of the foregoing Pre-Hearing Brief, Notice of Witnesses and medical records, have been served upon the claimant, by placing a copy of the same in the United States mail, first class postage prepaid, addressed to him at his office as shown below this the 31 day of July, 2018 as follows:

The Honorable T. Scott Beck, Commissioner
S.C. Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202-1715

Juliette Mims, Esquire
Mims Law Firm
100 E. Poinsett Street
Greer, SC 29651



Maggie E. Rogers, Paralegal
Speed, Seta, Martin, Trivett & Stubley, LLC
Post Office Box 11669
Columbia, SC 29211

(803) 748-2919

DEFENDANTS APAS AND EXHIBITS

Jennie Cox v. Palmetto State Transportation

WCC File No.: 1206236

Date of Injury: 5/31/12

Date of Hearing: August 9, 2018

Time: 12:00 p.m.

Hearing: To be determined by the Commissioner's office

**Location: County Square, 301 University Ridge, Conference Room E,
East Wing, Greenville, SC 29601**

Commissioner: T. Scott Beck

CA: Juliette Mims, Esquire

TAB	NAME OF PHYSICIAN/OTHER	DATE OF REPORTS	NO.
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UNIVERSITY MEDICAL GROUP

Center for Health and Occupational Services

OUTPATIENT VISIT

Patient: Jennie Cox
MRN: 250-94-3648

Date: 11/09/12
DOI: 5/31/12

Subjective: Patient follows up in clinic for her right shoulder. She states that she has had a lot of improvement. She is not having any pain and not requiring any pain medications. She states that she is continuing her physical therapy exercises as home and feels able to return to work.

We reviewed the job description sent by the company. There was a lifting requirement of 100 lbs. Ms. Cox stated that the amount was much more than she was required to lift at work. This was discussed with Scott Justice of the company who concurred that maximum lifting would be approximately 35 lbs.

Medications: Ibuprofen.
Allergies: Ativan.

Review of Systems: Constitutional: Negative. Musculoskeletal: Per HPI.

Objective: General: Patient is a pleasant female. She ambulates in the clinic without difficulty and moves easily about the exam room. Full range of motion of bilateral extremities. She continues to have some mild weakness with external rotation of the left shoulder. Internal rotation and supraspinatus testing within normal limits. She has excellent grip strength. Sensation and circulation in the arms are intact.

Impression: Left shoulder injury at MMI.

Plan:

1. Continue exercises at home.
2. Impairment rating for the left shoulder best fits in class I in the shoulder regional grid on page 401 in the *Guides to the Evaluation of Permanent Impairment, 6th Edition*. There was a shoulder contusion with soft tissue injury. There are residual symptoms and consistent objective findings at MMI. Impairment rating of the left shoulder is 2%.

Work Status: May return to work on 11/09/12 without restriction.

Stacey Newsom, M.D., MPH

SN/md 11/12/12

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd, Greenville, SC 29611

Julius W. McKay, II
Mark D. Cauthen
Daniel R. Settana, Jr.
M. Stephen Stubley
Janet Brooks Holmes
Peter P. Leventis, IV*
Kelli L. Sullivan*
George D. Gallagher*
Temus C. Miles, Jr.
David M. Bornemann
Brandon P. Jones
James E. L. Fickling+
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Erica E. Loudin

Of Counsel:
C. E. Hardin, Jr.

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*S.C. Certified Mediator
+ Also licensed in N.C.

March 1, 2016

Occupational Health
ATTN: Stacey Newsom, M.D.
Lexington Medical Park Otarre Pointe
3799 12th Street Extension, Suite 110
Cayce, SC 29033

RE: *Jennie Cox v. Palmetto State Transportation*
WCC No.: 1206236
Claim No.: WC34192
DOA: 5/31/12
Our File No.: 1800-0061

Dear Dr. Newsom:

Our firm represents the Employer and Carrier in the above referenced matter.

The claimant, Ms. Cox, treated with you at the Center for Health & Occupational Services for a chest and left shoulder injury that occurred on May 31, 2012. In regards to that treatment, she was released from your care on November 9, 2012. If possible, I would appreciate if you could answer the following questions based on the enclosed medical records since her release:

- 1) Are you of the opinion that Ms. Cox is at MMI regarding her chest and left shoulder injury?
- 2) If Ms. Cox is at MMI, has there been any change to the previous impairment rating assigned and/or your restriction and future medical treatment recommendations you made on 11/9/12?
- 3) If Ms. Cox is not at MMI, what additional medical treatment would you recommend?

Thank you for taking your time to answer the above questions. Please let me know if you require any additional information.

Sincerely,



Erica E. Loudin

EEL

March 9, 2016

McKay, Cauthen, Settana & Stublely, P.A.
P.O. Box 7217
Columbia, SC 29202

RE: Jennie Cox; WCC No.: 1206236

To Whom It May Concern:

I am writing this letter per your request to answer the three questions regarding Ms. Jennie Cox. I have done so below in numerical order.

- 1.) Yes
- 2.) No
- 3.) NA

I also would like to remind you that her appliances will continue to require maintenance over their life-time. They will also require re-surfacing as normal wear and tear occurs from their use. The possibility of having to remake both the maxillary and mandibular appliances cannot be ruled out due to Ms. Cox's age and expected lifespan.

Thank you for your consideration of Ms. Cox's claim.

Sincerely,



Don Ridgell, D.M.D.

Julius W. McKay, II
Mark D. Cauthen
Daniel R. Settana, Jr.
M. Stephen Stublely
Janet Brooks Holmes
Peter P. Leventis, IV*
Kelli L. Sullivan*
George D. Gallagher*
Temus C. Miles, Jr.
David M. Bornemann
Brandon P. Jones
James E. L. Fickling+
Charles A. Kinney, Jr.+
Erica E. Loudin

Of Counsel:
C. E. Hardin, Jr.

Law Offices
McKAY, CAUTHEN, SETTANA & STUBLEY, P.A.

Post Office Box 7217
Columbia, South Carolina 29202-7217

1303 Blanding Street
Columbia, South Carolina 29201

Douglas McKay, Jr.
(1917-2008)

Telephone
(803) 256-4645

Fax
(803) 765-1839

E-Mail
eloudin@mckayfirm.com

Web
www.mckayfirm.com

*S.C. Certified Mediator
+ Also licensed in N.C.

March 10, 2016

LMC Occupational Health
ATTN: Stacey Newsom, M.D.
Lexington Medical Park Otarre Pointe
3799 12th Street Extension, Suite 110
Cayce, SC 29033

RE: *Jennie Cox v. Palmetto State Transportation*
WCC No.: 1206236
Claim No.: WC34192
DOA: 5/31/12
Our File No.: 1800-0061

Dear Dr. Newsom:

Our firm represents the Employer and Carrier in the above referenced matter. The claimant, Ms. Cox, treated with you at the Center for Health & Occupational Services in Greenville, South Carolina for a chest and left shoulder injury that occurred on May 31, 2012. In regards to that treatment, she was released from your care on November 9, 2012. If possible, I would appreciate if you could answer the following questions based on the enclosed medical records:

- 1) Are you of the opinion that Ms. Cox is at MMI regarding her chest and left shoulder injury?
- 2) If Ms. Cox is at MMI, , has there been any change to the previous impairment rating assigned and/or your restriction and future medical treatment recommendations you made on 11/9/12?
- 3) If Ms. Cox is not at MMI, what additional medical treatment would you recommend?

Thank you for taking your time to answer the above questions. Please let me know if you require any additional information.

Sincerely,



Erica E. Loudin

EEL/dlw
Enclosures

3/15/16 I defer to Dr. Svazas' opinion dated
10/6/14 as I have not evaluated this patient
since 5/31/12.

Stacey Newsom Hallaway
E04320

30

Certificate to return to work or school

Mr.
Mrs.
Miss Jennie Cox

has been under my care from Thurs 1/31/13 to 2/12/2013

and is able to return to work/school on Wed 2/13/2013

Remarks Oral Surgery

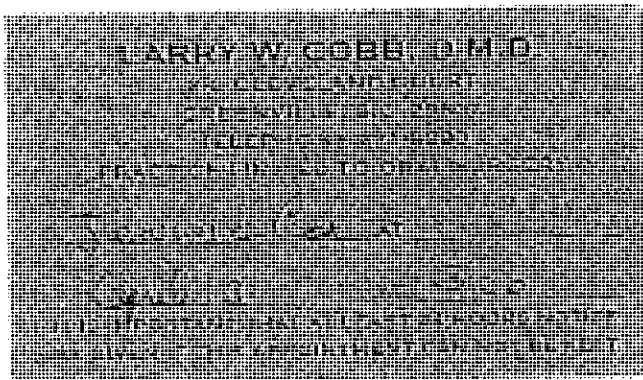
Dr. Larry Cobb Date 1/31/13

LARRY W. COBB, D.M.D.
2-C Cleveland Court
Greenville, S.C. 29607
864-271-9990

Time has been reserved for:

Jennie
On Thurs. Mar. 7 At 8:30 A.M.
Also _____ At _____ P.M.
Also _____ At _____ A.M.
Also _____ At _____ P.M.
Also _____ At _____ A.M.
Also _____ At _____ P.M.

If unable to keep appointment, kindly give 24 hours notice.



PIEDMONT ORAL SURGERY
W. Keith Walker, DDS
Larry W. Cobb, DMD
2C Cleveland Court
Greenville, South Carolina 29607
Tel: 864-271-9990 Fax: 864-235-7959

FAKED
6-24-13

RE: Jennie Cox

Dear Dr. Don Ridgell

I would like to take this opportunity to update you on the care of Jennie Cox.
These are the procedures that were performed: 4/29/13

Extractions: #

Implant Placement: #

#23 | XIFNT410 #23 | BIOMET 3i™
2013021029 2018-02
OSSEOTITE® Tapered Certain® Implant
4 X 10mm | 9550 | XIFNT410 #25 | BIOMET 3i™
2013021029 2018-02
OSSEOTITE® Tapered Certain® Implant
4 X 10mm | 9550 | XIFNT410 #30 | BIOMET 3i™
2013021029 2018-02
OSSEOTITE® Tapered Certain® Implant
4 X 10mm | 9550 | XIFNT410 #27 | BIOMET 3i™
2013021029 2018-02
OSSEOTITE® Tapered Certain® Implant
4 X 10mm | 9550 | XIFNT410 #30 | BIOMET 3i™
2013021029 2018-02
OSSEOTITE® Tapered Certain® Implant
4 X 10mm | 9550

Healing time: 3-4 months

Follow up Appointment:

May 9th, 2013

Thank you for referring your patient to our office. The confidence of your referral is greatly appreciated.

Sincerely,

Larry W. Cobb, DMD

Larry W. Cobb, DMD

✓ Flowers have been sent to patient from Dr. Cobb and Dr. Ridgell



PIEDMONT ORAL SURGERY
W. Keith Walker, DDS
Larry W. Cobb, DMD
2C Cleveland Court
Greenville, South Carolina 29607
Tel: 864-271-9990 Fax: 864-235-7959

UNCOVERY APPOINTMENT

Date: 7/17/13
To: Dr. Don Ridgell
Your patient, Jennie Cox was seen today.

RE: Implant(s) # 20, #23, #25, #27 + #30

☒ Uncovery today

☒ Surgical release scheduled on: 7/17/13

Comments:

Implants # 20, #23, #25, #27 + #30 uncovered
Certain loading abutments (straight) T SHA44 placed
on all implants

Follow up Note:

It has appointment with Dr. Ridgell 7-17-13 @ 1:30 pm

If you have any questions, please contact our office.
It is a pleasure working with you and providing treatment for your patients.

Larry W. Cobb D.M.D.
Larry W. Cobb DMD

PIEDMONT ORAL SURGERY
W. Keith Walker, DDS
Larry W. Cobb, DMD
2C Cleveland Court
Greenville, South Carolina 29607
Tel: 864-271-9990 Fax: 864-235-7959

RE: Jennie Cox
Dear Dr. Don Ridgell

I would like to take this opportunity to update you on the care of Jennie Cox.
These are the procedures that were performed: 7/17/13

Extractions: #

Implant Placement: # 3, # 5, # 6, # 11, # 12 & # 14

#3	XIFNT411 #3 2013030065 OSSEOTITE Tapered Certain Implant 4 X 11.5mm	BIOMET 3i™ 2018-03	#5	XIFNT411 #5 2013030065 OSSEOTITE Tapered Certain Implant 4 X 11.5mm	BIOMET 3i™ 2018-03	#6	XIFNT411 #6 2013030065 OSSEOTITE Tapered Certain Implant 4 X 11.5mm	BIOMET 3i™ 2018-03
Healing time: <u>4</u> months			XIFNT411 #11 2013030065 OSSEOTITE Tapered Certain Implant 4 X 11.5mm			XIFNT411 #12 2013030065 OSSEOTITE Tapered Certain Implant 4 X 11.5mm		

Follow up Appointment:

7-29-13

Thank you for referring your patient to our office. The confidence of your referral is greatly appreciated.

Encoded Healing Abutments
placed

Sincerely,
Larry W. Cobb, DMD

Larry W. Cobb, DMD

ENCODE #3 1EHA444 1124819-CN	ENCODE #5 1EHA444 1124819-CN	ENCODE #6 1EHA444 1124819-CN	ENCODE #11 1EHA444 1080437-CN	ENCODE #12 1EHA444 1124819-CN	ENCODE #14 1EHA444 1124819-CN

Flowers have been sent to patient from Dr. Cobb and Dr. _____

Certificate to return to work or school

Mr.

Mrs.
Miss

Jennie Cobb

has been under my care from

to

and is able to return to work/school on

8-8-13

Remarks

Jennie was here this AM for
oral surgery.

Dr.

Larry W. Cobb

Date

7-17-13

LARRY W. COBB, D.M.D.
2-C Cleveland Court
Greenville, S.C. 29607
864-271-9990

Certificate to return to work or school

Mr.

Mrs.

Miss

Jennie Cox

has been under my care from _____ to _____

and is able to return to work/school on _____

Remarks Ms Cox was also out of work on
July 15; July 16 in preparation for oral
surgery on July 17, 2013

Dr.

Larry W. Cobb

Date

7-18-13LARRY W. COBB, D.M.D.
2-C Cleveland Court
Greenville, S.C. 29607
864-271-9990

Attn:

Scott Justice

Certificate to return to work or school

Mr.
Mrs.
Miss

Jennie Cobb

has been under my care from _____ to _____

and is able to return to work/school on 8-12-13

Remarks Jennie does not need to go back to work 8-12-13

Dr. Larry W. Cobb Date 7-31-13

LARRY W. COBB, D.M.D.
2-C Cleveland Court
Greenville, S.C. 29607
864-271-9990

Time has been reserved for:

Jennie
On Thurs Aug 15 At 8:30 A.M.
Also Mon. Aug 26 At 8:00 A.M.
Also Thurs Sept. 5 At 8:30 A.M.
Also Mon. Sept. 16 At 8:30 A.M.

If unable to keep appointment, kindly give 24 hours notice.

PIEDMONT ORAL SURGERY, P.A.

W. KEITH WALKER, D.D.S.

LARRY W. COBB, D.M.D.

2 C CLEVELAND COURT

GREENVILLE, SOUTH CAROLINA 29607

**PRACTICE LIMITED
ORAL SURGERY**

**TELEPHONE
(864) 271-9990**

April 30, 2015

To Whom It May Concern:

It is my opinion that Jennie Cox has reached her maximum medical improvement from her severe maxillofacial injuries. She has sustained some permanent disabilities from these injuries. Using the American Association of Oral and Maxillofacial Surgeons guidelines to the evaluation of impairment of the oral and maxillofacial region the determination of disability is as follows:

Masticatory dysfunction:

15%- diet limited to soft or semi solid foods- 85% of normal function

Impairment of Craniomandibular Articulation:

Interincisal Range of Motion- 30mm 4% impairment

Lateral excursion Range of Motion- 5 to 6 mm 3% impairment

Facial Disorder- Scar 2%

Nerve Disorder- Permanent numbness of lower lip and chin on the left side 1%

Her total whole person disability of 25%

Larry W. Cobb, DMD

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eloudin@mckayfirm.com

Web

www.mckayfirm.com

*S.C. Certified Mediator
+ Also licensed in N.C.

February 23, 2016

Piedmont Oral Surgery
ATTN: Larry W. Cobb, D.M.D.
2 Cleveland Court
Greenville, SC 29607

RE: **Jennie Cox v. Palmetto State Transportation**
WCC No.: 1206236
Claim No.: WC34192
DOA: 5/31/12
Our File No.: 1800-0061

* Same as info sent
last April - Resending

Dear Dr. Cobb:

Same letter #

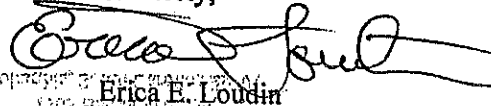
Our firm represents the Employer and Carrier in the above referenced matter.

The claimant, Ms. Cox, treated with you for a serious mouth and jaw injury, which occurred on May 31, 2012. In regards to that treatment, her last visit with you was on October 27, 2014. If possible, I would appreciate if you could answer the following:

- 1) Are you of the opinion that Ms. Cox is at MMI regarding her mouth/jaw injury?
- 2) If Ms. Cox is at MMI, what impairment rating and work restrictions, if any, would you assign?
- 3) If Ms. Cox is at MMI, what future medical treatment, if any, will she require?
- 4) If Ms. Cox is not at MMI, what additional medical treatment would you recommend?

Thank you for taking your time to answer the above questions. Please let me know if you require any additional information.

Sincerely,


Erica E. Loudin

Juliette Mims, Esquire
Michael DeCarolis

32



GREENVILLE HEALTH SYSTEM

Center for Health &
Occupational Services

1020 Grove Road
Greenville, SC 29605
(864) 455-2300 P
(864) 455-2399 F
ghs.org

OUTPATIENT VISIT

Name: Jennie Cox
DOB: 08/14/52

Date of Service: 10/06/14

SUBJECTIVE: Ms. Cox is being sent today for reevaluation of her left shoulder. She states that she has some residual difficulties in the left shoulder and wishes for these to be noted. The difficulties that she is having is in the lateral aspect of the left shoulder blade. She points to this location. Aggravating factors are when she reaches behind her or when she drives her zero-clearance lawnmower (she does have a sizable property that she mows). She states that after mowing for an hour in this capacity she will have some difficulties in this same area. In terms of her range of motion and strength, she is agreeable that these are doing quite well. She states that she has been sore after some of her long truck runs because she uses the left hand to secure the steering wheel while reaching up to flip switches or doing gear shifts with her right hand. She says that she will be quite sore in this area after one of these long road trips. When asked about sleeping on that side, she states that she typically does not sleep on that side. She says if she has to sleep in her truck berth she does not sleep on the left side due to difficulties with pain in her left jaw. She otherwise has no other difficulties with the left shoulder area. Of note, on this visit she does talk about some difficulties with the left ear, with intermittent hearing diminution. She gives the example of singing in church last night, being able to hear her voice in her right ear but not hearing on the left side. This prompted her to have a relative who is in the medical profession flush her left ear. She states some improvement after that, but has noted intermittent difficulties with the left ear on occasion.

PAST MEDICAL HISTORY: No significant factors identified.

MEDICATIONS: She is just taking over-the-counter Tylenol for her cervical pain and the left shoulder pain.

REVIEW OF SYSTEMS: Negative in terms of any respiratory complaints. Denies any cough or any wheezes. Does not have any effect on the left scapular region with deep breathing. Cardiovascular: She does not have any chest pain. No shortness of breath. GI: She has no complaints in this regard. As mentioned in the ENT arena, she does complain of some difficulties with occasional perceived left hearing loss, as if the left ear is clogged.

OBJECTIVE: On examination of the left shoulder, she is able to put the shoulder through full range of motion, both actively and passively. Crossover arm stretch does not elicit any pain. She is pain-free on both supraspinatus and infraspinatus testing. There is no weakness noted with these maneuvers. She demonstrates that when she reaches behind her the left lateral scapular border is painful. When performing this maneuver I hear an audible click and also can palpate a click within the soft tissue in this region. Performed provocative maneuvers for latissimus dorsi and these did not elicit any pain or click. Again, on external abduction and external rotation, another click was elicited in the same area of the scapular region. When palpating the lateral scapular border, no pain is elicited. The tissues do appear to be somewhat sinewy, that is less supple than on the unaffected right side. Lungs are clear to auscultation. Heart S1, S2. No murmurs or extra sounds. Abdomen is soft. Bowel sounds are positive. Ears canals patent bilaterally. TM's mobile with valsalva.

Name: Jennie Cox
DOB: 08/14/52

Date of Service: 10/06/14
Page 2

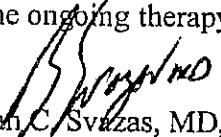
ASSESSMENT:

1. Individual with residual symptoms to the left shoulder region. I do believe that the complaints she has in the left scapular border are likely related to her previous injury to the shoulder.
2. Upon review of the chart, there was similar complaints of hearing loss on the left side.

PLAN:

1. I did advise Ms. Cox that, should she wish to pursue the left ear issues, she should request to see an ENT physician.
2. I do find that the patient is functioning at 100%, as she has returned to her truck driver position and is thriving in this career.
3. The left shoulder still appears to be somewhat problematic for this individual. I did suggest that physical therapy may help clear some of the soft tissue areas. Ms. Cox did express some reluctance to enter into physical therapy again, as she had a quite extensive course post injury. As the pain appears to be amenable to Tylenol over-the-counter, she should continue with this for symptomatic treatment.

WORK STATUS: I do find that she is fit for full duty as a truck driver. I find her at MMI. Due to the ongoing issues with the left shoulder, this clinic previously rated her at 2%. I would rate her at 6%, as she may need some ongoing therapy to this shoulder going forward.


Brian C. Svazas, MD, MPH

BCS/bts/nw 10/07/14

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd, Greenville, SC 29611

GHS Center for Health and Occupational Services

1020 Grove Road
Greenville, SC 29605
Phone (864)455-2300
Fax (864) 455-2399

Name

Jennie Cox

DOB

8-14-52

Company

Palmetto State Transportation

Date of Injury

5-31-12

Diagnosis:

Right Shoulder Contusion

Medications:

Tylenol etc

Work Status: May return to work on

6 Oct 2014

☒ Full Duty

☐ Modified Duty:

[None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☐ Lift, push or pull no more than _____ lbs. []
- ☐ Bend or Twist []
- ☐ Walk and Stand []
- ☐ Sit/Stand as needed.
- ☐ No climbing ladders or work at unprotected heights.
- ☐ Forceful or Repetitive use of (right/left) hand and arm []
- ☐ Overhead use of (right/left) arm []
- ☐ Squat or kneel []
- ☐ Awkward or Static postures []
- ☐ No use of _____
- ☐ No operating heavy machinery or Commercial Motor Vehicle.
- ☐ Elevate affected area _____
- ☐ Use crutches as needed.
- ☐ Use _____ splint.
- ☐ Other _____

Instructions:

- ☐ Stay active during your recovery.
- ☐ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☐ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water _____ times per day.
- ☐ Apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain, or drainage.
- ☐ Other: _____

Follow Up:

- ☐ Appointment Date: _____ Time: _____ Provider: _____
- ☒ Maximum Medical Improvement : Contact your employer prior to making further appointments.
- ☐ Referral to _____ You will be contacted with and appointment.

Physician/NP:

[Signature]

Date:

10-6-14

Return Yellow Copy to your Employer

Revised 1/24/14



GREENVILLE HEALTH SYSTEM

Plastic Surgery & Aesthetics
200 Palmetto Drive Suite B480
Greenville, SC 29615
864-454-4570 Fax: 864-454-4575

RETURN TO WORK STATUS

Patient Name: Jennie Cox was seen in our
office on 6/29/15

Date of Birth: 8/14/52

☐ May return to Work on 7/20/15 with no restrictions

☐ May return to Work with RESTRICTIONS From: _____ To: _____

☐ Unable to Work From: _____ To: _____

- ☐ Limit standing to no more than _____ hr/day.
- ☐ Limit sitting to no more than _____ hr/day.
- ☐ Limit walking to no more than _____ hr/day.
- ☐ No lifting over _____ pounds.
- ☐ No climbing of stairs/ladders.
- ☐ No reaching above shoulder level.
- ☐ No squatting.
- ☐ No bending or stooping.
- ☐ No use of R / L / Both hands.
- ☐ Other restrictions _____

Follow-up Appointment Date: _____

Dr. Fowler / E. Akins RN
Physician's Signature

6-29-15
Date

Wesley Culpepper, MD
Carl de Brux, MD
James Fowler, MD
John Jarrell, MD

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



Physician's Statement

Claimant's Name: Jennie Cox

Employer's Name: Palmetto State Transportation

Physician's Name: Donald L. Ridgell, D.M.D.

Insurance Carrier: Cherokee Insurance Company

Practice/Clinic: Unstate Prosthodontics

SCWCC File No: 1206236

Preparer's Name: Donald L. Ridgell

Phone: 864 2328882

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

Date of Injury or Illness: May 31, 2012

Date of first office visit: 10/4/12

Date of last visit: 12/8/14

Diagnosis or nature of Injury or Illness: Missing teeth/bone of jaws from trauma

Body part(s) injured: maxilla / mandibular jaw Body part(s) affected: Teeth / maxilla / mandible

Date of Maximum Medical Improvement: 6/12/14

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

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

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

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

☐ Claimant possesses retained hardware casually related to this injury.

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

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

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

Maintenance procedure annually - more expensive than natural teeth
Replace or refurbish appliances every 6-8 yrs.
Oral Surgeon visit 5 yrs for radiograph / CT scan

Donald L. Ridgell
Treating Physician

4/9/15
Date



Physician's Statement

Claimant's Name: Jennie Cox Employer's Name: Palmetto State Transportation
Physician's Name: Brian Svazas, M.D., MPH, FACOEM Insurance Carrier: Cherokee Insurance Company
Practice/Clinic: Center for Health & Occupational Services SCWCC File No: 1206236
Preparer's Name: _____
Phone: _____

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

Date of Injury or Illness: May 31, 2012

Date of first office visit: 6 Oct 2014 Date of last visit: 6 Oct 2014

Diagnosis or nature of injury or illness: (L) Shoulder

Body part(s) Injured: (L) Shoulder Body part(s) affected: _____

Date of Maximum Medical Improvement: 6 Oct 2014

Based on the AMA Guidelines, the claimant has sustained a 6 % medical impairment to (L) Shoulder
Injured body part(s) and a _____ % medical impairment to _____
other affected body part(s).

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

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

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

_____ Claimant possesses retained hardware casually related to this injury.

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

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

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

Physical Therapy

Brian Svazas
Treating Physician

8 Apr 2015
Date

PIEDMONT ORAL SURGERY, P.A.

W. KEITH WALKER, D.D.S.

LARRY W. COBB, D.M.D.

2 C CLEVELAND COURT

GREENVILLE, SOUTH CAROLINA 29607

**PRACTICE LIMITED
ORAL SURGERY**

**TELEPHONE
(864) 271-9990**

April 30, 2015

To Whom It May Concern:

It is my opinion that Jennie Cox has reached her maximum medical improvement from her severe maxillofacial injuries. She has sustained some permanent disabilities from these injuries. Using the American Association of Oral and Maxillofacial Surgeons guidelines to the evaluation of impairment of the oral and maxillofacial region the determination of disability is as follows:

Masticatory dysfunction:

15%- diet limited to soft or semi solid foods- 85% of normal function

Impairment of Craniomandibular Articulation:

Interincisal Range of Motion- 30mm 4% impairment

Lateral excursion Range of Motion- 5 to 6 mm 3% impairment

Facial Disorder- Scar 2%

Nerve Disorder- Permanent numbness of lower lip and chin on the left side 1%

Her total whole person disability of 25%

Larry W. Cobb, DMD



Physician's Statement

Claimant's Name: Jennie Cox

Employer's Name: Palmetto State Transportation

Physician's Name: Larry W. Cobb, D.M.D.

Insurance Carrier: Cherokee Insurance Company

Practice/Clinic: Piedmont Oral Surgery, P.A.

SCWCC File No: 1206236

Preparer's Name: Larry W. Cobb DMD

Phone: 864-271-9490

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

Date of Injury or Illness: May 31, 2012

Date of first office visit: 7/24/2012

Date of last visit: 4/27/2015

Diagnosis or nature of injury or illness: Multiple jaw fractures with fractured and avulsed teeth.

Body part(s) injured: Mandible / Maxilla, teeth Body part(s) affected: Mandible / Maxilla, teeth

Date of Maximum Medical Improvement: 4/27/2015

Based on the **AMA Guidelines**, the claimant has sustained a 25 % medical impairment to Jaws, teeth, soft tissue injured body part(s) and a _____ % medical impairment to _____ other affected body part(s).

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

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

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

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

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

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

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

She will need prosthetic maintenance and replacement sometime in her lifetime. Her prosthodontist will make this determination.

Larry W. Cobb DMD
Treating Physician

4/29/2015
Date

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 1206236

EMPLOYEE/CLAIMANT: JENNIE COX

EMPLOYER: PALMETTO STATE TRANSPORTATION

CARRIER: CHEROKEE INSURANCE COMPANY

1 SOUTH CAROLINA WORKERS' COMPENSATION HEARING

PURSUANT TO NOTICE OF WORKERS' COMPENSATION
HEARING, THE WITHIN HEARING WAS TAKEN ON THE 2ND DAY OF
FEBRUARY, 2017, COMMENCING AT THE HOUR OF 1:13 P.M., IN
ANDERSON, SOUTH CAROLINA, BEFORE THE HONORABLE AISHA
TAYLOR, ATTENDED BY COUNSEL AS FOLLOWS:

**TIMMI A. PARRISH
VERBATIM REPORTER**

ORIGINAL

TIMMI A. PARRISH
COURT REPORTING SERVICES
POST OFFICE BOX 551
ROEBUCK, SC 29376
864-921-8743

APPEARANCES

JULIETTE B. MIMS, ESQUIRE, OF
THE MIMS LAW FIRM
100 EAST POINSETT STREET
GREER, SOUTH CAROLINA 29651-3404

ADRIANNE L. TURNER, ESQUIRE, OF THE FIRM
TURNER LAW, LLC
POST OFFICE BOX 210638
COLUMBIA, SOUTH CAROLINA 29221-0638

ATTORNEYS FOR THE CLAIMANT,

ROBERT E. HORNER, ESQUIRE, OF THE FIRM
SPEED, SETA, MARTIN, TRIVETT & STUBLEY, LLC
POST OFFICE BOX 11669
COLUMBIA, SOUTH CAROLINA 29211

ATTORNEY FOR THE EMPLOYER/CARRIER.

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1 PURSUANT TO NOTICE OF HEARING, THE WITHIN HEARING
2 WAS TAKEN BY THE ABOVE-NAMED COURT REPORTER, A NOTARY
3 PUBLIC FOR THE STATE OF SOUTH CAROLINA, IN ANDERSON,
4 SOUTH CAROLINA.

5 * * * * * * * * * * * * * * *

6 **BY COMMISSIONER TAYLOR:**

7 TODAY IS THURSDAY, FEBRUARY 2ND, 2017. WE ARE
8 HERE ON WORKERS' COMPENSATION FILE NUMBER 1206236.
9 THIS IS THE CLAIM OF MS. JENNIE COX, WHO IS PRESENT
10 HERE TODAY AND REPRESENTED BY MS. JULIETTE MIMS AND
11 MS. ADRIANNE TURNER. THE EMPLOYER IN THIS MATTER IS
12 PALMETTO STATE TRANSPORTATION, AND THE CARRIER IS
13 CHEROKEE INSURANCE COMPANY. BOTH THE EMPLOYER AND
14 CARRIER ARE REPRESENTED TODAY BY MR. ROBERT E.
15 HORNER. I HAVE AN ORIGINAL DATE OF INJURY OF MAY
16 31ST, 2012. THE CLAIMANT HAS AN AVERAGE WEEKLY WAGE
17 OF \$1,327.69, WHICH YIELDS A COMPENSATION RATE OF
18 \$725.47. WE ARE HERE TODAY ON THE CLAIMANT'S FORM
19 50, REQUEST FOR HEARING.

20 I WILL ALLOW THE PARTIES TO PUT DETAILED
21 POSITION STATEMENTS ON THE RECORD. HOWEVER, PRIOR
22 TO DOING SO ARE THERE ANY OBJECTIONS TO APAs,
23 JURISDICTION, VENUE, OR ANY OTHER ITEMS? MS.
24 TURNER, ANY OBJECTIONS?

25 **BY MS. TURNER:**

1 NONE.

2 **BY THE COMMISSIONER:**

3 OKAY. THANK YOU. MR. HORNER, ANY OBJECTIONS?

4 **BY MR. HORNER:**

5 NO, MA'AM.

6 **BY THE COMMISSIONER:**

7 THANK YOU. WITHOUT OBJECTION THE COMMISSION
8 FILE BECOMES A PART OF THE RECORD WITH THE EXCEPTION
9 OF SELF-SERVING DECLARATIONS AND UNSTIPULATED
10 MEDICAL REPORTS.

11 MS. TURNER, DO YOU HAVE A POSITION STATEMENT
12 FOR THE RECORD, MA'AM?

13 **BY MS. TURNER:**

14 THANK YOU, COMMISSIONER. IT IS OUR POSITION
15 THAT MS. COX, ON MAY 31ST OF 2012, SUFFERED INJURIES
16 THAT RENDERED HER PERMANENTLY AND TOTALLY DISABLED.
17 SHE HAD CATASTROPHIC INJURY TO HER MOUTH, WHICH
18 CAUSED HER TO LOSE ALL OF HER TEETH AND HAVE TO USE
19 A PROSTHETIC. SHE ALSO SUFFERED INJURY TO HER
20 SHOULDER AND IS TO DATE STILL HAVING PROBLEMS WITH
21 SHOULDER PAIN AND NECK PAIN, AND EVENTUALLY HER
22 INJURIES RESULTED IN HER LOSING A SIGNIFICANT AMOUNT
23 OF WEIGHT DURING -- DUE TO HER INABILITY TO SUSTAIN
24 PROPER NUTRITION. AND ALTHOUGH SHE HAS BEEN ABLE TO
25 REGAIN SOME OF THAT WEIGHT, SHE HAS NOT BEEN ABLE TO

1 RECOUP HER LEVEL OF ENERGY. SHE'S MUCH WEAKER NOW
2 AND SUFFERS FROM EASILY -- EASY EXHAUSTION, NONE OF
3 WHICH SHE HAD BEFORE THESE INJURIES. SHE ALSO
4 SUFFERS FROM A NERVE CONDITION ON THE LEFT SIDE OF
5 HER FACE AND SOME LOSS OF HER SENSE OF SMELL,
6 SIGNIFICANT WORSENING DEPRESSION THAT HAS BEEN
7 EXACERBATED, OF COURSE, BY THE CONDITION -- HER
8 PHYSICAL CONDITION FOLLOWING HER ACCIDENT. SHE IS
9 NO LONGER ABLE TO WORK IN THE CAPACITY OF COMMERCIAL
10 TRUCK DRIVER AS SHE HAS FOR THE VAST MAJORITY OF HER
11 CAREER DUE TO THE INJURIES SHE SUSTAINED ON MAY THE
12 31ST OF 2012. WE ARE ASKING THAT YOU FIND HER TO BE
13 PERMANENTLY AND TOTALLY DISABLED AND FIND THAT
14 TEMPORARY TOTAL DISABILITY BENEFITS ARE DUE FROM THE
15 TIME THAT SHE WAS -- THAT SHE HAD TO STOP WORKING
16 DUE TO HER INABILITY TO CONTINUE DRIVING AT HER
17 COMPANY.

18 **BY THE COMMISSIONER:**

19 OKAY. THANK YOU. MADAM COURT REPORTER, WE'LL
20 GO OFF THE RECORD FOR A MOMENT.

21 **(OFF THE RECORD)**

22 **BY THE COMMISSIONER:**

23 MR. HORNER, YOUR POSITION STATEMENT, PLEASE.

24 **BY MR. HORNER:**

25 YES, MA'AM. IT IS THE POSITION OF THE

1 DEFENDANTS, I GUESS FIRST AND FOREMOST, THAT MS. COX
2 IS NOT PERMANENTLY AND TOTALLY DISABLED. THIS IS AN
3 ADMITTED INJURY BY ACCIDENT ON 5/31/2012. SHE
4 RECEIVED ALL THE TREATMENT AND T.T.D. THAT WAS OWED
5 TO HER. PERIODICALLY -- SHE'S HAD TO GO BACK
6 PERIODICALLY TO THE DOCTOR FOR VARIOUS THINGS THAT
7 HAVE BEEN PAID FOR, AND WHEN SHE'S BEEN OUT SHE WAS
8 PAID HER T.T.D. THERE IS FUTURE MEDICAL THAT NO ONE
9 HAS DISPUTED THAT INVOLVE THE CLEANING AND MAYBE
10 POTENTIAL REPLACEMENT OF SOME OF THE PROSTHESIS IN
11 HER JAW, AND THAT IS A FUTURE MEDICAL CARE ISSUE
12 THAT NO ONE HAS DISPUTED THAT IS OUT THERE.

13 SO, WHAT WE'RE LEFT WITH IS REALLY T.T.D., AND
14 OUR POSITION IS THAT MS. COX WENT OUT ON MARCH 3RD,
15 2016, AND CAME BACK ON MAY 31ST, 2016, THAT SHE TOOK
16 HERSELF OUT OF WORK, THAT IT WASN'T AT THE
17 INSTRUCTION OF A DOCTOR, AND ALTHOUGH SHE EVENTUALLY
18 PRODUCED A NOTE FROM HER DOCTOR, THE NOTE -- NEITHER
19 THE NOTE NOR THE RECORDS CAUSALLY RELATE HER
20 CURRENT, HER ONGOING PROBLEMS AT THAT TIME, WHICH
21 SHE DESCRIBED AS FATIGUE AND EXHAUSTION, AS BEING
22 CAUSALLY RELATED TO HER ACCIDENT, WHICH OCCURRED
23 FOUR YEARS BEFORE THAT. AND IT'S OUR POSITION THAT
24 AS TO T.T.D. AND AS TO PERM TOTAL THAT MEDICAL
25 CAUSATION HAS NOT BEEN MET IN THIS CASE, BECAUSE

1 WE'RE TALKING ABOUT A COMPLEX MEDICAL OPINION THAT
2 SOMEONE WHO FOUR YEARS LATER, WHO WORKED FOR FOUR
3 YEARS, HAS SOMEHOW NOW DEVELOPED MALNUTRITION OR
4 EXHAUSTION AS A RESULT OF AN INABILITY TO -- AN
5 ALTERATION OF HER DIET. SO IT'S OUR POSITION THAT
6 NO T.T.D. IS OWED FROM MARCH OF 2016 THROUGH MAY OF
7 2016 BECAUSE EVEN TO THE EXTENT THAT SHE MAY HAVE
8 BEEN WRITTEN OUT OF WORK BY HER FAMILY DOCTOR,
9 THERE'S NO CAUSATION. AND THEN SHE SEEKS T.T.D.
10 FROM JUNE 14TH, 2016, TO THE PRESENT, AND IT'S OUR
11 POSITION NO T.T.D. IS OWED BECAUSE OF THAT BECAUSE,
12 ONE, SHE TOOK HERSELF OUT OF WORK. SHE'S NEVER HAD
13 A DOCTOR'S EXCUSE WRITING HER OUT OF WORK. SHE JUST
14 SIMPLY STOPPED COMING TO WORK. SHE STILL HAS A JOB
15 AVAILABLE TO HER. THE JOB OFFER REMAINS TO THIS
16 DAY. SO, WE'VE MADE ACCOMMODATIONS. BUT HER
17 INABILITY TO EARN WAGES FROM JUNE 14, 2016, TO THE
18 PRESENT IS, ONE, LACK OF MEDICAL CAUSATION; TWO, NOT
19 WRITTEN OUT BY AN AUTHORIZED PHYSICIAN. IT'S A
20 DECISION SHE MADE. IT'S PERSONAL TO HER, AND WE
21 DON'T OWE TEMPORARY TOTAL BENEFITS FOR THAT. SHE
22 WAS WORKING UP UNTIL THE TIME SHE UNILATERALLY
23 DECIDED TO TAKE HERSELF OUT OF WORK.

24 AS TO THE PERMANENCY, WE BELIEVE THIS IS A
25 SCHEDULED MEMBER CASE. WE BELIEVE THAT SHE HAS A

1 RATING TO THE SHOULDER BY THE AUTHORIZED TREATING
2 PHYSICIAN, WHO GAVE HER SIX PERCENT. THE TEETH ARE
3 WORTH TWO WEEKS PER TOOTH. WE BELIEVE THE MEDICAL
4 RECORDS ESTABLISH THE NUMBER OF TEETH, BUT IT'S IN
5 THE NEIGHBORHOOD OF SOMEWHERE UP TO 16 OR 17 TEETH,
6 NO MORE THAN 20, BASED UPON WHAT ARE IN THE MEDICAL
7 RECORDS. WE BELIEVE THAT THERE IS A SEVEN PERCENT
8 IMPAIRMENT TO THE MANDIBLE, WHICH IS A SCHEDULED
9 MEMBER UNDER THE CODE. WE BELIEVE THAT BASED ON THE
10 TWO PERCENT RATING FOR SCARRING SHE'S ENTITLED TO
11 SOMETHING FOR THAT, AND THAT'S A RESULT OF THE GASH
12 ON THE CHIN. THERE'S ONE PERCENT TO THE FACIAL
13 NERVE, WHICH IS NOT A SCHEDULED MEMBER UNDER THE
14 ACT, THAT I COULD FIND, ACCORDING TO THE REGS. AS
15 TO THESE ISSUES OF SMELL AND HEARING AND THINGS LIKE
16 THAT, ONE, THERE IS NO MEDICAL CAUSATION WHATSOEVER;
17 TWO, WE'RE HERE ON A PERMANENCY HEARING. THERE'S NO
18 CAUSATION, BUT THERE IS NO IMPAIRMENT. SO SHE CAN'T
19 RECOVER FOR THESE BECAUSE THERE'S NO IMPAIRMENT BEEN
20 GIVEN FOR ANYTHING OTHER THAN THE BODY PARTS THAT I
21 JUST IDENTIFIED. SO IT'S OUR POSITION THAT
22 CERTAINLY MS. COX IS ENTITLED TO A SCHEDULED MEMBER
23 AWARD FOR HER SHOULDER, HER TEETH, HER MANDIBLE,
24 SCARRING, AND ONE PERCENT TO THE FACIAL NERVE, BUT
25 THAT SHE IS OTHERWISE ABLE TO RETURN TO WORK, SHE IS

1 NOT PERMANENTLY AND TOTALLY DISABLED, AND THAT THE
2 REQUIREMENTS OF THE JOB THAT SHE CONTENDS SHE CAN'T
3 DO ARE THE SAME REQUIREMENTS THAT SHE DID DO FOR
4 FOUR YEARS, AND THAT WE'RE NOT TALKING ABOUT
5 HYPOTHETICAL JOB SCENARIOS USING THE DEPARTMENT OF
6 LABOR STATISTICS. WE'RE TALKING ABOUT AN ACTUAL,
7 LEGITIMATE JOB WHICH SHE DID FOR 11 OF THE LAST 12
8 YEARS THAT REMAINED AVAILABLE TO HER AND STILL
9 REMAINS AVAILABLE TO HER IF SHE CHOSE TO TAKE IT.

10 **BY THE COMMISSIONER:**

11 MR. HORNER, WILL YOU ADDRESS THE FORM 14-B BY
12 DR. COBB THAT GIVES 25 PERCENT TO JAWS, TEETH, AND
13 SOFT TISSUE?

14 **BY MR. HORNER:**

15 YES, MA'AM. THAT IS -- FIRST OFF, THAT IS --
16 IT'S A WHOLE PERSON IMPAIRMENT, AND SOUTH CAROLINA
17 ONLY RECOGNIZES WHOLE PERSON IMPAIRMENTS WHEN
18 THEY'RE INVOLVING THE SPINE. THE SPINE IS WHAT WE
19 USE FOR WHOLE PERSON IMPAIRMENTS. OTHERWISE, SOUTH
20 CAROLINA IS A SCHEDULED MEMBER STATE UNDER 42-9-30,
21 AND HER SCHEDULED -- AND SHE HAS A RATING
22 SPECIFICALLY TO THE MANDIBLE. THE OTHER ISSUE WITH
23 THAT 14-B IS THAT UNDER THE MAXILLOFACIAL GUIDELINES
24 THAT PERCENTAGE INCLUDES HER TEETH. SO HER TEETH
25 ARE BUILT INTO THAT RATING. AND SO, BECAUSE SOUTH

1 CAROLINA IS A SCHEDULED MEMBER STATE WHERE THE TEETH
2 ARE A SPECIFIC BODY PART THAT HAS A SPECIFIC VALUE
3 TO IT, THAT YOU CAN'T GO OFF THIS 25 PERCENT WHOLE
4 PERSON IMPAIRMENT BECAUSE, ONE, IT'S A WHOLE PERSON
5 IMPAIRMENT, WHICH WE DON'T RECOGNIZE BECAUSE IT'S
6 NOT THE SPINE; AND, TWO, HE'S INCLUDING THE TEETH,
7 WHICH 42-9-30 REQUIRES BE PULLED OUT OF THAT. AND
8 SO WHEN YOU PULL THAT OUT OF THAT, YOU KNOW,
9 BASICALLY HE'S USING A DIFFERENT GUIDELINE. IT'S
10 NOT THE AMA GUIDELINES, AND WHEN HE WAS RATING HER,
11 HE WAS RATING HER FOR DYSFUNCTION TO INCLUDE THE
12 TEETH, WHICH WE THINK CAN'T BE -- WHICH IS IMPROPER
13 IN THIS CASE IN WHICH SHE'S ENTITLED TO HER TWO
14 WEEKS PER TOOTH AS A RESULT OF THE LOSS.

15 **BY MS. TURNER:**

16 COMMISSIONER?

17 **BY THE COMMISSIONER:**

18 SURE.

19 **BY MS. TURNER:**

20 THERE IS NOTHING IN THAT REPORT WHERE THOSE
21 IMPAIRMENT RATINGS ARE GIVEN THAT INDICATES THAT THE
22 TEETH ARE BEING CONSIDERED AS PART OF THE RATING TO
23 THE MANDIBLE. SHE HAD SEVERAL FRACTURES IN HER JAW.
24 THAT RATING, WE WOULD -- IT'S OUR POSITION THAT THAT
25 RATING WAS DUE TO THE RESULTING DIFFICULTY THAT SHE

1 HAS WITH CHEWING, NOT BECAUSE HER NATURAL TEETH ARE
2 ALL GONE BUT BECAUSE OF THE INABILITY TO COMPLETELY
3 FIX THE FRACTURES AND THE MISALIGNMENT THAT HAPPENED
4 THAT PERSISTS WITH HER JAW. IT'S A CHEWING
5 IMPAIRMENT THAT THE DOCTOR ASSIGNED. HE DID NOT --
6 HE DID NOT ASSIGN THAT RATING, AT LEAST NOT FROM HIS
7 REPORT -- AND I WOULD SAY THAT INTERPRETATION SHOULD
8 BE THAT THE TEETH ARE NOT INCLUDED. THOSE ARE
9 SEPARATE BODY PARTS TO THOSE RATINGS.

10 **BY MR. HORNER:**

11 AND IF I CAN BRIEFLY?

12 **BY THE COMMISSIONER:**

13 AND I'LL JUST NOTE FOR THE RECORD THE ACTUAL
14 REPORT DOESN'T SAY ANYTHING ABOUT THE TEETH, BUT
15 THEN THE TEETH ARE ADDED ON THE FORM 14-B. SO I'LL
16 JUST TAKE THAT ---

17 **BY MR. HORNER:**

18 RIGHT. HE INCLUDES THEM ALL ON THE 14-B AND
19 SAYS THAT THEY ARE INCLUDED AS PART OF THE BODY PART
20 THAT HE IS RATING. HIS STATEMENT SAYS, "IMPAIRMENT
21 OF THE ORAL AND MAXILLOFACIAL REGION AND THE
22 MASTICATORY DYSFUNCTION," WHICH, AS YOU NOTED, ON
23 THE 14-B INCLUDES THE TEETH THEMSELVES IN THERE,
24 MULTIPLE JAW FRACTURES WITH FRACTURED AND AVULSED
25 TEETH, MANDIBLE, MAXILLA, TEETH. BODY PARTS

1 INJURED, TEETH. IMPAIRMENT, JAWS, TEETH, SOFT
2 TISSUE. AND SO, YOU CAN LOOK AT THE GUIDELINES. I
3 THINK YOUR HONOR CAN TAKE JUDICIAL NOTICE OF OTHER
4 GUIDELINES, JUST LIKE YOU COULD THE AMAs, IF YOU
5 NEED CLARIFICATION. BUT UNDER THOSE GUIDELINES IT
6 TALKS ABOUT -- THEY RATE THE MOUTH AS A WHOLE. AND
7 SO IN THIS CASE -- AND IT'S PRETTY OBVIOUS TO SEE
8 THAT, YOU KNOW, THE FIFTEEN PERCENT DIET ADDS UP TO
9 THE FOUR, PLUS A THREE, PLUS A TWO, PLUS A ONE IF
10 YOU ADDED THOSE NUMBERS UP. BUT ON THE 14-B HE'S
11 INCLUDING THE JAW, THE TEETH, THE MANDIBLE, THE
12 MAXILLA, AND ANY SOFT TISSUE DAMAGE SHE MAY HAVE HAD
13 DONE. AND, AGAIN, IT'S A WHOLE PERSON IMPAIRMENT,
14 AND THE BODY PARTS THAT WERE INJURED HAVE SCHEDULED
15 MEMBER RATINGS FOR THEM. AND I'M NOT SURE YOUR
16 HONOR COULD AWARD THE TEETH AS PART OF SOMETHING
17 ELSE WHEN THE TEETH ARE ACTUALLY LISTED AS A
18 SCHEDULED MEMBER. I THINK THAT WOULD PROBABLY BE AN
19 ERROR OF LAW TO SAY, "WELL, I'M NOT GOING TO GIVE
20 YOU TWO WEEKS PER TOOTH." AND I THINK SHE WOULD GET
21 A DOUBLE RECOVERY IF YOU, BASED ON THE 14-B,
22 INCLUDED THE TEETH PER THE 14-B BUT THEN INCLUDED
23 THE TEETH UNDER 42-9-30.

24 **BY THE COMMISSIONER:**

25 ALL RIGHT. THANK YOU. MADAM COURT REPORTER,

1 WILL YOU PLEASE SWEAR MS. COX.

2 **BY THE COURT REPORTER:**

3 MA'AM, IF YOU WOULD RAISE YOUR RIGHT HAND,
4 PLEASE.

5 * * * * *

6 THE WITNESS WAS DULY SWORN TO TELL THE TRUTH, THE
7 WHOLE TRUTH, AND NOTHING BUT THE TRUTH CONCERNING THE
8 MATTER HEREIN:

9 **JENNIE COX,**

10 BEING FIRST DULY SWORN, TESTIFIED ON HER OATH AS
11 FOLLOWS:

12 **BY THE COMMISSIONER:**

13 MS. TURNER.

14 **BY MS. TURNER:**

15 THANK YOU.

16 **DIRECT EXAMINATION BY MS. TURNER:**

17 Q. MS. COX, I HATE TO ASK THIS. WELL, NOT REALLY
18 BECAUSE WE SHOULD ALL BE OKAY WITH IT. BUT TELL US
19 HOW OLD YOU ARE AT THIS POINT.

20 A. SIXTY-FOUR.

21 Q. SIXTY-FOUR. WHAT'S YOUR EDUCATIONAL BACKGROUND?

22 A. HIGH SCHOOL GRADUATE.

23 Q. YOU GRADUATED FROM 12TH GRADE?

24 A. YES.

25 Q. WHAT WAS YOUR FIRST JOB AFTER YOU GRADUATED HIGH

1 SCHOOL?

2 A. I WORKED AT HER MAJESTY IN MAULDIN.

3 Q. OKAY. AND WHAT TYPE OF FACILITY WAS THAT?

4 A. A SEWING FACTORY.

5 Q. OKAY. HOW LONG DID YOU WORK IN THE TEXTILE
6 INDUSTRY?

7 A. QUITE A FEW YEARS. I DON'T REMEMBER EXACTLY.

8 Q. OKAY. WHEN DID YOU GET INTO TRUCK DRIVING?

9 A. IN 1985.

10 Q. OKAY. WHAT HAPPENED IN 1985 THAT CAUSED YOU TO
11 PURSUE A CAREER IN TRUCK DRIVING?

12 A. I GOT A DIVORCE, AND I WANTED A JOB THAT I COULD BE
13 HOME WITH MY DAUGHTERS AND BE A MOMMA AND NOT BE
14 HELD AGAINST ME SO I WOULDN'T LOSE MY JOB BECAUSE OF
15 SICKNESS WITH THEM. AND I STARTED DRIVING DUMP
16 TRUCKS, AND THEN THEY OFFERED ME THAT OPPORTUNITY.

17 Q. OKAY. AND SINCE 1985 HAVE YOU PRETTY MUCH
18 EXCLUSIVELY DRIVEN TRUCKS FOR A LIVING?

19 A. YES, MA'AM.

20 Q. OKAY. HAVE YOU EVER DONE ANY TYPE OF OFFICE WORK OR
21 SEDENTARY WORK WHERE YOU JUST SIT BEHIND A DESK AND

22 ---

23 A. NO, MA'AM.

24 Q. --- WORK THAT WAY? OKAY. PRIOR TO MAY 31ST OF
25 2012, HAD YOU EVER BEEN HURT ON ANY JOB THAT YOU'VE

1 HAD?

2 A. NO.

3 Q. OKAY. AND ON MAY 31ST OF 2012, HOW LONG HAD YOU
4 BEEN EMPLOYED AT THE COMPANY WHERE YOU WERE HURT?
5 HOW LONG DID YOU HAVE THE SAME JOB AT THAT POINT?
6 DO YOU REMEMBER?

7 A. NO, I DON'T.

8 Q. OKAY. SO ---

9 A. IT'S BEEN A LONG TIME.

10 Q. HAD YOU BEEN AT PALMETTO STATE FOR MORE THAN TEN
11 YEARS AT THAT TIME?

12 A. I DON'T REMEMBER ---

13 Q. YOU DON'T KNOW. OKAY.

14 A. --- EXACTLY HOW LONG I WORKED FOR THEM.

15 Q. THAT'S FINE. OKAY. TELL ME WHAT HAPPENED ON 5-31-
16 2012.

17 A. I STOPPED IN ATLANTA TO LOAD MORE FREIGHT ON MY
18 TRAILER, AND I REMEMBER ROLLING THE MACHINE SO THEY
19 COULD REARRANGE FREIGHT TO THE BACK, AND AFTER THAT
20 I HAVE NO RECOLLECTION.

21 Q. OKAY. YOU SAID THAT YOU STOPPED IN ATLANTA. WHERE
22 DID YOUR LOAD ORIGINATE? WHERE DID YOU START?

23 A. IN GREENVILLE, SOUTH CAROLINA.

24 Q. AND WHERE WERE YOU HEADED?

25 A. TO BROWNSVILLE, TEXAS.

1 Q. OKAY. AND ATLANTA WAS A SCHEDULED STOP, IS THAT
2 RIGHT?

3 A. YES.

4 Q. OKAY. DO YOU REMEMBER COMING TO OR REGAINING
5 CONSCIOUSNESS AFTER YOU FELL?

6 A. FOR A FEW SECONDS. I OPENED MY EYES, AND I WAS FLAT
7 ON THE FLOOR, AND I OPENED MY EYES AND ALL I SEEN
8 WAS BLOOD, AND I TRIED TO RAISE MYSELF UP, AND I
9 COULDN'T. AND I FINALLY GOT RAISED UP ENOUGH --
10 'CAUSE I WAS HAVING REAL BAD LEFT-SIDE PAIN, AND I
11 THOUGHT I WAS HAVING A HEART ATTACK, AND THEN I
12 REALIZED IT WAS MY OWN BLOOD.

13 Q. OKAY. AND WERE YOU -- YOU WERE TRANSPORTED FROM
14 THERE IN AN AMBULANCE, IS THAT RIGHT?

15 A. I WAS -- ALL I REMEMBER ABOUT -- I DON'T KNOW WHAT I
16 RODE IN. ALL I REMEMBER IS THE GUY SAID HE WAS
17 FIXING TO GET ME OUT OF PAIN, AND THEY SAID THEY
18 TOOK ME TO GRADY.

19 Q. AND GRADY IS A HOSPITAL IN ---

20 A. ATLANTA.

21 Q. --- ATLANTA. OKAY. AND WERE YOU LATER TRANSFERRED
22 TO A FACILITY CLOSER TO HOME?

23 A. MY FAMILY SAID THAT THEY ASKED THEM WHEN THEY WERE
24 GOING TO GET ME INTO SURGERY. THEY SAID THEY
25 COULDN'T GET ME IN THAT NIGHT; IT WOULD BE TWO MORE

1 DAYS. SO THEY SENT ME TO GREENVILLE IN A REGULAR
2 AMBULANCE, BECAUSE I HAD TO RIDE IN A REGULAR
3 AMBULANCE BECAUSE IF MY HEAD KEPT SWELLING THEY
4 WOULD HAVE TO INSERT A BREATHING TUBE.

5 Q. DO YOU REMEMBER WHAT YOUR -- WHAT YOU LEARNED HAD --
6 WHAT YOUR INJURIES WERE AS FAR AS YOUR JAW? DO YOU
7 REMEMBER WHAT YOUR DOCTOR TOLD YOU AS FAR AS WHAT
8 PHYSICAL DAMAGES YOU'D SUSTAINED IN THAT FALL?

9 A. AFTERWARDS -- I REGAINED CONSCIOUS -- I HAD DONE HAD
10 THE SURGERY AND EVERYTHING. I DON'T REMEMBER NONE
11 OF THAT. I THOUGHT I JUST -- 'CAUSE THEY REALLY HAD
12 ME VERY DRUGGED UP.

13 Q. OKAY. FOR WHAT PERIOD OF TIME AFTER THE ACCIDENT DO
14 YOU HAVE TROUBLE REMEMBERING WHAT HAPPENED?

15 A. I REMEMBER I FELT GOOD THAT DAY, AND I HAD DONE HAD
16 THE SURGERY, AND I DIDN'T REALIZE WHAT THEY HAD
17 DONE, AND I ASKED THE DOCTOR IF I COULD GO HOME, AND
18 HE SAID YEAH, AND THEN HE SAID -- HE TOLD ME MY
19 MOUTH WAS WIRED SHUT. HE TOLD ME I COULDN'T STAY BY
20 MYSELF. AND SO I HAD TO GO HOME WITH MY DAUGHTER
21 FOR FOUR WEEKS. AND I STILL COULDN'T EAT. ALL I
22 HAD WAS DRINK THROUGH A STRAW.

23 Q. AND SO YOU HAD SURGERY TO ADJUST THE DAMAGE TO ---

24 A. YES.

25 Q. --- YOUR JAW ON JUNE 1ST OF 2012; DOES THAT SOUND

1 RIGHT?

2 A. I COULDN'T TELL YOU NO DATES 'CAUSE I WAS KIND OF
3 DRUGGED UP. THEY DID TELL ME THIS JAWBONE WAS
4 BROKEN, AND IT HAD PLATES.

5 Q. OKAY. NOW, AT SOME POINT DID YOU HAVE TO GO IN FOR
6 ANOTHER PROCEDURE TO HAVE YOUR PLATES REMOVED?

7 A. YEAH, I -- IT GOT INFECT -- THEY HAD TOOK ONE PLATE
8 OUT WHEN THEY PUT THESE IMPLANTS IN. THEY HAD DONE
9 TOOK THE INSIDE PLATE OUT, BUT THE OUTSIDE ONE HAD
10 TO BE REMOVED BECAUSE IT GOT INFECTED.

11 Q. AND YOU WERE FITTED WITH A PROSTHETIC? ORIGINALLY
12 YOU WERE GIVEN DENTURES, IS THAT RIGHT?

13 A. YES.

14 Q. AND EVENTUALLY YOU WERE GIVEN A DIFFERENT AND MAYBE
15 A MORE PERMANENT SET OF DENTURES, IS THAT RIGHT?

16 A. IMPLANTS.

17 Q. IMPLANTS. OKAY. NOW, IT'S NOT -- IS IT -- IS YOUR
18 PROSTHETIC PERMANENTLY ATTACHED TO -- IS IT
19 PERMANENTLY IMPLANTED, OR CAN YOU TAKE IT ON AND
20 OFF?

21 A. THE BOTTOM ONES ARE. THEY TAKE THEM OUT TWICE A
22 YEAR AND CLEAN THEM. BUT THE TOP I CAN SNAP OUT.

23 Q. OKAY. WHEN WERE YOU ABLE TO RETURN TO WORK, IF YOU
24 REMEMBER?

25 A. FROM THE ORIGINAL ---

1 Q. FROM THE ORIGINAL ACCIDENT.

2 A. I DON'T REMEMBER THE EXACT DATE, NO.

3 Q. OKAY. DO YOU REMEMBER WHEN YOU WENT BACK TO WORK
4 YOU WENT BACK JUST FULL DUTY RIGHT AWAY OR IF YOU
5 WERE ON SOME RESTRICTIONS FOR A ---

6 A. I DID WORK IN THE GUARD SHACK, WHAT THEY CONSIDERED
7 LIGHT DUTY, WHILE I WAS GOING THROUGH ALL THIS, AND
8 THEN ONCE THAT WAS OVER, THEN THEY SENT ME BACK TO
9 -- I WENT TO THE WORKERS' COMP DOCTOR, AND SHE SAID
10 I COULD GO BACK TO WORK. I TOLD HER, I SAID, "I
11 CAN'T EVEN EAT." SHE SAID, "WE DON'T WORRY ABOUT
12 THE MOUTH."

13 Q. DID YOU EVENTUALLY -- WHAT WAS YOUR ABILITY LIKE
14 AFTER THE ACCIDENT TO -- AS FAR AS CHEWING SOLID
15 FOOD?

16 A. I CARRIED ENSURE AND SOFT FOODS WITH ME IN THE TRUCK
17 IN A COOLER, AND THAT'S BASICALLY WHAT I LIVED ON.

18 Q. DID YOU HAVE ANY TROUBLE CHEWING SOLID FOOD BEFORE
19 ---

20 A. NO.

21 Q. --- THE ACCIDENT?

22 A. NO.

23 Q. DID YOU EAT THINGS LIKE STEAK AND ---

24 A. YES.

25 Q. --- CORN AND ALL THAT BEFORE THE ---

1 A. YES.

2 Q. PRETTY MUCH ANYTHING YOU WANTED ---

3 A. YES.

4 Q. --- BEFORE THE ACCIDENT? DID YOU EVER HAVE ANY
5 TROUBLE CHEWING ANY KIND OF FOOD THAT YOU WANTED
6 BEFORE ---

7 A. NO.

8 Q. --- THE ACCIDENT? OKAY. AFTER THE ACCIDENT DID YOU
9 START HAVING SOME TROUBLE KEEPING YOUR WEIGHT UP?

10 A. YES.

11 Q. OKAY. WHY WERE YOU HAVING TROUBLE WITH THAT?

12 A. I COULD NO LONGER EAT WHAT I DID BEFORE.

13 Q. DID YOU SEE A DOCTOR ABOUT YOUR TROUBLES WITH EATING
14 ENOUGH TO KEEP YOUR WEIGHT UP?

15 A. YES. I HAD TO DRINK A LOT OF ENSURE, STILL DO,
16 ENSURE AND CARNATION INSTANT BREAKFAST. AND WHEN I
17 WENT OUT THIS LAST TIME I CALLED SCOTT AND TOLD HIM
18 THE PROBLEM. I ASKED SCOTT -- TOLD HIM I NEEDED TO
19 SEE A WORKERS' COMP DOCTOR AGAIN.

20 Q. WELL, WHAT DID YOU TELL HIM THE PROBLEM WAS?

21 A. I TOLD HIM, I SAID, "SCOTT, I JUST CAN'T DO IT; I'M
22 TOO WEAK, AND I NEED TO FIND OUT WHAT'S GOING ON."
23 AND HE SAID HE'D CALL WORKERS' COMP, AND HE WOULD
24 FIND OUT WHAT THEY SAID, AND HE'D CALL ME BACK. HE
25 SAID ---

1 **BY MR. HORNER:**

2 OBJECTION, YOUR HONOR. SHE CAN'T -- A LITTLE
3 TOO MUCH HEARSAY.

4 **BY THE COMMISSIONER:**

5 SUSTAINED. YOU CAN'T TELL ME WHAT THE DOCTOR
6 SAID. JUST LISTEN TO THE QUESTIONS YOUR ATTORNEY
7 ASKS YOU AND JUST TRY TO ANSWER HER SPECIFIC
8 QUESTION, OKAY? SHE'LL ASK YOU ANOTHER ONE.

9 **BY THE WITNESS:**

10 OH, WHAT DID I SAY THE DOCTOR ---

11 **DIRECT EXAMINATION RESUMED BY MS. TURNER:**

12 Q. OKAY. DID YOU SPECIFICALLY ASK TO GO BACK TO THE
13 DOCTOR?

14 A. YES.

15 Q. OKAY. WERE YOU ABLE -- DID THEY SEND YOU BACK TO
16 THE DOCTOR?

17 A. WORKERS' COMP SAID NO. SO THEN I ---

18 Q. YOU WEREN'T SENT BACK TO A DOCTOR AT THAT TIME?

19 A. NO.

20 Q. AND WHEN WAS THAT? WHEN WAS THIS CONVERSATION THAT
21 YOU HAD?

22 A. IN JUNE.

23 Q. IN JUNE OF WHEN?

24 A. 2016.

25 Q. OKAY. BETWEEN THE TIME THAT YOU HAD THE ACCIDENT

1 AND WERE GOING THROUGH YOUR RECOVERY AND JUNE OF --
2 OR WHEN YOU STARTED TO LOSE WEIGHT, HOW MUCH WEIGHT
3 DID YOU LOSES EVENTUALLY? WHAT WAS THE MAXIMUM
4 AMOUNT OF WEIGHT THAT YOU LOST, TO YOUR KNOWLEDGE?

5 A. AT ONE POINT I WEIGHED 95 POUNDS. I LOST SOMETHING
6 LIKE 20 POUNDS.

7 Q. DID YOUR ABILITY TO SUSTAIN THE SAME ENERGY LEVEL
8 CHANGE FROM THE TIME THAT YOU HAD THIS ACCIDENT AND
9 MOVING FORWARD?

10 A. YES.

11 Q. OKAY. WHAT HAPPENED TO YOUR ENERGY LEVEL THEN?

12 A. NORMALLY I'D COME HOME FROM A RUN AND WAS OFF THAT
13 AFTERNOON, WHATEVER. I'D SADDLE UP HORSES AND GO
14 TRAIL RIDING, WHICH I LOVED TO DO. I KEPT MY OWN
15 GRASS MOWED. I DONE ALL MY HOUSEWORK, DONE ALL THE
16 PAYING OF MY BILLS. AND IT JUST GOT TO THE POINT I
17 COULDN'T DO IT.

18 Q. OKAY. DID YOU HAVE ANY OF THOSE TROUBLES
19 BEFOREHAND, BEFORE THE ---

20 A. NO, MA'AM.

21 Q. --- INJURY? DID YOU HAVE ANY TROUBLE DRIVING FOR
22 THE FULL AMOUNT OF TIME THAT YOU WERE ALLOWED TO
23 DRIVE BY LAW?

24 A. NO, MA'AM.

25 Q. HOW MUCH -- HOW LONG COULD YOU -- WERE YOU ALLOWED

1 TO DRIVE BY LAW BEFORE THIS ACCIDENT?

2 A. TEN HOURS.

3 Q. OKAY. ARE YOU ABLE AS WE SIT HERE TODAY TO DO A
4 TEN-HOUR DRIVING ---

5 A. NO.

6 Q. --- TRIP?

7 A. NO.

8 Q. ARE YOU ABLE TO DO AN EIGHT-HOUR DRIVING TRIP?

9 A. NO.

10 Q. OKAY. WHY NOT? WHAT PREVENTS YOU FROM BEING ABLE
11 TO DRIVE DURING THAT TIME -- OR FOR THAT LONG?

12 A. ENERGY AND -- I DON'T HAVE ENOUGH ENERGY. AND FROM
13 MY NECK ALL THE WAY DOWN TO MY -- WHEN THIS SHOULDER
14 HURTS, IT CAUSES MY NECK AND ALL TO HURT, AND I JUST
15 GET IN A LOT OF PAIN WITH IT.

16 Q. OKAY. NOW, DO YOU FEEL LIKE IT WOULD BE -- DO YOU
17 FEEL SAFE DRIVING A BIG TRUCK AT THIS POINT?

18 A. NO, I DO NOT.

19 Q. WHY NOT?

20 A. I DON'T KNOW IF I COULD STAY ALERT ENOUGH OR HAVE
21 THE STRENGTH TO DRIVE IT.

22 Q. ARE THERE SPECIFIC THINGS OR DUTIES THAT YOU HAVE AS
23 FAR AS WHEN YOU WERE DOING YOUR TRUCK DRIVING THAT
24 YOU DID ON A REGULAR BASIS THAT YOU NO LONGER HAVE
25 THE STRENGTH TO DO?

1 A. YOU'VE GOT TO HOOK THE TRUCK AND THE TRAILER UP,
2 DRIVE THE TRUCK, DROP THE TRAILER, HOOK ANOTHER ONE
3 UP. AND NORMALLY AS A PART OF THAT WE HAD TO HOOK
4 THE AIR LINES, ELECTRICAL LINES UP, UNDO THEM WHEN
5 YOU GET READY TO DROP IT, AND PULL WHAT WE CALL A
6 PIN TO DROP -- UNHOOK IT FROM THE TRAILER, AND
7 OPENING AND CLOSING THE DOORS ON ONE OF THEM.
8 'CAUSE MOST OF THEM YOU DID HAVE TO THAT AT STOPS.

9 Q. ARE THOSE THINGS THAT YOU HAVE TROUBLE OR DIFFICULTY
10 WITH NOW?

11 A. I DON'T THINK I COULD EVEN GET THEM UNHOOKED. WE
12 ALSO HAD TO RAISE THE HOOD AND CHECK OUR OIL AND
13 WATER AND STUFF. AND I AM A LITTLE PERSON, AND I
14 WOULD -- I COULDN'T JUST PULL IT OVER. I'D HAVE TO
15 GO BACK THERE TO THE FENDER AND JUST KIND OF PUSH IT
16 OVER. THEN IT COMES ON OVER. BUT RIGHT NOW THERE'S
17 NO WAY I COULD DO THAT.

18 Q. HAVE THERE BEEN -- WELL, WHAT CAUSED -- IN YOUR
19 OPINION, WHAT CAUSED YOU TO NOT BE ABLE TO PERFORM
20 THOSE SAME PHYSICAL TASKS?

21 BY MR. HORNER:

22 OBJECTION, YOUR HONOR. IT CALLS FOR A MEDICAL
23 CONCLUSION.

24 BY MS. TURNER:

25 I THINK ---

1 **BY MR. HORNER:**

2 AND I WOULD OBJECT TO THAT.

3 **BY MS. TURNER:**

4 I'M SORRY.

5 **BY THE COMMISSIONER:**

6 OKAY. YOU CAN RESPOND.

7 **BY MS. TURNER:**

8 _____THE CLAIMANT IS ABLE TO TESTIFY AS TO HER OWN
9 MEDICAL PROGRESSION.

10 **BY THE COMMISSIONER:**

11 OVERRULED.

12 **DIRECT EXAMINATION RESUMED BY MS. TURNER:**

13 Q. WHY ARE YOU WEAKER NOW THAN YOU WERE IN THE PAST?

14 A. BECAUSE I STILL CANNOT EAT LIKE I DID BEFORE. I
15 STILL DRINK A LOT OF ENSURE, CARNATION, SCRAMBLED
16 EGGS, GRITS, GRILLED CHICKEN. I CAN PRETTY MUCH EAT
17 THAT. BUT THE FRIED CHICKEN -- 'CAUSE FOOD GETS UP
18 UNDER THESE TEETH. I HAVE TO USE LITTLE BRUSHES TO
19 BRUSH 'EM OUT. YOU KNOW, WHEN YOU GO OUT TO EAT,
20 YOU DON'T WANT TO BE SITTING THERE BRUSHING THIS
21 STUFF OUT FROM UNDER YOUR TEETH AT THE TABLE OR GO
22 IN THE BATHROOM WITH A BUNCH OF PEOPLE. SO, THERE
23 ARE A LOT OF PROCEDURES TO TAKE CARE OF THESE TEETH.
24 AND I JUST CAN'T BITE BEEF. IT'S EXTREMELY HARD FOR
25 ME TO CHEW BEEF.

1 Q. ARE YOU -- AS A RESULT OF YOUR INJURIES AND THE
2 TREATMENT THAT FOLLOWED, DO YOU HAVE ANY NUMBNESS IN
3 YOUR FACE OR IN YOUR JAW AREA?

4 A. THE LEFT SIDE OF MY JAW FEELS LIKE YOU'VE HAD A
5 STROKE, THE WAY YOU'D IMAGINE A STROKE PERSON
6 FEELING. I'VE NEVER HAD ONE. RIGHT HERE IS NUMB.
7 WHEN YOU PUSH ON IT, IT'S LIKE A MILLION LITTLE
8 NEEDLES STICKING IN IT. I HAVE A HARD TIME SLEEPING
9 ON THIS SIDE BECAUSE OF THIS FEELING HERE. SO I
10 HAVE TO GO TO SLEEP ON THIS SIDE. I CANNOT GO TO
11 SLEEP ON THE LEFT SIDE 'CAUSE IT'S -- I MEAN, I HAVE
12 TO KEEP MESSING WITH MY PILLOW IF I'M WATCHING T.V.
13 OR SOMETHING TO MAKE SURE IT'S NOT TOUCHING THIS
14 SIDE OF MY JAW HERE.

15 Q. HAVE YOU NOTICED ANY CHANGES IN YOUR SPEECH PATTERN
16 SINCE YOU HAD THIS ACCIDENT?

17 A. YES.

18 Q. OKAY. WHAT CHANGES HAVE YOU UNDERGONE WITH THAT?

19 A. SOME WORDS I CAN'T PRONOUNCE BECAUSE OF THE WAY MY
20 TONGUE GOES UP TO THE TOP OF MY MOUTH, AND SOMETIMES
21 I TALK REALLY LOW AND PEOPLE HAVE A HARD TIME
22 UNDERSTANDING ME.

23 Q. HAVE YOU -- PRIOR TO THIS ACCIDENT WERE YOU ON ANY
24 MEDICATION FOR ANXIETY OR DEPRESSION?

25 A. THEY GAVE ME XANAX WHEN MY GRANDSON -- THE GENERIC

1 OF XANAX -- WHEN MY GRANDSON GOT KILLED IN 2008.

2 Q. AFTER THIS ACCIDENT HAVE YOU EXPERIENCED ANY
3 INCREASED DEPRESSION, OR HAS IT REMAINED THE SAME,
4 OR GOTTEN BETTER?

5 A. IT'S REMAINED THE SAME. I MEAN, IT'S GOTTEN WORSE
6 BECAUSE I'M NOT WORKING, AND I REALLY WANT TO WORK,
7 BUT I HAVE TO ADMIT IT TO MYSELF I CAN'T.

8 Q. AND IS IT -- IS THE ISSUE THAT YOU JUST -- YOU DON'T
9 LIKE DRIVING TRUCKS ANYMORE?

10 A. I LOVE DRIVING. I LOVE PALMETTO STATE, THE GUYS
11 THAT WORK THERE, BUT I CAN'T DO IT ANYMORE. TO ME
12 IT'S ALMOST LIKE A DEATH.

13 Q. HOW MANY SURGICAL PROCEDURES HAVE YOU HAD TO UNDERGO
14 AS A RESULT OF THE INJURIES YOU SUSTAINED? AND ARE
15 YOU OKAY?

16 A. I CAN'T REMEMBER, BECAUSE MY SISTER TOOK ME TO MOST
17 OF THEM WHEN THEY WERE DOING ALL THIS SURGERY. I
18 CAN REMEMBER GOING TO DR. FOWLER TO REMOVE THE
19 SCREWS. AND THEN HE SENT ME ON TO THE ORAL SURGEON.
20 BUT MY SISTER WOULD TAKE ME. THEY WOULD KNOCK ME
21 OUT. AND I WENT TO THE OTHER DOCTOR AND DON'T EVEN
22 REMEMBER GOING 'CAUSE I WAS STILL PRETTY DRUGGED UP
23 FROM THEM DOING ALL THIS MOUTH SURGERY. SO I DON'T
24 KNOW HOW MANY TIMES WE WENT THERE.

25 Q. ARE YOUR -- THE PROSTHETIC THAT YOU HAVE, IS IT A

1 COMFORTABLE APPLIANCE FOR YOU?

2 A. IT GETS REAL DRY SOMETIMES. THAT'S THE REALLY BAD
3 THING. AND THEY DON'T -- WHEN I CLOSE MY TEETH,
4 THEY DON'T LINE UP. AND DR. FOWLER HAD LEFT SOME
5 TEETH HERE AND SOME TEETH HERE AND ONE TOOTH IN THE
6 FRONT. AND I ASKED HIM, I SAID, "DR. FOWLER, WHY
7 DID YOU LEAVE THIS ONE TOOTH IN THE FRONT?" AND MY
8 JAWS WERE SO LOPSIDED THAT HE SAID HE HAD TO HAVE
9 SOMETHING TO TRY TO LINE MY JAW -- MY GUMS BACK UP.

10 Q. DO YOU STILL HAVE -- DOES IT HURT SOMETIMES?

11 A. YEAH.

12 Q. TELL ME ABOUT YOUR SHOULDER SYMPTOMS. HOW IS THAT
13 NOW? DO YOU STILL HAVE PAINFUL SYMPTOMS IN YOUR
14 SHOULDERS?

15 A. WHEN I USE MY ARM A LOT, THIS PLACE WHERE IT HIT ME,
16 IT GETS SORE, AND THEN IT RADIATES UP MY NECK IN
17 HERE. AND WHEN HE PUT ME BACK TOGETHER, THESE
18 MUSCLES HERE IN THIS SIDE OF THE NECK ARE TIGHTER ON
19 THE LEFT SIDE. BUT WHEN THIS ONE HURTS, USUALLY I
20 JUST USE SALONPAS 'CAUSE THEY SAID THERE WASN'T
21 NOTHING BROKE IN THERE OR ANYTHING, SO SOFT TISSUE
22 ON THE SHOULDER BLADE.

23 Q. YOU -- AT SOME POINT YOUR EMPLOYER ASKED YOU TO GO
24 TO WORK HARDENING, IS THAT RIGHT?

25 A. YES.

1 Q. OKAY. HAD YOU HAD SOME FORM OF PHYSICAL THERAPY
2 BEFORE THEN?

3 A. I HAD START -- I HAD -- JUST TO SEE IF IT WOULD HELP
4 I WENT TO GREENVILLE LIFE CENTER, AND I HAD A GIRL
5 TO WORK WITH ME THERE AND ---

6 Q. WELL, TELL ME -- I'M SORRY; TELL THE COMMISSIONER,
7 WHY DID YOU GO TO GREENVILLE LIFE CENTER?

8 A. TO SEE IF I ---

9 Q. WHAT PROMPTED YOU TO GO THERE?

10 A. TO SEE IF I COULD AT LEAST GET A LITTLE MUSCLE MASS
11 BACK AND TO GET -- A TRAINER HELPED ME WORK ON THAT.

12 Q. OKAY. NOW, WAS THAT SOMETHING THAT WAS PAID FOR BY
13 WORKERS' COMP, OR WAS THAT SOMETHING YOU HAD TO DO
14 FOR YOURSELF?

15 A. I HAD TO PAY IT MYSELF.

16 Q. OKAY. AND THEN YOU DID GO TO WORK HARDENING, IS
17 THAT RIGHT?

18 A. YES.

19 Q. DID THE WORK HARDENING HELP YOUR SYMPTOMS?

20 A. NO.

21 Q. OKAY. WHAT EFFECT DID WORK HARDENING HAVE ON YOUR
22 SYMPTOMS?

23 A. IT MADE THEM WORSE.

24 Q. WHAT TYPES OF THINGS DID YOU DO AT WORK HARDENING
25 THAT CAUSED YOUR SYMPTOMS TO BE WORSE?

1 A. THEY HAD ME PUSHING A SLED, PULLING A SLED. IT WAS
2 IN A BOOKCASE-TYPE THING. YOU HAD TO START AT THE
3 BOTTOM. IT HAD THREE SHELVES, THE BOTTOM SHELF, THE
4 MIDDLE SHELF, THE TOP, AND THEY WANTED ME TO LIFT 30
5 POUNDS, I THINK IT WAS, FROM THE BOTTOM TO THE
6 MIDDLE 30 TIMES AND THEN FROM THE MIDDLE TO THE TOP.
7 AND AT FIRST THEY STARTED OFF IN LIKE TO NOT
8 (INAUDIBLE) ON THE BOX, 'CAUSE (INAUDIBLE). AND
9 THEN THEY SWITCHED IT TO REGULAR WEIGHTS, AND THEN
10 THEY CUT IT DOWN, THE WEIGHT DOWN ON IT.

11 Q. AND DID YOU GIVE -- DID YOU TRY YOUR BEST WHEN YOU
12 WERE IN WORK HARDENING?

13 A. YES, MA'AM; I DID.

14 Q. AND THROUGHOUT THE COURSE OF YOUR RECOVERY, HAVE YOU
15 TRIED TO WORK WHEN YOU COULD?

16 A. YES, MA'AM.

17 Q. HAD YOU RATHER BE WORKING ---

18 A. DEFINITELY.

19 Q. --- NOW? HAVE YOU -- DID YOU ADDRESS WITH YOUR
20 EMPLOYER AT ALL ANY OF YOUR CONCERNS ABOUT THE --
21 ABOUT WHETHER IT WOULD BE SAFE FOR YOU TO DRIVE
22 TRUCKS AT THIS TIME?

23 A. THE ONLY THING I SAID -- SCOTT TOLD ME THEY SAID I
24 COULD GO BACK TO WORK. I SAID, "SCOTT," -- 'CAUSE
25 IT WASN'T MY WORKERS' COMP DOCTOR. SHE SAID SHE

1 COULD NOT KEEP ME OUT ANY LONGER. SHE HAD TO SIGN,
2 'CAUSE THE WORKERS' COMP DOCTOR DIDN'T SEE ME, BUT
3 THE FAMILY DOCTOR DID. AND SHE TOLD ME, SHE SAID,
4 "JENNIE, I'M GOING TO HAVE TO PUT YOU BACK TO WORK."
5 AND SO SCOTT SAID, "THEY'RE SAYING YOU CAN WORK,"
6 AND I SAID, "SCOTT, I'M TELLING YOU I CANNOT WORK.
7 SO, IF I GET BACK ON THAT ROAD, IF YOU TELL ME -- IF
8 YOU'RE THINKING THAT I CAN GO BACK 'CAUSE OF THAT
9 PIECE OF PAPER, I'LL GO BACK. BUT ARE YOU GONNA BE
10 RESPONSIBLE FOR WHAT HAPPENS?" AND HE SAID, "NO."
11 AND I SAID, "WELL, WHAT DO WE DO?" AND SCOTT SAID,
12 "WELL, LET THE ATTORNEYS WORK IT OUT."

13 Q. DO YOU THINK, JENNIE, AT THIS POINT THAT YOU WILL BE
14 ABLE TO DRIVE BIG TRUCKS AGAIN LIKE YOU DID BEFORE?

15 A. NO.

16 Q. OKAY. DO YOU FEEL LIKE YOU WOULD BE ABLE TO MAYBE
17 TAKE UP A DIFFERENT CAREER AT THIS POINT?

18 A. NO, NOT NOW.

19 Q. ARE YOU ASKING THE COMMISSIONER TODAY TO FIND THAT
20 YOU ARE NOT ABLE TO HAVE GAINFUL EMPLOYMENT ANYMORE?

21 A. YES.

22 BY MS. TURNER:

23 IF I MIGHT HAVE JUST A MOMENT.

24 BY THE COMMISSIONER:

25 SURE.

1 **BY MS. TURNER:**

2 I THINK WE'RE THROUGH. THANK YOU.

3 **BY THE COMMISSIONER:**

4 ALL RIGHT. THANK YOU. MR. HORNER.

5 **BY MR. HORNER:**

6 THANK YOU, COMMISSIONER.

7 **CROSS EXAMINATION BY MR. HORNER:**

8 Q. MS. COX, YOU WOULD AGREE WITH ME THAT YOU'VE BEEN A
9 SMALL PERSON YOUR WHOLE LIFE, RIGHT?

10 A. YES.

11 Q. OKAY. AND DO YOU RECALL -- AND LET'S JUST GET THIS
12 -- I'M NOT -- YOU'VE MADE AN ISSUE OF YOUR WEIGHT,
13 HAVEN'T YOU, AND THAT YOU LOST SOME WEIGHT, AND THAT
14 IT RESULTED IN YOU BEING TIRED AND FATIGUED; ISN'T
15 THAT TRUE?

16 A. I LOOKED LIKE A PERSON THAT HAD ANOREXIA.

17 Q. AND YOU'RE CLAIMING HERE TODAY THAT YOU ARE UNABLE
18 TO DRIVE THE TRUCK BECAUSE OF SOME LOST WEIGHT THAT
19 YOU SAY IS RELATED TO THE ACCIDENT, CORRECT?

20 A. I CAN'T EAT.

21 Q. THAT'S YOUR ARGUMENT, CORRECT, THAT YOU'VE LOST SOME
22 WEIGHT, YOU'VE LOST SOME ENERGY, AND YOU'VE LOST THE
23 ABILITY TO DO THE JOB, IS THAT RIGHT?

24 A. YES.

25 Q. OKAY. DO YOU KNOW WHAT YOU WEIGHED TEN MONTHS

1 BEFORE THIS ACCIDENT?

2 A. I COULD LOOK AT MY DOCTOR'S RECORDS AND FIND OUT.

3 Q. I DID THAT, AND SHE SAID YOU WEIGHED 114 POUNDS.
4 DOES THAT SOUND ABOUT RIGHT?

5 A. ABOUT 116, 120 NORMALLY.

6 Q. OKAY. IF SHE WROTE DOWN 114 IN HER OFFICIAL RECORDS
7 -- NOW, SHE DOESN'T MAKE YOU UNDRESS, DOES SHE?

8 A. NO.

9 Q. OKAY. BUT IF SHE SAID 114 IN THE OFFICIAL RECORDS,
10 WOULD YOU BE INCLINED TO AGREE WITH THAT ON JULY
11 1ST, 2011?

12 A. IF THAT'S WHAT SHE WROTE DOWN. SHE WROTE DOWN WHAT
13 I WEIGHED.

14 Q. AND IN JULY OF 2011 YOU DIDN'T HAVE ANY PROBLEMS
15 EATING; YOU WEREN'T LIMITED TO WHAT YOU COULD EAT,
16 WERE YOU? YOU COULD EAT WHATEVER YOU WANTED? YOU
17 COULD EAT A STEAK IF YOU WANTED IN JULY OF 2011?

18 A. YES.

19 Q. OKAY, ALL RIGHT. NOW, DO YOU KNOW WHAT YOU WEIGHED
20 ON THE DAY OF THE ACCIDENT?

21 A. NO, SIR. I DID NOT WEIGH THAT DAY.

22 Q. ALL RIGHT. WELL, I LOOKED AT A HOSPITAL RECORD THAT
23 SAID YOU WEIGHED 113 POUNDS. WOULD YOU PROBABLY
24 AGREE THAT'S PROBABLY CORRECT?

25 A. IF IT'S -- WHEN I HAD MY ACCIDENT?

1 Q. YES, MA'AM. YOU WOULDN'T HAVE ANY REASON TO
2 DISAGREE WITH THAT, WOULD YOU?

3 A. NO.

4 Q. ALL RIGHT. SO, YOU WERE OUT, IT LOOKED LIKE -- THE
5 ACCIDENT HAPPENED ON MAY 31ST, AND FROM THE DOCTOR'S
6 RECORDS IT LOOKS LIKE YOU WERE RELEASED TO FULL DUTY
7 IN NOVEMBER OF THE SAME YEAR, 2012. DOES THAT SOUND
8 RIGHT?

9 A. YES.

10 Q. AND WHILE YOU WERE OUT YOU GOT A CHECK, RIGHT?

11 A. YES.

12 Q. AND THEN YOU WENT BACK TO LIGHT DUTY, YOU SAID, IN
13 THE GUARD HOUSE FOR A PERIOD OF TIME, AND THEN YOU
14 WENT BACK TO DRIVING TRUCKS?

15 A. YES.

16 Q. NOW, IT HASN'T REALLY BEEN DISCUSSED, BUT AT THE
17 TIME OF YOUR ACCIDENT AND LEADING UP TO IT YOU WERE
18 DRIVING AS A TEAM WITH ANOTHER DRIVER?

19 A. YES.

20 Q. AND AS PART OF THAT TEAM YOU HAD A DEDICATED ROUTE
21 THAT WENT FROM BASICALLY THE UPSTATE THROUGH ATLANTA
22 AND DOWN TO BROWNSVILLE, TEXAS?

23 A. YES.

24 Q. AND AS PART OF A TEAM DRIVER YOU STILL HAD TO DRIVE
25 YOUR TEN HOURS UNDER THE D.O.T. REGS, CORRECT?

1 A. RIGHT.

2 Q. AND WHEN YOU WERE DONE WITH YOUR TEN HOURS AND THE
3 LAW SAID YOU COULDN'T DRIVE ANYMORE, YOU WOULD GET
4 IN THE SLEEPER AND YOUR TEAMMATE OR YOUR OTHER CO-
5 DRIVER WOULD DRIVE FOR THE NEXT TEN HOURS, IS THAT
6 RIGHT?

7 A. RIGHT.

8 Q. AND SO, YOU HAD THAT JOB STARTING WELL BEFORE YOUR
9 ACCIDENT, RIGHT?

10 A. YES.

11 Q. AND THAT ROUTE THAT YOU HAD ENDED IN OCTOBER OF
12 2015?

13 A. YES.

14 Q. WHEN YOU RETURNED TO WORK IN NOVEMBER OF 2012, YOU
15 RETURNED TO THE EXACT SAME JOB YOU HAD BEFORE THE
16 ACCIDENT, CORRECT?

17 A. YES.

18 Q. SAME ROUTE, SAME DRIVER, SAME DELIVERIES?

19 A. YES.

20 Q. NOW ---

21 A. NOT THE SAME DRIVER.

22 Q. YOU HAD A DIFFERENT TEAMMATE?

23 A. YES.

24 Q. OKAY. SO, UNDER -- AS A SOLO DRIVER YOU'RE STILL
25 ONLY ALLOWED TO DRIVE THE SAME TEN HOURS YOU COULD

1 DRIVE AS A TEAM DRIVER; ISN'T THAT TRUE?

2 A. RIGHT.

3 Q. IT'S TEN HOURS WHETHER YOU'RE ALONE OR WITH SOMEBODY
4 ELSE IN THE TRUCK?

5 A. RIGHT.

6 Q. ALL RIGHT. SO, YOU RETURNED TO WORK IN NOVEMBER OF
7 2012, AND IT LOOKS LIKE IN THE SUMMER OF 2013 YOU
8 WENT BACK AND HAD A SECOND SURGERY ON YOUR IMPLANT;
9 DOES THAT SOUND RIGHT?

10 A. ON THE JAW FOR THE PLATE.

11 Q. NOW, YOU HAD ONE IN 2015 AS WELL. DO YOU REMEMBER
12 BEING OUT IN 2013 FOR ABOUT SIX OR EIGHT WEEKS? AND
13 YOU MAY NOT REMEMBER, AND THAT'S OKAY IF YOU DON'T.

14 A. I REMEMBER THIS ONE HERE.

15 Q. YOU REMEMBER THE ONE IN 2015 WHEN YOU WERE OUT FOR
16 SIX OR EIGHT WEEKS OVER THE SUMMER, IS THAT RIGHT?

17 A. YES, WHEN THEY TOOK THIS ONE OUT.

18 Q. SO, NOW, IN 2013 YOU DON'T EVEN RECALL BEING OUT OF
19 WORK, BUT DO YOU GENERALLY RECALL WORKING THE ENTIRE
20 YEAR IN 2013?

21 A. NO, I DON'T ---

22 Q. YOU DON'T RECALL? I'M NOT ASKING YOU TO RECALL
23 SPECIFICS, BUT WOULD YOU AGREE WITH ME THAT IN 2013
24 YOU REMEMBER WORKING PRETTY MUCH THE WHOLE YEAR?

25 A. PRETTY MUCH.

1 Q. OKAY. AND I SUBMITTED YOUR WAGE RECORDS AS AN
2 EXHIBIT, BUT WOULD IT SURPRISE YOU TO LEARN THAT YOU
3 MADE ABOUT 60,000 THAT YEAR?

4 A. NO, IT WOULD NOT SURPRISE ME.

5 Q. AND DURING 2013 WOULD IT SURPRISE YOU AT ONE POINT
6 WHILE YOU WERE STILL WORKING IN 2013 YOUR WEIGHT GOT
7 DOWN TO 95 POUNDS?

8 A. IT WAS 2016 WHEN I WENT BACK TO -- AND I DROPPED
9 DOWN TO 95.

10 Q. OKAY. SO YOU DON'T REMEMBER IN 2013 GOING TO DR.
11 ELLIS, WHO WEIGHED YOU AND SAID YOU WERE AT 95
12 POUNDS?

13 A. I ---

14 Q. DON'T REMEMBER?

15 A. NO, I DON'T.

16 Q. OKAY, ALL RIGHT. SO, WE'RE AT 2013. NOW, IN 2014
17 DID YOU WORK THE FULL -- YOU WORKED THE FULL YEAR IN
18 2014, TOO, DIDN'T YOU?

19 A. I THINK SO.

20 Q. AND I SUBMITTED YOUR WAGE RECORDS, AND WOULD IT
21 SURPRISE YOU TO LEARN THAT YOU MADE ABOUT \$70,000 IN
22 2014?

23 A. NO.

24 Q. OKAY. AND IN 2013 AND 2014 YOU HAD THE SAME
25 LIMITATIONS ON WHAT YOU COULD EAT THAT YOU DO NOW,

1 DIDN'T YOU?

2 A. YES.

3 Q. YOU'VE BASICALLY HAD THOSE LIMITATIONS SINCE THEY
4 PUT THE IMPLANTS IN PLACE?

5 A. YES.

6 Q. SO, 2014 YOU WORKED. WOULD IT SURPRISE YOU TO KNOW
7 THAT ON APRIL 14TH, 2014, WHILE YOU WERE WORKING,
8 THAT YOU WEIGHED 101 POUNDS?

9 A. NO, IT WOULD NOT.

10 Q. OKAY. AND IN 2014, LATER THAT YEAR YOU GOT UP TO
11 110. WOULD IT SURPRISE YOU IF YOUR WEIGHT
12 FLUCTUATED SIX, SEVEN, EIGHT POUNDS OVER THE COURSE
13 OF THE YEAR?

14 A. YEAH, BECAUSE UNDOUBTEDLY I WAS DOING SOMETHING
15 DIFFERENT, BECAUSE, I MEAN, I'M NOT MAKING IT UP.

16 Q. YOU WERE WORKING FULL TIME IN 2014, GOT DOWN TO 101,
17 AND THEN GOT UP BACK TO 111 WITH THE SAME DIETARY
18 RESTRICTIONS THAT YOU HAD IN 2016, CORRECT?

19 A. YES.

20 Q. ALL RIGHT. NOW, LET'S GO TO 2015.

21 A. NOW, PART OF THAT I HAD THOSE OTHER DENTURES IN. I
22 DIDN'T HAVE THESE.

23 Q. AND I THINK THAT'S WHAT HAPPENED IN 2013. THEY TOOK
24 THE TEMPORARY DENTURES OUT AND PUT THE PERMANENT
25 PLATE -- MORE PERMANENT PLATE IN. I THINK THAT'S

1 WHAT THE RECORDS WILL REFLECT, THAT YOU MAY HAVE
2 MISSED A COUPLE WEEKS IN 2013 FOR THAT SURGERY. BUT
3 IN 2015 YOU HAD LIKE A SPOT ON YOUR CHIN THAT WAS
4 BOTHERING YOU, IS THAT RIGHT?

5 A. YES.

6 Q. AND IT FELT LIKE A KNOT? I THINK YOU TESTIFIED IN
7 YOUR DEPOSITION IT FELT LIKE A KNOT?

8 A. YEAH, IT WAS A KNOT, AND IT STARTED OOZING, AND ONCE
9 I STARTED OOZING STUFF I WENT BACK.

10 Q. AND WHO TOOK THAT OUT?

11 A. DR. FOWLER.

12 Q. DR. FOWLER. ALL RIGHT. AND SO YOU WERE OUT IN 2015
13 FOR SIX OR EIGHT WEEKS, AND AT THAT TIME, FEBRUARY
14 15TH -- THIS IS BEFORE YOU HAD THE PLATE COME OUT --
15 YOU WERE WEIGHING 108. DOES THAT SOUND ABOUT RIGHT?

16 A. PROBABLY.

17 Q. ALL RIGHT. AND THEN AFTERWARDS YOU WERE STILL IN
18 THE 108, 109 RANGE; DOES THAT SOUND ABOUT RIGHT?

19 A. I GUESS SO.

20 Q. ALL RIGHT. SO, WOULD YOU AGREE WITH ME THAT BASED
21 ON THE NUMBERS I READ TO YOU, EVER SINCE YOUR
22 ACCIDENT YOU'VE BEEN SOMEWHERE BETWEEN 95 POUNDS AND
23 113, 114 POUNDS OR SO?

24 A. YES.

25 Q. AND YOU NEVER TOOK YOURSELF OUT OF WORK BEFORE 2016,

1 CORRECT?

2 A. I HAD A TEAM DRIVER, AND IT KIND OF MADE IT A LITTLE
3 MORE EASIER FOR ME.

4 Q. SO YOU HAD A TEAM DRIVER AND IT MADE IT A LITTLE
5 EASIER. YOU STILL HAD TO DRIVE THE SAME TEN HOURS,
6 THOUGH, RIGHT?

7 A. YES.

8 Q. AND ARE YOU AWARE THAT IN SEPTEMBER OR OCTOBER OF
9 LAST YEAR THAT YOU WERE OFFERED A JOB AS A TEAM
10 DRIVER BACK AT PALMETTO, THAT THEY COULD PUT YOU TO
11 WORK AS A TEAM DRIVER AGAIN?

12 A. YES.

13 Q. AND AS FAR AS A SOLO DRIVER, YOU REALLY ONLY SOLOED
14 FROM OCTOBER OF '15 TO MARCH OF '16, FOR ABOUT FIVE
15 MONTHS, WHEN YOU TOOK YOURSELF OUT, CORRECT?

16 A. YES.

17 Q. ALL RIGHT. BUT YOU DIDN'T GO BACK IN OCTOBER AS A
18 TEAM DRIVER, AND YOU HAVEN'T ACCEPTED A JOB AS A
19 TEAM DRIVER SINCE YOU TOOK YOURSELF OUT OF WORK IN
20 JUNE, IS THAT RIGHT?

21 A. AND THEY'VE BEEN TOLD WHY I DON'T WANT TO GO ON
22 TEAM.

23 Q. OKAY. SO, WE'VE DISCUSSED YOUR WEIGHT. YOU WENT TO
24 DR. ELLIS, RIGHT?

25 A. YES.

1 Q. SHE WROTE YOU OUT OF WORK, CORRECT?

2 A. YES, BECAUSE OF THE MALNUTRITION.

3 Q. OKAY. AND AT ONE POINT SHE UPPED YOUR MEDICATIONS
4 FOR DEPRESSION, TOO; DO YOU REMEMBER THAT?

5 A. YES.

6 Q. AND YOU HAVE A LONG HISTORY OF DEPRESSION AND
7 ANXIETY, DON'T YOU?

8 A. SINCE MY SON -- GRANDSON GOT KILLED.

9 Q. WOULD IT SURPRISE YOU TO KNOW THAT IN 2000 -- DO YOU
10 REMEMBER HAVING SOME CHRONIC ABDOMINAL PAIN ISSUES
11 BACK IN 2000 OR SO?

12 A. NO.

13 Q. OKAY. DO YOU REMEMBER GOING TO A PAIN CLINIC IN
14 GREENVILLE TO SEE IF THEY COULD DO ANYTHING FOR THE
15 CHRONIC ABDOMINAL PAINS YOU WERE HAVING?

16 A. NO.

17 Q. WOULD IT SURPRISE YOU TO KNOW THAT THE RECORDS FROM
18 2000 FROM GREENVILLE REFLECT THAT YOU WERE ON ZOLOFT
19 AND YOU WERE ON TRANXENE, WHICH IS AN ANTIANXIETY
20 MEDICATION? IF I TOLD YOU YOU HAD BEEN ON AN
21 ANTIDEPRESSANT AND AN ANTIANXIETY MEDICATION SINCE
22 2000, WOULD YOU HAVE ANY REASON TO DISBELIEVE THAT
23 MEDICAL RECORD?

24 A. NO.

25 Q. BUT YOU DID SAY YOUR GRANDSON DIED, YOU SAID, IN

1 2008?

2 A. YES.

3 Q. AND THAT WAS VERY TRAUMATIC?

4 A. YES.

5 Q. IT WAS A CAR ACCIDENT, IS THAT RIGHT?

6 A. YES.

7 Q. IT WAS VERY SUDDEN? AND THAT MADE YOUR DEPRESSION
8 WORSE; IS THAT TRUE?

9 A. YES.

10 Q. SO ---

11 A. THAT DOESN'T MEAN THAT I TOOK THE MEDICATION. I
12 MEAN, I WAS PRESCRIBED IT, BUT ---

13 Q. YOU MAY NOT HAVE ALWAYS TAKEN IT?

14 A. RIGHT.

15 Q. WELL, YOU WERE CONTINUED TO BE PRESCRIBED THAT
16 ANTIANXIETY AND THE ANTIDEPRESSANT REALLY WITH DR.
17 ELLIS SINCE YOU'VE BEEN SEEING HER AS FAR BACK AS MY
18 NOTES GO, WHICH IS 2011. WOULD YOU AGREE WITH THAT?

19 A. YES.

20 Q. AND WHETHER YOU TOOK IT OR NOT, YOU WERE CLEARLY
21 GETTING THE PRESCRIPTION FOR IT AND HAD AN INCREASE
22 IN SYMPTOMS WHEN YOUR GRANDSON DIED?

23 A. I CALLED HER. SHE PUT ME ON XANAX WHEN MICHAEL
24 DIED. I CALLED HER.

25 Q. NOW, WHEN THIS ACCIDENT HAPPENED IN 2012, 2013 --

1 2012, AND THEN YOU WERE RETURNING TO WORK IN '13,
2 '14, '15, YOU DIDN'T HAVE ANY WORSENING DEPRESSION
3 IN 2012, 2013, 2014, OR 2015, DID YOU?

4 A. YEAH, I HAD DEPRESSION DURING ALL THIS, 'CAUSE MY
5 DAUGHTER WOULD GET UP IN THE MIDDLE OF THE NIGHT
6 WHEN I HAD TO STAY WITH HER, AND I WOULD BE SITTING
7 ON HER DECK CRYING. AND SHE'S LIKE, "MOM, WHAT'S
8 WRONG?" AND I WAS LIKE, "I WANT TO GO HOME, AND I
9 WANT TO GO TO WORK." AND SHE SAID, "YOU KNOW YOU
10 CAN'T."

11 Q. BUT ONCE YOU WENT BACK TO WORK AND YOU WERE RELEASED
12 AND YOU STARTED RUNNING YOUR TEAM ROUTE AGAIN IN '13
13 AND '14 AND '15, YOU DIDN'T GO TO DR. ELLIS AND SAY,
14 "I NOW HAVE MORE DEPRESSION THAT I EVER HAD." YOU
15 DIDN'T SAY THAT, DID YOU?

16 A. NO, 'CAUSE I WANTED TO WORK MY JOB.

17 Q. AND, NOW, ARE YOU AWARE THAT HER RECORDS REFLECT
18 THAT ONCE SHE SAW YOU IN MARCH SHE ACTUALLY SAID
19 YOUR DEPRESSION FROM MARCH AND APRIL AND MAY OF 2016
20 WAS GETTING BETTER, THAT YOUR SADNESS WAS DECREASING
21 IN MARCH AND APRIL AND MAY OF 2016? WERE YOU AWARE
22 THAT THAT'S WHAT WAS IN HER NOTES?

23 A. NO.

24 Q. NOW, YOU HAD A CONVERSATION WITH DR. ELLIS, BASED
25 UPON HER RECORDS, THAT SHE SAID SHE COULDN'T KEEP

1 WRITING YOU OUT OF WORK, IS THAT RIGHT?

2 A. RIGHT.

3 Q. AND SHE -- THE RECORDS REFLECT THAT SHE SAID AS LONG
4 AS YOU MAINTAIN THE WEIGHT YOU WERE AT THAT, WHICH
5 WAS 107 AT THE TIME, THAT SHE COULDN'T JUSTIFY YOU
6 BEING OUT OF WORK. SHE TOLD YOU THAT?

7 A. SHE SAID I HAD TO BE OVER A HUNDRED POUNDS.

8 Q. OVER A HUNDRED POUNDS. AND YOU WERE OVER A HUNDRED
9 POUNDS -- WELL, LET ME ASK YOU, DO YOU KNOW WHAT YOU
10 WERE IN APRIL OF '16 WHEN YOU WERE NOT WORKING?

11 A. NO. I -- I DIDN'T KNOW I WAS SUPPOSED TO KEEP A
12 DIARY OF ALL MY WEIGHTS.

13 Q. OKAY. WELL, AND IT'S IMPORTANT BECAUSE IT'S AN
14 ISSUE THAT'S BEEN BROUGHT UP IN THE CASE, AND THAT'S
15 WHY -- I'M NOT -- I'M NOT TRYING TO GIVE YOU A HARD
16 TIME ABOUT YOUR WEIGHT. I'M JUST SAYING IT'S BEEN
17 AN ISSUE THAT'S BEEN BROUGHT UP AS A JUSTIFICATION,
18 AND I'M JUST TRYING TO EXPLORE IT. IN MAY OF 2016,
19 WHEN SHE MADE THE COMMENT SHE WAS UNABLE TO KEEP YOU
20 OUT OF WORK ANYMORE, YOU WEIGHED 107. ARE YOU AWARE
21 THAT TWO WEEKS LATER HER RECORDS REFLECT YOU
22 ACTUALLY WENT UP TO 109.6?

23 A. NO.

24 Q. ARE YOU AWARE OF WHAT YOU WEIGHED WHEN YOU LEFT THE
25 LIFE CENTER? AFTER YOUR PERSONAL TRAINER EXPERIENCE

1 AT THE LIFE CENTER, ARE YOU AWARE OF WHAT YOU
2 WEIGHED WHEN YOU LEFT THERE?

3 A. I THINK IT WAS 116.

4 Q. OKAY. I HAVE DOWN ON THE LAST DAY YOU WEIGHED 120.
5 AND SO -- BUT DESPITE BEING UP TO 120 POUNDS AFTER
6 GOING THROUGH YOUR PERSONAL TRAINER, YOU DIDN'T
7 RETURN TO WORK, CORRECT?

8 A. NO.

9 Q. BUT YOU WOULD AGREE WITH ME, BASED ON THE NUMBERS I
10 WENT THROUGH WITH YOU, 120, YOU ACTUALLY WEIGHED
11 MORE THAN YOU HAVE IN THE LAST SIX YEARS?

12 A. YES.

13 Q. LET'S TALK ABOUT BRIEFLY YOUR WORK HARDENING. DO
14 YOU REMEMBER WHEN I TOOK YOUR DEPOSITION?

15 A. YES.

16 Q. WE MET LAST SUMMER, IS THAT RIGHT?

17 A. WE MET IN DECEMBER, DIDN'T WE?

18 Q. WELL, THAT WAS FOR THE MEDIATION.

19 A. OH, THE OTHER STUFF. YEAH.

20 Q. YEAH, WE MET OVER THE SUMMER. AND DO YOU RECALL AT
21 THAT TIME STATING A DESIRE TO BE PUT IN A PROGRAM TO
22 HELP YOU BUILD MUSCLE MASS?

23 **BY MS. TURNER:**

24 COMMISSIONER, I'M GOING TO OBJECT TO THE USE OF
25 THE DEPOSITION IN THAT MANNER. HE HASN'T ASKED HER

1 A QUESTION WITH WHICH TO USE THE DEPOSITION TO
2 IMPEACH HER. HE CAN JUST ASK HER THE QUESTIONS
3 RATHER THAN...

4 **BY THE COMMISSIONER:**

5 SUSTAINED.

6 **CROSS EXAMINATION RESUMED BY MR. HORNER:**

7 Q. HAVE YOU PREVIOUSLY TESTIFIED UNDER OATH AS TO
8 WHETHER -- WELL, LET ME ASK YOU THIS. IN THE SUMMER
9 OF 2016 DID YOU ASK FOR ANY SORT OF TREATMENT FROM
10 YOUR EMPLOYER?

11 A. NO.

12 Q. YOU DIDN'T ASK FOR ANY TREATMENT AT ALL IN 2016?

13 A. THE ONLY TIME I TALKED TO SCOTT WAS TO ASK HIM IF
14 WORKERS' COMP -- AND HE SAID NO, BUT...

15 Q. DID YOU -- ISN'T IT TRUE THAT YOU MADE A REQUEST TO
16 BE PUT IN SOME SORT OF PROGRAM TO HELP YOU BUILD
17 BACK MUSCLE MASS OR BUILD UP YOUR STRENGTH?

18 A. I ASKED MY ATTORNEY IF I COULD DO IT.

19 Q. OKAY. AND DO YOU REMEMBER TESTIFYING THAT THAT WAS
20 SOMETHING THAT WOULD BE BENEFICIAL, THAT YOU THOUGHT
21 WOULD BE BENEFICIAL TO YOU IN TRYING TO RETURN TO
22 WORK?

23 A. YES.

24 Q. AND, LIKEWISE, DO YOU REMEMBER TESTIFYING THAT THE
25 TEAM DRIVER ISSUE WAS AN ISSUE THAT MIGHT HELP YOU

1 GET BACK TO WORK?

2 A. NO.

3 Q. NOW, WHEN YOU TOOK YOURSELF OUT OF WORK IN JUNE, DR.
4 ELLIS DIDN'T WRITE YOU OUT, CORRECT?

5 A. YEAH, SHE DID.

6 Q. IN JUNE SHE DID NOT WRITE YOU OUT OF WORK, CORRECT?

7 A. SHE DID WRITE ME OUT FOR TWO WEEKS.

8 Q. SHE WROTE YOU OUT FOR TWO WEEKS.

9 A. AND THEN SHE WROTE ME ---

10 Q. SHE WOULDN'T CONTINUE TO WRITE YOU OUT OF WORK?

11 A. NO. SHE WROTE ME OUT AGAIN AFTER THAT.

12 Q. OKAY. SO, DO YOU REMEMBER TELLING ME IN THE
13 DEPOSITION, WHEN I SAID, "DID YOU TAKE YOURSELF OUT
14 OF WORK IN JUNE WITHOUT A DOCTOR," YOU SAID, "YES"?
15 YOU TOLD ME YOU MADE THAT DECISION, THAT YOU
16 COULDN'T DO THE JOB ANYMORE.

17 A. I CAN'T DO THE JOB.

18 Q. SO -- BUT AT THAT TIME YOU DO RECALL WANTING TO BE
19 PUT INTO SORT OF A WEIGHTLIFTING PROGRAM TO SORT OF
20 HELP YOU BUILD MUSCLE MASS TO SEE IF YOU COULD GET
21 BACK TO WORK, RIGHT?

22 A. THE PROGRAM AT GHS IS A LOT DIFFERENT THAN THAT ONE
23 YOU SENT ME TO.

24 Q. AND GHS WAS THE LIFE CENTER?

25 A. YES.

1 Q. AND THOSE WERE 30-MINUTE SESSIONS?

2 A. YES.

3 Q. AND THOSE WERE WITH A PERSONAL TRAINER, RIGHT?

4 A. YES.

5 Q. AND WHAT YOU DID WITH WORK HARDENING WAS SPECIFIC
6 TASKS RELATED TO, LIKE YOU SAID, PULLING WEIGHTS AND
7 MOVING WEIGHTS AND SHIFTING THINGS AROUND, CORRECT?

8 A. YES.

9 Q. WAS IT YOUR UNDERSTANDING THAT THE WHOLE PURPOSE OF
10 THE WORK HARDENING WAS TO PREPARE YOU TO RETURN TO
11 WORK?

12 A. YES. AND I REALLY HAD A HARD TIME, BUT WHEN I
13 PUSHED THE SLED, I'D PUSH IT FIVE MINUTES AND TAKE A
14 FIVE-MINUTE BREAK 'CAUSE THEY KNEW I WAS STRUGGLING.

15 Q. NOW, YOU TESTIFIED WHEN YOUR ATTORNEY WAS ASKING YOU
16 QUESTIONS THAT YOUR JOB WAS PRIMARILY -- WITH
17 PALMETTO -- WAS PRIMARILY YOU'D HOOK THE TRAILER UP,
18 AND THEN YOU WOULD PULL INTO WHEREVER YOU WERE
19 DROPPING THE FREIGHT ALONG THE ROUTE, RIGHT?

20 A. YES.

21 Q. AND YOU WEREN'T RESPONSIBLE FOR MOVING THE FREIGHT
22 THAT YOU WERE DROPPING AT YOUR CUSTOMER, WERE YOU?

23 A. SOMETIMES WE WERE.

24 Q. OKAY. IT WAS RARE, THOUGH; ISN'T THAT TRUE?

25 A. YES.

1 Q. AND DO YOU REMEMBER IN 2012, WHEN YOU WERE TRYING TO
2 GET BACK TO WORK, WHERE YOU HAD A CONVERSATION WITH
3 YOUR DOCTOR AND SCOTT JUSTICE WHERE YOU ALL AGREED
4 THAT IN YOUR JOB YOU DIDN'T HAVE TO LIFT A HUNDRED
5 POUNDS AS ---

6 A. SHE NEVER TOLD ME A HUNDRED POUNDS.

7 Q. OKAY. DO YOU RECALL HAVING A CONVERSATION WITH DR.
8 NEWSOM, WHO IS THE WORK COMP DOCTOR, THAT IT WAS
9 MORE LIKE OCCASIONAL 35 POUNDS, WAS THE TRUE LIMIT
10 OF WHAT YOU HAD TO BE CAPABLE OF LIFTING OR PUSHING?
11 DO YOU RECALL THAT CONVERSATION?

12 A. NO.

13 Q. IF THAT'S IN HER RECORDS, THAT YOU AND SCOTT JUSTICE
14 AND HER HAD THAT CONVERSATION AND THAT'S WHY SHE
15 CLEARED YOU TO WORK, WOULD YOU HAVE ANY REASON TO
16 DISAGREE WITH HER RECORDS?

17 A. NO. AT THAT TIME WHEN SHE RELEASED ME, I COULD'VE
18 PUSHED IT. I DON'T THINK I COULD PICK IT UP.

19 Q. SO, LET'S FAST-FORWARD. WE'VE TALKED ABOUT YOU HAVE
20 SOME DENTAL IMPLANTS AND YOU'VE HAD A PLATE OR TWO
21 PUT IN; YOU HAD THE ONE PLATE REMOVED. LET'S TALK
22 ABOUT YOUR LEFT SHOULDER BRIEFLY. YOU UNDERWENT
23 PHYSICAL THERAPY FOLLOWING YOUR ACCIDENT FOR YOUR
24 LEFT SHOULDER, CORRECT?

25 A. CORRECT.

1 Q. AND NOTHING WAS TORN OR BROKEN IN YOUR LEFT
2 SHOULDER, RIGHT?

3 A. RIGHT.

4 Q. AND YOU WENT THROUGH PHYSICAL THERAPY. NOW, DO YOU
5 REMEMBER -- NOW, YOU RETURNED TO WORK IN 2012 AND
6 2013 AND 2014 WITH YOUR LEFT SHOULDER BEING
7 GENERALLY IN THE SAME CONDITION IT IS NOW; ISN'T
8 THAT TRUE?

9 A. MY SHOULDER IS WORSE.

10 Q. NOW, YOU WENT BACK IN 2014. DO YOU REMEMBER THAT,
11 GOING TO A -- WANTING A SECOND OPINION IN 2014 FOR
12 YOUR SHOULDER?

13 A. TO THE WORKERS' COMP DOCTOR?

14 Q. YOU WENT TO SEE DR. SVAVAS?

15 A. OH, YEAH.

16 Q. DO YOU REMEMBER THAT?

17 A. YEAH.

18 Q. DO YOU REMEMBER HIM TELLING YOU THAT YOU COULD GO TO
19 PHYSICAL THERAPY FOR YOUR LEFT SHOULDER IF YOU
20 WANTED?

21 A. NO.

22 Q. IF THAT'S IN HIS NOTES, WOULD YOU HAVE ANY REASON TO
23 DISAGREE WITH THAT?

24 A. I HAVEN'T READ HIS REPORT.

25 Q. DO YOU REMEMBER TELLING ME IN THE DEPOSITION THAT

1 YOU WERE SICK AND TIRED OF PHYSICAL THERAPY AT THAT
2 POINT IN TIME?

3 A. NO.

4 Q. ALL RIGHT.

5 A. I MEAN, THE THERAPY THAT WORKERS' COMP GAVE ME WAS
6 ON THIS ARM ONLY, AND THAT WAS TO GET IT SO I COULD
7 -- 'CAUSE I COULDN'T LIFT ANYTHING, AND IT -- LIKE I
8 COULDN'T PICK IT UP. I HAD TO TAKE THIS ARM AND USE
9 THIS ARM. AND THAT WAS THE ONLY THING THAT WORKERS'
10 COMP PAID FOR.

11 Q. OKAY. WELL, THEY'VE PAID FOR ALL THE DENTAL STUFF,
12 CORRECT?

13 A. I'M TALKING ABOUT AS FAR AS THE PHYSICAL PART.

14 Q. SO -- BUT YOU WOULD AGREE WITH ME THAT AFTER YOU
15 WENT THROUGH PHYSICAL THERAPY, YOU WERE RELEASED
16 FROM PHYSICAL THERAPY AND YOU WENT BACK TO WORK FOR
17 2012, '13, '14, '15, AND '16?

18 A. I COULD NOT TELL YOU.

19 Q. AND AFTER THE INITIAL COURSE OF PHYSICAL THERAPY,
20 YOU NEVER WENT BACK TO PHYSICAL THERAPY, DID YOU?

21 A. WHICH ONE?

22 Q. FOR YOUR LEFT SHOULDER.

23 A. FOR MY LEFT SHOULDER? THEY RELEASED ME.

24 Q. RIGHT. AND AFTER YOU WENT TO SEE DR. SVAVAS YOU
25 NEVER REQUESTED ANOTHER VISIT OR PHYSICAL THERAPY

1 FOR YOUR LEFT SHOULDER AFTER THAT ONE EXAM, DID YOU?

2 A. NOW, IS DR. SVAVAS THE ONE THAT TOOK DR. NEWSOM'S
3 PLACE?

4 Q. YES, MA'AM.

5 A. HE NEVER SUGGESTED I GO TO IT.

6 Q. OKAY. IF IT'S IN HIS RECORDS THAT SAY, "I OFFERED
7 HER PHYSICAL THERAPY, AND SHE REFUSED," WOULD YOU
8 HAVE ANY REASON TO BELIEVE THAT'S NOT TRUE?

9 A. THAT'S NOT TRUE. I DID NOT REFUSE.

10 Q. OKAY. BUT YOU DIDN'T GO TO ANYBODY IN 2014 OR '15
11 OR '16 AND SAY, "MY LEFT SHOULDER IS BOTHERING ME SO
12 BAD I CAN'T WORK ANYMORE"?

13 A. I DID NOT WANT TO GIVE MY JOB UP.

14 Q. NOW, YOUR DIET, YOU SAID THAT YOU -- YOU DRINK SOME
15 ENSURE NOW, IS THAT RIGHT?

16 A. I STILL DRINK ENSURE AND CARNATION.

17 Q. AND YOU'VE TESTIFIED HERE TODAY AND PREVIOUSLY THAT
18 YOU ARE ABLE TO EAT SOLID FOODS, IS THAT RIGHT?

19 A. SOME.

20 Q. AND YOU CAN EAT GRILLED CHICKEN BREASTS, IS THAT
21 RIGHT?

22 A. YES.

23 Q. AND YOU CAN EAT MASHED POTATOES?

24 A. YES.

25 Q. YOU CAN EAT SOME OTHER VEGETABLES AS LONG AS THEY'RE

1 NOT HARD OR IF THEY DON'T GET UNDERNEATH YOUR
2 PROSTHESIS, IS THAT RIGHT?

3 A. WHEN YOU ROLL FOOD IN YOUR MOUTH -- I DON'T THINK
4 YOU REALIZE IT UNTIL YOU GET THESE THINGS. WHEN
5 YOU'RE EATING, YOU ROLL THAT FOOD AROUND. I CANNOT
6 DO THAT. I DON'T HAVE ENOUGH ROOM IN HERE TO EVEN
7 DO IT, AND THESE TEETH DO NOT MATCH UP.

8 Q. BUT YOU'VE BEEN EATING AT LEAST ONE MEAL A DAY SINCE
9 2012?

10 A. NO, SIR; I HAVE NOT.

11 Q. WERE YOU AWARE THAT DR. ELLIS' RECORDS SAY THAT YOU
12 WEREN'T HAVING A PROBLEM EATING AT LEAST ONE OR TWO
13 MEALS A DAY?

14 A. I DO NOT EAT. SOME DAYS I GO WITHOUT, JUST DRINKING
15 ENSURE. I DO NOT EAT TWO MEALS A DAY. IF I BUY A
16 CHICKEN SANDWICH AT McDONALD'S, I HAVE TO TEAR ALL
17 THE BREAD LOSE TO RIGHT DOWN TO THE CHICKEN AND PUT
18 MAYONNAISE ON IT TO HAVE ENOUGH MOISTURE IN MY MOUTH
19 TO EAT THAT LITTLE CHICKEN SANDWICH.

20 Q. BUT THAT HASN'T CHANGED SINCE 2012?

21 A. THAT HASN'T CHANGED SINCE I GOT THESE THINGS.

22 Q. AND YOU WERE ABLE TO WORK FOR FOUR YEARS ON THAT
23 DIET AND ON ENSURE AND ON CARNATION?

24 A. I WAS PUSHING MYSELF. I KNEW I WAS GOING DOWNHILL.

25 Q. YOU KNEW YOU WERE GOING DOWNHILL. IN LOOKING AT

1 YOUR RECORDS I DON'T SEE WHERE YOU EVER TURNED DOWN
2 A JOB, AS NEAR AS I CAN TELL. DOES THAT SOUND ABOUT
3 RIGHT?

4 A. WHAT; WHEN THEY ASKED ME TO RUN AN EXTRA RUN?

5 Q. WHEN THEY ASKED YOU TO RUN -- YEAH.

6 A. YEAH. THAT'S RIGHT.

7 Q. NOW, PALMETTO TRANSPORT, THEY DON'T FORCE YOU TO
8 TAKE EVERY RUN, DO THEY?

9 A. NO. THEY JUST TELL YOU THEY DON'T HAVE ANOTHER
10 DRIVER TO DO IT.

11 Q. OKAY. BUT YOU'RE FREE TO SAY NO, AND YOU DON'T GET
12 TERMINATED FOR THAT, RIGHT?

13 A. NO.

14 Q. AND YOU COULD TAKE EVERY THIRD RUN IF YOU WANTED;
15 ISN'T THAT TRUE?

16 A. WHEN I WAS ON A DEDICATED RUN, YES.

17 Q. RIGHT. AND YOU COULD STILL DO THAT WHEN YOU STOPPED
18 IN MARCH? ISN'T IT TRUE THAT YOU COULD REFUSE RUNS
19 IF YOU DIDN'T FEEL LIKE YOU ---

20 A. AND I TOLD MY DISPATCHER -- I DIDN'T TELL SCOTT IN
21 MARCH. I TOLD MY DISPATCHER. HE DID CALL ME, AND I
22 SAID, "I CAN'T GO." I SAID, "LOOK, I'M JUST WORE
23 OUT; I NEED A BREAK."

24 Q. AND THAT WAS IN MARCH?

25 A. THAT WAS IN MARCH.

1 Q. PRIOR TO MARCH OF 2016 YOU NEVER TURNED DOWN A RUN,
2 DID YOU?

3 A. NO, I DID NOT.

4 Q. OKAY. AND I ASKED YOU -- WE TALKED ABOUT IT LAST
5 SUMMER, THAT YOU NEVER EVEN TRIED TO GO BACK ON
6 ANYTHING LESS THAN A HUNDRED PERCENT. YOU NEVER
7 TRIED TO GO BACK ON 80 PERCENT OR 70 PERCENT OF THE
8 RUNS THAT YOU USED TO DO, DID YOU?

9 A. NO, 'CAUSE I AM THE KIND OF PERSON THAT I WAS GOING
10 TO PUSH MYSELF TO -- I LOVE MY JOB, AND I JUST --
11 YOU KNOW, I DONE IT KNOWING THAT I SHOULDN'T HAVE,
12 BUT I DONE IT.

13 Q. BUT NOTHING PREVENTED YOU FROM SAYING NO?

14 A. SO, UNDOUBTEDLY, DOING WHAT I LOVED WAS THE WRONG
15 THING TO DO.

16 Q. WELL, YOU ALSO GOT PAID FOR THAT, RIGHT? I MEAN, IT
17 WAS YOUR PROFESSION AS WELL, CORRECT?

18 A. IT WAS MY PROFESSION, BUT...

19 Q. AND THE MORE YOU RAN, THE MORE YOU GOT PAID,
20 CORRECT?

21 A. THAT -- THAT WASN'T WHAT I WAS LOOKING AT.

22 Q. OKAY. THAT WASN'T WHAT YOU WERE LOOKING AT, BUT YOU
23 NEVER TURNED DOWN A JOB?

24 A. I THOUGHT I WAS HELPING THE COMPANY MORE THAN I WAS
25 HELPING MY DARN SELF.

1 Q. AND WHEN YOU CAME BACK IN JUNE FOR TWO WEEKS, YOU
2 DIDN'T TURN DOWN A JOB THEN EITHER; YOU DIDN'T SAY
3 LET ME TRY HALF THE RUNS OR TWO-THIRDS OF THE RUNS
4 ---

5 A. THAT'S NOT IN MY ---

6 Q. --- OR ANYTHING OF THAT NATURE?

7 A. NO.

8 Q. AND, IN FACT, WHEN YOU WENT OUT OF WORK, YOU NEVER
9 EVEN OFFERED OR ASKED SCOTT ABOUT WHETHER YOU COULD
10 SIT IN THE GUARD SHACK AGAIN, DID YOU?

11 A. YES, I DID.

12 Q. YOU DID?

13 A. YES, I DID.

14 Q. WHEN DID THAT HAPPEN?

15 A. I SAID, "SCOTT," I SAID, "UNLESS YOU GOT SOMETHING
16 LIGHT I CAN DO, LIKE SITTING IN THE GUARD SHACK."
17 AND HE SAID, "NO, WE DON'T HAVE NOTHING LIKE THAT."

18 Q. AND WHEN YOU TOOK YOURSELF OUT IN JUNE, YOU DID NOT
19 OFFER TO -- YOU WERE ALL OR NOTHING IN JUNE; ISN'T
20 THAT TRUE?

21 A. I WAS -- NO. I WAS SO TIRED 'TIL WHEN I'D COME IN
22 OFF OF THAT MARYLAND RUN THAT I DONE GOOD TO GET
23 MYSELF OUT OF THAT MAN'S TRUCK AND GO TO MY CAR.

24 Q. AND THAT MARYLAND RUN WAS IN THE TWO-WEEK PERIOD
25 WHERE YOU RETURNED TO WORK, RIGHT?

1 A. YES.

2 Q. NOW, WE'VE TALKED ABOUT YOUR WEIGHT AND WHAT IT WAS
3 AND HOW DR. ELLIS THOUGHT YOU COULD WORK AT THAT
4 WEIGHT, CORRECT?

5 A. NO, DR. ELLIS DID NOT WANT TO SEND ME BACK TO WORK,
6 BUT SHE WAS NOT MY WORKERS' COMP DOCTOR.

7 Q. SHE SAID - - -

8 A. Y'ALL WOULDN'T LET HER.

9 Q. YOU WOULD AGREE WITH ME THAT SHE SAID, "AT THAT
10 WEIGHT I CAN'T JUSTIFY WRITING YOU OUT OF WORK"?

11 A. 'CAUSE I WEIGHED A HUNDRED POUNDS. SHE DID NOT WANT
12 TO SEND ME BACK, BUT ACCORDING TO Y'ALL'S RULES SHE
13 HAD TO.

14 Q. THE LIFE CENTER, THE PERSONAL TRAINER YOU WENT TO
15 SEE, YOU DID ALL ON YOUR OWN, IS THAT RIGHT?

16 A. YES, I DID.

17 Q. AND THAT ACTUALLY WAS BEFORE YOU GOT -- YOU WENT TO
18 WORK HARDENING, RIGHT?

19 A. YES.

20 Q. AND ISN'T IT TRUE THAT WHEN YOU WENT TO WORK
21 HARDENING, YOU WANTED TO GO TO WORK HARDENING? IT
22 WAS SOMETHING YOU WANTED TO TRY?

23 A. I HAD NEVER HEARD OF WORK HARDENING OR STRENGTHENING
24 BEFORE YOU SENT ME TO THAT. I THOUGHT WE WERE
25 TALKING ABOUT THE SAME THERAPY I WAS IN WHEN WE HAD

1 THAT DEPOSITION.

2 Q. BUT IT WAS A LITTLE MORE INTENSE, RIGHT?

3 A. OH, IT LIKED TO KILLED ME. THE NEXT DAY I COULDN'T
4 EVEN GET MY HEAD OFF THE PILLOW.

5 Q. NOW, WHEN YOU TALK ABOUT YOUR NECK, YOU HAVE TROUBLE
6 WITH YOUR NECK, YOU'RE TALKING ABOUT THE FRONT OF
7 YOUR NECK, IS THAT RIGHT?

8 A. I'M TALKING ABOUT FROM RIGHT HERE, AND THERE IS A
9 PLACE RIGHT THERE THAT YOU CAN MASH WHERE THAT
10 MACHINE HIT ME. WE HAVE PICTURES OF WHERE THE
11 MACHINE HIT ME. AND IT'S BEEN THAT WAY EVER SINCE
12 MAY THE 31ST, 2012. THE DOCTORS WERE WELL AWARE OF
13 IT. THERE'S PICTURES OF IT, RIGHT HERE, AND WHEN
14 THIS -- IF I DO A LOT OF LIFTING OR ANYTHING, THIS
15 RIGHT HERE STARTS HURTING AND RADIATES TO THE
16 SHOULDER. MY SHOULDERS BURN; MY NECK HURTS.

17 Q. JUST FOR THE RECORD, BECAUSE WHEN THIS ALL GETS
18 TYPED UP, IT WON'T REFLECT THAT, YOU WERE FIRST
19 GESTURING TO THE BACK OF YOUR LEFT SHOULDER, AND
20 WHEN YOU SAID ACROSS YOUR SHOULDERS AND UP INTO YOUR
21 NECK, YOU WERE GESTURING ACROSS THE FRONT OF YOUR
22 NECK, CORRECT?

23 A. YES, BECAUSE WHEN I -- LIKE WHEN I HAVE A LOT OF --
24 LIKE WHEN HE REPLACES THESE TEETH RIGHT HERE, THEY
25 HAVE TO BEND MY HEAD SO FAR BACK 'CAUSE THEY HAVE TO

1 OPEN MY MOUTH SO WIDE. SO THEY HAVE TO PUT
2 SOMETHING BACK THERE, 'CAUSE, IF NOT, I HAVE TO STOP
3 THEM AND SAY, "DOC, YOU'RE KILLING ME."

4 Q. AND YOU GO EVERY SIX MONTHS TO HAVE YOUR TEETH
5 CLEANED, IS THAT RIGHT?

6 A. YES.

7 Q. AND THE DENTIST, IT'S NOT A NORMAL -- YOU HAVE TO GO
8 BACK TO DR. (INAUDIBLE), AND HE HAS TO ACTUALLY
9 REMOVE THE BOTTOM PLATE, IS THAT RIGHT, WHEN HE
10 CLEANS THE BOTTOM?

11 A. YES.

12 Q. BUT SINCE YOU'VE BEEN GOING BACK TO GET THESE
13 CLEANINGS, OTHER THAN THE SURGERY IN 2005 YOU
14 HAVEN'T ASKED HIM TO DO ANYTHING DIFFERENT OR
15 COMPLAINED ABOUT ANYTHING OTHER THAN THE GENERAL
16 PROBLEMS YOU'VE HAD SINCE THE BEGINNING, IS THAT
17 RIGHT?

18 A. YEAH. I TOLD HIM, I SAID, "DOC, I CAN'T EAT. THESE
19 TEETH DON'T LINE UP."

20 **BY MR. HORNER:**

21 COMMISSIONER, I THINK THAT'S ALL I HAVE.

22 **BY THE COMMISSIONER:**

23 ALL RIGHT. THANK YOU. MS. TURNER, ANY
24 REDIRECT?

25 **BY MS. TURNER:**

1 JUST A LITTLE BIT, I PROMISE.

2 **BY THE COMMISSIONER:**

3 SURE.

4 **REDIRECT EXAMINATION BY MS. TURNER:**

5 Q. JENNIE, DURING THE TIME THAT YOU WENT TO WORK
6 HARDENING -- WELL, LET ME ASK YOU THIS. DEFENDANTS'
7 COUNSEL MENTIONED THAT YOU HAD BEEN OFFERED A JOB AS
8 A TEAM DRIVER?

9 A. YES.

10 Q. AND DURING THAT TIME YOU WENT TO WORK HARDENING TO
11 SEE IF YOU COULD GET BACK TO THE POINT WHERE YOU
12 COULD DRIVE?

13 A. YES.

14 Q. OKAY. AND YOU DID GO TO WORK HARDENING, IS THAT
15 RIGHT?

16 A. YES.

17 Q. AND ARE YOU AWARE THAT ACCORDING TO THE DISCHARGE
18 REPORT FOR WORK HARDENING THAT YOU DID NOT MEET THE
19 REQUIREMENTS FOR FLOOR-TO-WAIST LIFTING?

20 A. NO, I DIDN'T KNOW WHAT THEY SAID.

21 Q. OKAY. IF I TOLD YOU THAT YOUR PROGRESS REPORT AS OF
22 12-5-16 SAID THAT YOU COULD LIFT ONLY TEN POUNDS
23 CONSTANTLY FROM FLOOR TO WAIST, DOES THAT SOUND
24 ABOUT RIGHT TO YOU, GIVEN YOUR EXPERIENCE IN WORK
25 HARDENING?

1 A. YES.

2 Q. OKAY. AND THERE WAS SOME TALK ABOUT A 35 POUND --
3 OR AN AGREEMENT THAT THERE WAS A 35 FLOOR-TO-WAIST
4 LIFTING OR LIFTING REQUIREMENT ON YOUR ACTUAL JOB.
5 WOULD YOU AGREE WITH ME THAT THEN POUNDS IS STILL
6 LESS THAN 35?

7 A. YES.

8 Q. ALL RIGHT. DOES IT SOUND RIGHT TO YOU THAT THE WORK
9 HARDENING EVALUATION FOUND THAT YOU DID NOT MEET THE
10 JOB STANDARDS FOR VERTICAL PUSHING AND PULLING?

11 A. NO.

12 Q. OKAY. IF I TOLD YOU THAT YOU WERE EVALUATED AT
13 BEING ABLE TO CARRY ONLY 20 POUNDS OCCASIONALLY,
14 DOES THAT SOUND RIGHT TO YOU?

15 A. YES.

16 Q. OKAY. AND AS FAR AS THE -- AS FAR AS YOUR
17 ACTIVITIES WITH PUSHING AND PULLING THE SLED THERE,
18 DID YOU HAVE SOME DIFFICULTY ---

19 A. YES.

20 Q. --- DOING THAT? HOW DID YOU HAVE TO PERFORM THAT
21 WHEN YOU WERE AT WORK HARDENING?

22 A. IT WAS ON A TILE FLOOR AND NOT ON CARPET, BUT THEY
23 -- I PUSHED IT FOR FIVE MINUTES AND RESTED FIVE
24 MINUTES.

25 Q. OKAY. AND IS -- DID YOU WORK AS HARD AS YOU COULD

1 AT DOING THAT?

2 A. YES. YES, MA'AM.

3 **BY MS. TURNER:**

4 THANK YOU. COMMISSIONER, I DON'T -- JUST ONE
5 SECOND, COMMISSIONER.

6 **RECROSS EXAMINATION BY MR. HORNER:**

7 Q. MS. COX, AS FAR AS WORK HARDENING GOES, YOU WERE
8 ASKED QUESTIONS ---

9 **BY THE COMMISSIONER:**

10 SHE WASN'T DONE YET.

11 **BY MR. HORNER:**

12 I'M SORRY.

13 **BY THE COMMISSIONER:**

14 SHE WAS JUST CONSULTING. THAT'S OKAY.

15 **BY MS. TURNER:**

16 AND I APOLOGIZE. I'M SORRY.

17 **REDIRECT EXAMINATION RESUMED BY MS. TURNER:**

18 Q. I'M GOING TO SHOW YOU SOME PICTURES. YOU HAVE A
19 SCAR THAT IS UNDER YOUR CHIN, RIGHT?

20 A. UH-HUH.

21 Q. THAT'S FROM YOUR -- THAT'S FROM THE ACCIDENT, IS
22 THAT RIGHT?

23 A. YES.

24 Q. IT IS -- THAT'S THE SCAR THAT YOU HAD TO HAVE SOME
25 SUTURES FOR, RIGHT?

1 A. YES.

2 **BY MS. TURNER:**

3 AND, COMMISSIONER, WE HAVE SOME PHOTOGRAPHS IN
4 HERE. I DON'T KNOW IF YOU WOULD WANT TO VIEW ---

5 **BY THE COMMISSIONER:**

6 DO I HAVE COPIES IN HERE OR IS THIS GOING TO BE
7 SEPARATE?

8 **BY MS. TURNER:**

9 THEY ARE HERE.

10 **BY THE COMMISSIONER:**

11 OKAY, ALL RIGHT.

12 **REDIRECT EXAMINATION RESUMED BY MS. TURNER:**

13 Q. MS. COX, I WANT YOU TO TAKE A LOOK AT THE -- SOME OF
14 THE PHOTOGRAPHS THAT I'M ABOUT TO SHOW YOU TO TELL
15 ME WHETHER THEY DEPICT YOUR INJURIES AT THE TIME
16 BACK IN 2012 WHEN YOU HAD YOUR ACCIDENT.

17 A. THAT WAS -- THIS ONE HERE?

18 Q. YES.

19 A. MY DAUGHTERS MADE THEM. SO THIS ONE HERE, I THINK,
20 WAS AT MEMORIAL AFTER THEY TRANSFERRED ME HOME.

21 Q. OKAY.

22 A. THIS ONE HERE WAS AT GRADY.

23 Q. OKAY. BUT THIS IS A PICTURE ---

24 A. YES.

25 Q. --- OF YOU AT THAT TIME? AND AT THE TIME YOU HAD

1 YOUR ACCIDENT, THERE WAS SOME TRAUMA TO YOUR NECK.

2 DO YOU KNOW WHAT THAT CAME FROM?

3 A. ALL I KNOW IS IT'S FROM WHERE MY HEAD HIT THE FLOOR
4 HERE AND TOOK IT BACKWARDS.

5 Q. OKAY. IS THAT A PICTURE OF WHAT WAS GOING ON WITH
6 JUST YOUR THROAT THERE, SOME ABRASIONS?

7 A. YES. THIS SIDE -- THIS SIDE WAS YELLOW AND BLUE.
8 AND I ASKED THEM LATER WHEN I SOBERED UP A LITTLE
9 BIT WHY.

10 Q. OKAY. AND WAS THERE ALSO SOME BRUISING ON YOUR
11 SHOULDER AREA?

12 A. YES, ON MY BACK.

13 Q. OKAY. AND I WON'T GO THROUGH EVERY ONE OF THEM.
14 OKAY. NOW, YOU STILL HAVE A SCAR, RIGHT? IT'S
15 GOTTEN SOMEWHAT BETTER SINCE THE TIME OF THE
16 ACCIDENT?

17 A. YES.

18 Q. OKAY. COULD YOU SHOW THE ---

19 **BY THE COMMISSIONER:**

20 YOU CAN COME ON UP SO I CAN SEE.

21 **BY THE WITNESS:**

22 THERE'S ONE HERE FROM WHEN THEY TOOK THE LAST
23 PLATE OUT.

24 **BY THE COMMISSIONER:**

25 LET THE RECORD REFLECT THE CLAIMANT IS SHOWING

1 ME THE BOTTOM PART OF HER LEFT JAW. DO YOU WANT TO
2 COME -- MR. HORNER, HAVE YOU SEEN IT ALREADY, OR DO
3 YOU NEED TO COME UP AND SEE WHAT I'M LOOKING AT?
4 AND I DO SEE -- I DO SEE A SMALL SCAR. IT'S
5 DISCOLORED.

6 **BY THE WITNESS:**

7 YEAH, AND THEN THE OTHER ONE WAS UNDER HERE
8 WHERE YOU COULD SEE THE BONE.

9 **BY THE COMMISSIONER:**

10 YES, MA'AM. OKAY. I GUESS COMBINED THE TOTAL
11 SCAR IS PROBABLY -- BOTH SCARS COMBINED ARE
12 APPROXIMATELY TWO TO TWO AND A HALF INCHES IN TOTAL
13 LENGTH. THANK YOU.

14 **BY MS. TURNER:**

15 WE WOULD JUST OFFER THE PHOTOGRAPHS INTO
16 EVIDENCE.

17 **BY THE COMMISSIONER:**

18 OKAY. ANY OBJECTION TO THE PHOTOGRAPHS, MR.
19 HORNER?

20 **BY MR. HORNER:**

21 NO, COMMISSIONER.

22 **BY THE COMMISSIONER:**

23 OKAY. ALL RIGHT. THANK YOU. THE PHOTOGRAPHS
24 WILL BE MARKED COMBINED AS CLAIMANT'S EXHIBIT "A."
25 **(COURT REPORTER MARKS PHOTOGRAPHS CLAIMANT'S EXHIBIT "A,"**

1 **RETAINED IN COMMISSION FILE.)**

2 **BY MS. TURNER:**

3 THERE WAS ONE MEDICAL RECORD THAT I WANTED TO
4 DIRECT YOUR HONOR'S ATTENTION TO.

5 **BY THE COMMISSIONER:**

6 OKAY.

7 **BY MS. TURNER:**

8 LET'S SEE. AT -- IT'S AT CLAIMANT'S APAs 247.
9 THIS IS A RECORD FROM DR. COBB INDICATING THAT HER
10 -- THAT SHE WAS EXTREMELY MALNOURISHED AT THE TIME
11 AND THAT THE MALNOURISHMENT WAS AFFECTING NEGATIVELY
12 AND PUTTING IN JEOPARDY HER ENTIRE RECOVERY, AND
13 ALSO REFERRING HER FOR CONSULTATION TO TREAT THE
14 MALNOURISHMENT.

15 **REDIRECT EXAMINATION RESUMED BY MS. TURNER:**

16 Q. MS. COX, DID YOU -- DID YOU HAVE -- DID YOU GET SOME
17 HELP EARLY ON WITH TRYING TO GET ENOUGH NUTRITION?
18 AS A RESULT OF DR. COBB'S RECOMMENDATION OR
19 REFERRAL, DID YOU GET TO GO SEE SOMEONE ABOUT
20 NUTRITION?

21 A. YES.

22 Q. OKAY. WAS THAT HELPFUL AT THE TIME?

23 A. YES.

24 Q. MS. COX, IN 2016 DID YOU PROVIDE YOUR EMPLOYER WITH
25 OUT-OF-WORK EXCUSES FROM DR. ELLIS?

1 A. YES.

2 Q. OKAY. SO YOU DID, IN FACT, PROVIDE SOME OUT-OF-WORK
3 EXCUSES FOR THAT?

4 A. YES.

5 **BY MS. TURNER:**

6 OKAY. THANK YOU.

7 **BY THE COMMISSIONER:**

8 ALL RIGHT. THANK YOU. MR. HORNER, ANY
9 RECROSS?

10 **BY MR. HORNER:**

11 VERY BRIEFLY.

12 **BY THE COMMISSIONER:**

13 SURE.

14 **RECROSS EXAMINATION BY MR. HORNER:**

15 Q. MS. COX, YOU WERE ASKED ABOUT THE WORK HARDENING AND
16 VARIOUS STANDARDS OR GOALS. WHEN FIRST PHYSICAL
17 THERAPY OR CORA REHAB IDENTIFIED A GOAL OR A
18 STANDARD, YOU HAVE NO IDEA WHAT THAT'S BASED ON, DO
19 YOU?

20 A. NO, I DON'T.

21 Q. OKAY. AND WHEN YOU RETURNED IN 2012 TO WORK, THAT
22 WAS BASED UPON YOU OCCASIONALLY HAVING TO MOVE OR
23 PUSH OR PULL 35 POUNDS; ISN'T THAT TRUE?

24 A. I DON'T KNOW IF I WAS EVER TOLD THAT.

25 Q. OKAY. YOU WOULD AGREE WITH ME, THOUGH, THAT THE

1 PRIMARY -- MOST OF THE HOURS THAT YOU INCURRED AT
2 PALMETTO WERE THE ACTUAL DRIVING, IS THAT RIGHT?

3 A. YES.

4 Q. THE DRIVING TIME. AND 35 POUNDS SOUNDS ABOUT RIGHT,
5 DOESN'T IT?

6 A. I WOULD SAY SO.

7 Q. OKAY. I MEAN, YOU'RE NOT DISPUTING IT AND SAYING
8 IT'S A HUNDRED POUNDS?

9 A. NO, IT'S NOT.

10 Q. OKAY. AND, LIKE I SAID, IF THE RECORDS SAY YOU
11 THOUGHT IT WAS 35 FOUR YEARS AGO, YOU DON'T HAVE ANY
12 REASON TO BELIEVE YOU DIDN'T SAY THAT, RIGHT?

13 A. NO.

14 Q. AND BY THE TIME YOU LEFT CORA -- YOU WERE TALKING
15 ABOUT PUSHING AND PULLING AND MOVING SLEDS AROUND
16 AND THINGS LIKE THAT. YOU -- WERE YOU AWARE THAT
17 YOU WERE ACTUALLY, YOU KNOW -- YOU HAD ACTUALLY
18 IMPROVED OVER THE SIX WEEKS YOU WERE THERE?

19 A. NO.

20 Q. DID YOU FEEL LIKE YOU IMPROVED OVER THE SIX WEEKS
21 YOU WERE THERE?

22 A. NO, I DID NOT. I WENT FROM THERE STRAIGHT HOME.
23 NO, I REALLY STOPPED AND GOT A HOT DOG AND WENT HOME
24 AND GOT ON THE COUCH.

25 Q. NOW, WHEN YOU HAD THE CUT IN YOUR CHIN, THAT WAS

1 SUTURED, IS THAT RIGHT? THEY PUT SOME STAPLES OR
2 SOME SUTURES IN THERE, IS THAT RIGHT; STITCHES?

3 A. I DON'T KNOW, 'CAUSE I DO REMEMBER BEING -- COMING
4 TO AT THAT TIME AT GRADY, AND I WASN'T REAL SOBER,
5 BUT I WAS SOBER ENOUGH I REMEMBER ASKING THAT DOCTOR
6 -- BEFORE HE COULD LET ME LEAVE THAT HAD TO BE SEWED
7 UP 'CAUSE IT WAS BARE BONE. AND I DO REMEMBER
8 ASKING THE DOCTOR, I SAID, "HAVE YOU EVER DONE THIS
9 BEFORE?" AND HE SAID, "A FEW." AND AFTER THAT,
10 ZAP, I WAS GONE AGAIN.

11 Q. YOU DIDN'T HAVE ANY OTHER PROCEDURES ON THE SCAR
12 ITSELF, ON THE CUT ITSELF, OTHER THAN THE INITIAL
13 ---

14 A. NOT AT GRADY, NO.

15 **BY MR. HORNER:**

16 THAT'S ALL I'VE GOT FOR YOU.

17 **BY THE COMMISSIONER:**

18 ALL RIGHT. ANYTHING ON REDIRECT?

19 **BY MS. TURNER:**

20 JUST REAL QUICKLY.

21 **REDIRECT EXAMINATION BY MS. TURNER:**

22 Q. WHEN YOU SAY YOU WERE NOT REAL SOBER, WHY WAS THAT?
23 WHAT ---

24 A. I HAD A LOT OF DRUGS IN ME.

25 Q. WHERE DID THE DRUGS COME FROM?

1 A. WHERE DID THE -- (INAUDIBLE STATEMENT.)

2 **BY MS. TURNER:**

3 THAT'S ALL. THANK YOU.

4 **BY THE COMMISSIONER:**

5 FOR THE RECORD, ARE THERE ANY OTHER WITNESSES
6 FOR THE CLAIMANT?

7 **BY MS. TURNER:**

8 NO.

9 **BY THE COMMISSIONER:**

10 OKAY. ALL RIGHT. MR. HORNER, YOU MAY CALL
11 YOUR FIRST WITNESS.

12 **BY MR. HORNER:**

13 CAN I HAVE JUST A MINUTE?

14 **BY THE COMMISSIONER:**

15 SURE.

16 **BY MR. HORNER:**

17 WE DON'T HAVE ANY WITNESSES.

18 **BY THE COMMISSIONER:**

19 OKAY, ALL RIGHT. AND I NOTED IN THE PREHEARING
20 CONFERENCE -- I MAY HAVE MESSED THAT UP -- THAT YOU
21 HAD DEBATED WHETHER OR NOT YOU WERE GOING TO CALL
22 MR. JUSTICE, AND SO I DIDN'T GIVE YOU AN OPPORTUNITY
23 TO DO THAT, BUT...

24 **BY MR. HORNER:**

25 WELL ---

1 **BY THE COMMISSIONER:**

2 I DON'T KNOW THAT WE NEED TO, BUT IT'S UP TO
3 YOU.

4 **BY MR. HORNER:**

5 I DON'T THINK THAT WE DO.

6 **BY THE COMMISSIONER:**

7 OKAY, ALL RIGHT. VERY GOOD. I WILL READ THE
8 APA SUBMISSIONS INTO THE RECORD, BUT, AGAIN, THESE
9 WILL BE UPLOADED THE COMMISSION'S ECASE SYSTEM. FOR
10 THE CLAIMANT I HAVE APA NUMBERS ONE THROUGH 13,
11 WHICH ARE PAGES ONE THROUGH 284. IN ADDITION, I DO
12 ALSO HAVE CLAIMANT'S EXHIBIT "A," WHICH IS A SERIES
13 OF COLOR PHOTOGRAPHS, WHICH WILL BE RETAINED IN THE
14 COMMISSION'S FILE.

15 FOR THE DEFENDANTS I HAVE APA SUBMISSIONS
16 NUMBERS 14 THROUGH 19 AND EXHIBITS 20 THROUGH 25,
17 WHICH ARE PAGES 285 THROUGH 371. I WILL NOTE,
18 THOUGH, EXHIBIT NUMBER 25 IS THE CLAIMANT'S
19 DEPOSITION, BUT I DON'T KNOW THAT SHE WAS FORMALLY
20 IMPEACHED, SO WE MAY NOT NEED THAT.

21 **BY MR. HORNER:**

22 NO, YOUR HONOR. I DO HAVE IT GOING THROUGH
23 375.

24 **BY THE COMMISSIONER:**

25 OH, YOU HAVE SUPPLEMENTALS. YOU HAVE

1 SUPPLEMENTALS.

2 **BY MR. HORNER:**

3 AND I WOULD NOTE THAT AS PART OF 23 AND 24
4 THERE IS VIDEO FROM THE PRIVATE INVESTIGATOR THAT
5 GOES WITH THE REPORT AND SOME STILL PHOTOS. I HAVE
6 THOSE ON A FLASH DRIVE. I DON'T KNOW IF I CAN
7 UPLOAD VIDEO TO THE COMMISSION. I DON'T KNOW HOW
8 THAT WORKS.

9 **BY THE COMMISSIONER:**

10 I THINK YOU CAN. SO TRY IT, AND IF IT DOESN'T
11 WORK, THEN MAIL ME THAT FLASH DRIVE.

12 **BY MR. HORNER:**

13 OKAY.

14 **BY THE COMMISSIONER:**

15 OKAY. AND THEN ---

16 **BY MS. TURNER:**

17 I'M SORRY, COMMISSIONER. THERE WAS SOMETHING
18 -- YOU SAID SOMETHING ABOUT SUPPLEMENTING?

19 **BY THE COMMISSIONER:**

20 NO. THERE WAS A SUPPLEMENTAL BRIEF THAT HAD
21 EXHIBIT NUMBER 26, WHICH IS PAGES 372 TO 375.

22 **BY MS. TURNER:**

23 I DON'T KNOW THAT WE HAVE THAT.

24 **BY MR. HORNER:**

25 THEY WERE -- THEY MAY NOT HAVE MADE IT IN THE

1 MAIL IN TIME.

2 **BY THE COMMISSIONER:**

3 IT'S PAYROLL RECORDS?

4 **BY MR. HORNER:**

5 THEY WERE THE WAGE RECORDS THAT I QUESTIONED

6 HER ABOUT THAT SHE CONFIRMED ---

7 **BY MS. TURNER:**

8 OH, OKAY.

9 **BY MR. HORNER:**

10 --- WERE HER WAGES FOR '13 AND '14.

11 **BY THE COMMISSIONER:**

12 THEY WERE JUST SERVED VIA MAIL, SO THEY MAY BE

13 IN YOUR OFFICE, JUST NOT IN THE FILE YET, BUT...

14 **BY MR. HORNER:**

15 YOU CAN HAVE MY COPY IF YOU WANT.

16 **BY MS. TURNER:**

17 THANK YOU.

18 **BY MR. HORNER:**

19 SHE BASICALLY CONFIRMED THAT THOSE WERE HER

20 WAGES.

21 **BY THE COMMISSIONER:**

22 OKAY. ALL RIGHT. THAT CONCLUDES THIS MATTER.

23 THANK YOU VERY MUCH.

24 (THERE BEING NO FURTHER QUESTIONS, THIS HEARINGS WAS

25 CONCLUDED AT THE HOUR OF 2:43 P.M.)

CERTIFICATE OF NOTARY PUBLIC
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 1206236

EMPLOYEE/CLAIMANT: JENNIE COX

EMPLOYER: PALMETTO STATE TRANSPORTATION

CARRIER: CHEROKEE INSURANCE COMPANY

I, TIMMI A. PARRISH, A NOTARY PUBLIC FOR THE STATE OF SOUTH CAROLINA, DULY COMMISSIONED AND QUALIFIED AS SUCH, DO HEREBY CERTIFY THAT THE FOREGOING **74** PAGES REPRESENTS A TRUE AND ACCURATE TRANSCRIPT OF THE FOREGOING HEARING OF **JENNIE COX**, TAKEN ON THE 2ND DAY OF FEBRUARY, 2017.

THAT THE WITNESS WAS DULY PLACED UNDER OATH AND ADMONISHED TO SPEAK THE WHOLE TRUTH. THAT THE ORAL HEARING WAS DULY TAKEN AND TRANSCRIBED AS TO THE QUESTIONS PROPOUNDED AND THE ANSWERS GIVEN.

THAT ALL THE OFFERED EXHIBITS, STIPULATIONS AND OBJECTIONS, IF ANY, INVOLVED IN THIS CASE ARE DULY ATTACHED OR INCLUDED HEREIN.

IN WITNESS WHEREOF, I HAVE SET MY HAND AND OFFICIAL SEAL THIS 10TH DAY OF MAY, 2017.

TIMMI A. PARRISH
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES: 11-20-2018

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

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 1206236

JENNIE COX,	)	
	)	
CLAIMANT,	)	
	)	
VS.	)	TRANSCRIPT OF PROCEEDINGS
	)	
PALMETTO STATE	)	FEBRUARY 12, 2019
TRANSPORTATION,	)	
	)	
EMPLOYER,	)	
	)	
AND	)	
	)	
CHEROKEE INSURANCE	)	
COMPANY,	)	
	)	
CARRIER,	)	
	)	
DEFENDANTS.	)	

THIS HEARING WAS HELD BEFORE

COMMISSIONER T. SCOTT BECK, REPORTED BY SKYLET KEAN,
COURT REPORTER AND NOTARY PUBLIC IN AND FOR THE STATE
OF SOUTH CAROLINA; SAID PROCEEDINGS WERE HELD AT THE
COUNTY ADMINISTRATION BUILDING, 366 NORTH CHURCH
STREET, SPARTANBURG, SOUTH CAROLINA, ON TUESDAY,
FEBRUARY 12, 2019, COMMENCING AT 1:30 P.M.

APPEARANCES

FOR THE CLAIMANT:

JULIETTE B. MIMS, ESQUIRE

MIMS LAW FIRM

100 EAST POINSETT STREET

GREER, SOUTH CAROLINA 29651

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FOR THE DEFENDANTS:

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SPEED, SETA, MARTIN & TRIVETT & STUBLEY, LLC

POST OFFICE BOX 11669

COLUMBIA, SOUTH CAROLINA 29211

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PROCEEDINGS

THE COURT: Today's date is February 12, 2019. This is Workers' Compensation File No. 1206236. The claimant in this matter is Jennie Cox represented today by Attorney Juliette Mims and Adrienne Turner. Employer is Palmetto State Transportation. The carrier is Cherokee Insurance Company. They are represented today by Attorney George Gallagher. Date of the accident in this matter is May 31st, 2012. Average weekly wage is \$1327.69 yielding a compensation rate of \$725.47.

We are here today on remand from the Full Commission via order dated May 21st, 2018. I received APAs from both the claimant and the defendant in this matter as well as a list of documents that are contained and what's been marked as Claimant's Exhibit No. 1. It's my understanding those have been objected to by the defendants.

And it's my understand at the last proceeding I agreed with your position on those documents, Mr. Gallagher?

MR. GALLAGHER: Yes, sir. We objected on the ground that they were evidence that was generated after the original record that was before the Full

Commission order and ergo not relevant.

THE COURT: And as such, Ms. Mims, you're asking me to have these proffered in this file?

MS. MIMS: That is correct, Your Honor.

THE COURT: And I'm going to grant that request. Those documents will be proffered.

(PROFFERED CLAIMANT'S EXHIBIT NO. 1 WAS MARKED FOR IDENTIFICATION.)

THE COURT: The other thing I have is a photograph that's been submitted. That has been marked as Claimant's Exhibit No. 2.

(CLAIMANT'S EXHIBIT NO. 2 WAS MARKED FOR IDENTIFICATION.)

THE COURT: Mr. Gallagher, it's my understanding that you have no objection to that being admitted into evidence?

MR. GALLAGHER: That's correct.

THE COURT: And as such it is hereby admitted.

All right. Other than those items that we addressed, are there any objections to APAs, jurisdiction, venue or any other matter? Ms. Mims?

MS. MIMS: No, Your Honor.

THE COURT: Mr. Gallagher?

MR. GALLAGHER: No, sir.

1 **THE COURT:** Ms. Mims, are you trying this
2 case OR is Ms. Turner trying?

3 **MS. MIMS:** She's going to try the
4 claimant. I mean, questioning the claimant.

5 **THE COURT:** Okay. I'm not sure which one
6 you want me to address.

7 **MS. TURNER:** I'm just asking the
8 questions. Yes, sir.

9 **THE COURT:** All right. As I mentioned --
10 it's without objection the Commission file becomes a
11 part of the record with the exception of self-serving
12 declarations and unstipulated medical reports.

13 So Ms. Mims, regarding our conversation in
14 the pre-hearing conference, the record as a whole is
15 being made a part of this.

16 Also during the pre-hearing conference in
17 this matter there's been a lot of discussion. I
18 think this is the third time I've -- third or fourth
19 time I think we've been together on this matter.
20 This is, in fact, a remand from the Full Commission.

21 Again, the date of that remand order was
22 May 21st of 2018. The instructions from the panel to
23 me are very clear. And they are for me to determine
24 permanency on the compensable body parts and those
25 compensable body parts are defined by the panel in

1 Finding of Fact No. 1 in the Full Commission decision
2 and order. Those body parts include teeth, the
3 mandible, the left shoulder, the facial nerve and
4 scarring, if any, to the chin. That is the scope of
5 this proceeding today in accordance with that order.
6 There will be no other decisions or determinations
7 made in this proceeding.

8 MS. MIMS: Did you say the shoulder? I'm
9 sorry. Shoulder?

10 THE COURT: Left shoulder. I assume --
11 let me not assume. Should there be an appeal in this
12 matter to whatever decision that I make, I would
13 direct that appeal to go back to the original panel.
14 I think it's in the interest of judicial economy for
15 the same people that sent it down here to get it if
16 and when it should go back up.

17 Any difference of opinion on that?

18 MR. GALLAGHER: I would agree with that,
19 Commissioner.

20 MS. MIMS: I would agree with that.

21 THE COURT: Okay.

22 MR. GALLAGHER: Commissioner, and I'm
23 sorry. I didn't mean to interrupt you, but I just
24 don't want to complicate this thing any more
25 procedurally as well. But I do believe -- I don't

1 think the order says it specifically, but there is a
2 future medical issue as well with regard to hardware
3 appliances that she has as a result of these
4 injuries. I am prepared to stipulate to that. I
5 mean, it is what it is to that extent.

6 So I think under 42-15-60 even though the
7 remand instructions may not have specifically
8 referenced that, I do believe that any award of
9 permanency requires a finding on entitlement to
10 future medical. And like I said, a lot of it is
11 appliance hardware type stuff that would be...

12 **THE COURT:** Are there things other than
13 hardware?

14 **MR. GALLAGHER:** There are -- no, sir. Not
15 that I am stipulating to. I would agree that -- my
16 understanding is that she has some type of appliance
17 that was used to fix her jaw. So there's a
18 prosthetic appliance there. There's also dental
19 implants. So those two things I am definitely
20 prepared to stipulate to. I don't know if there's
21 anything else from the claimant's perspective that
22 they are seeking to add, but --

23 **THE COURT:** Well, as I am not instructed
24 to make a determination on that, I can certainly
25 accept a stipulation. But I don't think the Full

1 Commission order allows me the latitude of litigating
2 future medical beyond anything you might stipulate
3 to.

4 MR. GALLAGHER: I'm just prepared to
5 stipulate, too, just as a matter of simplicity and
6 not complicate anything further.

7 THE COURT: And then that's something if
8 y'all take it back up with the panel you're going to
9 have to address as well as the other issues that we
10 talked about the last time we convened.

11 MR. GALLAGHER: That might be all there
12 is. I don't know if there's anything else.

13 MS. MIMS: I assumed that we would go by
14 the 14B. She will need prosthetic maintenance and
15 replacement which she does every six months which is
16 beyond --

17 THE COURT: Yeah. He's conceding to that.
18 He stipulated to that.

19 MS. MIMS: He is?

20 MR. GALLAGHER: Yes. Yes.

21 MS. MIMS: I heard something -- I'm sorry.
22 And then there was -- the doctor with the shoulder
23 indicated there would be future medical care needed
24 for her left upper extremity.

25 THE COURT: In what form?

1 **MS. MIMS:** "Would need future medical care
2 related to his or her work-related injury or illness
3 based on a reasonable degree of medical certainty."

4 **MS. TURNER:** Physical therapy, I think is
5 what...

6 **MS. MIMS:** Physical therapy. I'm trying
7 to find the actual note.

8 **THE COURT:** Mr. Gallagher.

9 **MR. GALLAGHER:** Well, Commissioner, the
10 problem with any of these 14Bs is I don't know what's
11 possible and what's, you know, actually necessary.
12 You know, I know doctors will put the laundry list of
13 things that they may need possibly conceivably but
14 don't necessarily need them at this particular point
15 in time. So I don't know what the nature of that --
16 what the nature of that is.

17 **THE COURT:** Physical therapy.

18 **MR. GALLAGHER:** I have physical therapy.

19 **MS. TURNER:** Physical therapy.

20 **MR. GALLAGHER:** I don't know that anybody
21 is recommending anything now or has recommended
22 anything on her shoulder at this point. You know,
23 for the sake of not complicating this any further,
24 I'm going to just say I would -- if and when that
25 becomes necessary, I don't think we have a problem

1 with that.

2 THE COURT: So you'll stipulate --

3 MR. GALLAGHER: Limited to physical
4 therapy.

5 THE COURT: Which is what the form says.

6 MR. GALLAGHER: That's right.

7 MS. MIMS: That's what the forms say.
8 Yes. Thank you, Your Honor.

9 MR. GALLAGHER: Other than that, the rest
10 of the future medicals is fairly well-specified and I
11 think it's a little bit more concrete than that.

12 MS. MIMS: Well, if I may. Will the order
13 reflect what the treating doctors for the mouth, the
14 mandible, Larry Cobb's 14B and Dr. Ridgell? Will it
15 reflect what they -- what they have written in terms
16 of the maintenance procedures annually and --

17 THE COURT: Is it to the hardware?

18 MS. MIMS: Yes.

19 THE COURT: He's conceded to that.

20 MS. MIMS: Yeah. I know he's conceded to
21 that, but I just want it to be clear and also is the
22 maintenance. He's conceded to that as well.

23 THE COURT: Hardware including repair,
24 maintenance or replacement.

25 MS. MIMS: Because there's two different

1 doctors that were giving.

2 MR. GALLAGHER: I think they're
3 recommending the same thing. So I --

4 THE COURT: It's my understanding -- let
5 me just make sure I get this right. You're
6 stipulating that she's entitled to future medical
7 care in the form of repair, maintenance or
8 replacement of any hardware in accordance with
9 42-15-60?

10 MR. GALLAGHER: Correct.

11 THE COURT: And further stipulating that
12 she's entitled to the physical therapy for the left
13 shoulder if and when that becomes necessary?

14 MR. GALLAGHER: Correct.

15 THE COURT: Did I cover it?

16 MS. MIMS: Well, you know, it just -- it
17 goes into a little bit more detail. "Replace or
18 refurbish appliances every six to eight years. Oral
19 surgeon visit five years for --

20 THE COURT: If it has to do with the
21 hardware, it's covered --

22 MS. MIMS: Then we're fine.

23 THE COURT: -- under the stipulation.

24 MS. MIMS: Okay.

25 THE COURT: And you've got that on the

1 record.

2 MS. MIMS: Thank you.

3 THE COURT: And Mr. Gallagher has conceded
4 to that.

5 MS. MIMS: Thank you.

6 THE COURT: Have you not, Mr. Gallagher?

7 MR. GALLAGHER: I have.

8 THE COURT: Thank you. Anything else?

9 MS. MIMS: I don't. Nothing else.

10 THE COURT: All right. Ms. Cox, would you
11 raise your right hand, please.

12 JENNIE COX,

13 AFTER HAVING BEEN DULY SWORN TO TELL THE TRUTH,
14 TESTIFIED AS FOLLOWS:

15 THE COURT: Please state your full name
16 for the record.

17 THE WITNESS: Jennie Kay Cox.

18 THE COURT: Ms. Turner.

19 You're going to need to keep your voice up
20 a little bit. Okay?

21 THE WITNESS: Okay. I'll try.

22 THE COURT: If you can. If you can.

23 Okay. Ms. Turner.

24 MS. TURNER: Thank you, Commissioner.

25 DIRECT EXAMINATION

1 **BY MS. TURNER**

2 Q. Ms. Cox, how old are you?

3 A. Sixty-five.

4 Q. Okay. Tell me about your educational or
5 tell the Commissioner about educational background.

6 A. Graduated high school. Took some classes
7 at Greenville Tech and went to truck driving school.

8 Q. And went to?

9 **THE COURT:** Truck driving school.

10 **THE WITNESS:** Truck driving school.

11 **BY MS. TURNER**

12 Q. Okay. And what was your first job after
13 you graduated high school?

14 A. I worked at Her Majesty in Mauldin in a
15 sewing factory.

16 Q. Okay. What kind of facility is that?

17 A. Sewing factory for children's garments.

18 Q. Okay. Do you remember how long you worked
19 in the textile industry?

20 A. Off and on several years.

21 Q. Okay. You don't remember exactly how
22 long?

23 A. No.

24 Q. Okay. When did you get into the truck
25 driving industry?

1 A. In -- I'm trying to think of what year.
2 Every one they redone '85 up there.

3 Q. Okay.

4 A. It was in the '80s.

5 Q. Do you think it might have been around
6 1985?

7 A. I don't remember the exact date.

8 Q. Okay. Well, since you started driving
9 trucks, have you pretty much exclusively done that --

10 A. Yes.

11 Q. -- to make a living? Okay. At any time
12 have you done any like kind of office work, sedentary
13 things, anything like that?

14 A. On rainy days I might answer the phone at
15 one of the companies I worked for. Other than that,
16 no.

17 Q. Okay. Prior to May 31st of 2012, had you
18 ever been injured on any job you've ever had?

19 A. No.

20 Q. Okay. And by May 31st of 2012 about how
21 long had you been employed at Palmetto if you
22 remember?

23 A. I think it's about ten years. Not
24 positive but I think that's about...

25 Q. Okay.

1 A. Nine or ten.

2 Q. Tell me what happened on May 31st of 2012.

3 A. I run teams and we'd run down to Atlanta
4 and pick up some more freight going to Brownsville,
5 Texas from Kemet. And then we go to --

6 **THE COURT REPORTER:** A little louder,
7 please, ma'am.

8 **BY MS. TURNER**

9 Q. You are very soft-spoken.

10 A. It's hard for me to talk real loud.

11 Q. You might want to get a little closer --

12 **THE COURT:** I don't think the microphone
13 even works.

14 **MS. TURNER:** Don't worry about sitting
15 close to that then.

16 **THE COURT:** Speak up.

17 **BY MS. TURNER**

18 Q. Well, I think she said she's got some --

19 A. No. It's just hard for me to talk louder.
20 I can't even yell at the kids no more.

21 (Laughter.)

22 **THE WITNESS:** But anyway, we were loading
23 the freight onto the trailer and getting ready to
24 load it and we had to offload some. And when I did a
25 machine that was real heavy fell on top of me and

1 pinned me to the dock.

2 **BY MS. TURNER**

3 Q. While you were on the back of the truck?

4 A. No. It was on the dock.

5 Q. Okay. All right. Do you remember the
6 machine falling on you?

7 A. No.

8 Q. Okay. What is the next thing you remember
9 after standing on the dock?

10 A. I woke up. I came to. I guess I woke up.
11 I come to. And all I seen was blood and I was like
12 "Why am I looking at blood?" And I wasn't breathing
13 and I caught my breath and took a deep breath. And I
14 seen the blood and I was like "This is my blood."

15 So I was flat out on the floor and my
16 co-driver was signing the bills and I couldn't --
17 couldn't yell or nothing. So I tried to push myself
18 up and I couldn't get up. So I finally got up --
19 raised up enough to just move my head a little --
20 about this much (indicating) off the floor. And I
21 seen my co-driver signing the bills and he happened
22 to look. And I remember the look on his face was
23 like, oh, my gosh. And he started running to me and
24 I put my head back down. And I couldn't tell all
25 these teeth and where the blood was coming from and I

1 couldn't breathe. And I kept telling him I can't
2 breathe. I'd keep passing out and I'd come to and I
3 wasn't breathing. And I said, "Roll me over so I can
4 breathe." And they said, "No, we can't." And I
5 said, "You've got to. I'm going to die."

6 So they rolled me over and I asked -- I
7 remember asking to call my -- to call work. And I
8 remember somehow giving my dispatcher my -- Sonya's
9 number to let my kids know I was hurt.

10 Q. Sonya is your daughter?

11 A. Yeah. And the next thing I know is guys
12 rolling me over and I was like, "Please stop." And
13 it was the ambulance, the ambulance people. And he
14 said, "I'm going to roll you." And I said, "No,
15 don't move me. Please just don't move me." And he
16 said, "I've got to." So undoubtedly they gave me
17 another one of them shots and from then on I don't
18 know where I was at.

19 Q. Okay. Things got a little better after
20 the shot?

21 A. Oh, yeah. I do remember coming to but
22 don't know where I was at. They hadn't gave me
23 another shot and the pain was so bad, but then one of
24 the guys at the desk seen me and he come running and
25 told me, "Jennie, Ms. Cox, you can't do this." I was

1 like "I'm hurting, man." And then he popped that
2 shot in there again and I was gone again. And the
3 next thing I know, I wake up somewhere else.

4 Q. Okay.

5 A. I remember them trying to get an earring
6 off my ear and that woman had gotten mad at the guy.
7 And I was coming --

8 Q. Because he didn't know how to take off an
9 earring?

10 A. He couldn't get it off and that woman come
11 over there and I thought she was going to pull my
12 earlobe off. But they knocked me out when they done
13 that when they --

14 Q. Okay.

15 A. -- pulled on that ear.

16 Q. What hospital did you end up at?

17 A. I was told I was at Brady. No, Grady.
18 Not Brady. Grady. That's what I was told once I --

19 Q. In Atlanta?

20 A. Uh-huh.

21 Q. Okay. Did you learn while you were at
22 Grady --

23 A. No.

24 Q. What do you remember about the injuries
25 that you -- that you actually suffered? Like do you

1 remember what you were told had happened to your --

2 A. I wasn't told nothing.

3 Q. -- jaw?

4 A. I remember -- I don't remember riding to
5 Greenville. I don't even remember arriving there.
6 But I know a doctor come in and he's saying stuff to
7 me. And I finally told him. I said, "You're a
8 little grumpy, ain't you?" Of course, I wasn't
9 grumpy because I was very heavily sedated.

10 Q. Yes, ma'am.

11 A. And he patted my arm and I said, "Man, I'm
12 hurting." And he patted my arm and then he said,
13 "I'm fixing to fix you up," and he did.

14 Q. Okay.

15 A. And to this day I still thought I seen my
16 other daughter cause they -- I thought they was
17 putting me on an elevator and they was forgetting my
18 daughter. And she says, "Mom, that never happened."

19 Q. Okay.

20 A. So I guess it's kind of like drugs real
21 bad. Real good drugs.

22 Q. Depend on how you look at it. Yes, ma'am.
23 Okay. So did you have the surgery?

24 A. Yeah, but I was never allowed to come to
25 till after that surgery.

1 Q. Okay. When you're talking about surgery,
2 what surgery did you have?

3 A. That's when they put -- my left jaw was
4 broken right here (indicating).

5 Q. Okay.

6 A. And it had two -- it had -- it's got a rod
7 in it now but it had a plate on each side of that rod
8 which has been taken out because it got infected at
9 two different times.

10 Q. Okay. That was sometime later in your
11 treatment that --

12 A. Right.

13 Q. -- the infection happened?

14 A. At that day. And my mouth was wired shut
15 and I -- you know, I was still drugged up pretty
16 good. And I asked that doctor. I said, "What can I
17 eat?" He said, "You ain't going to eat nothing."
18 And I said, "I can't eat?" And he said, "No, your
19 mouth is wired shut." I said Okay. You know, I
20 could have only liquids for a month. And I sit on
21 Sonya's porch and every day I cried. Every night she
22 would find me sitting out there crying when she'd
23 come see me. And then she said, "Momma, what's
24 wrong?" I said, "I want to go back to work." And
25 she said, "Momma, you know you can't go." I said, "I

1 know but that's my life."

2 Q. Yes, ma'am.

3 A. And I never gave up on that hope. That
4 was what I wanted. I'd go in a restaurant and the
5 food smelt so good. Sonya would put some on the tip
6 of a spoon for me to swallow but nothing, you know.
7 I learned to like milkshakes.

8 Q. Yes, ma'am. Okay. Prior to the accident
9 do you remember how many teeth you had right before
10 this accident happened?

11 A. Had most of my teeth.

12 Q. Most of them. You don't remember exactly
13 how many?

14 A. Huh-uh.

15 Q. Okay. We've entered a picture into
16 evidence. Are you aware of whether or not the
17 machine falling on you itself at that time, did that
18 knock some of your teeth out?

19 A. All of them in that picture it took out.

20 Q. Okay. Let me show you the picture. Is
21 this a representation, an accurate representation of
22 what your mouth and teeth looked like after the
23 accident?

24 A. As far I -- I couldn't tell you because I
25 was under so much anesthesia.

1 Q. Okay. But this is after the accident and
2 not before?

3 A. Yes. Sonya and them took those at the
4 hospital.

5 Q. All right.

6 A. And all of them had to be removed --

7 Q. Can you...

8 A. -- to get in there.

9 Q. Can you count and say for the record just
10 how many teeth you can actually see in this picture?

11 A. One, two, three, four, five, six. Six of
12 them.

13 Q. You only see six? Let's count together.

14 A. I think it's one, two, three, four, five,
15 six.

16 Q. Wait. What are these?

17 A. I guess that's a tooth. I don't know.

18 Q. Okay. Well --

19 A. What side of the jaw is that? That's the
20 right side?

21 Q. Right. Well, okay.

22 A. That's the left side.

23 Q. That's fine. I count 13.

24 **MR. GALLAGHER:** That's quite a difference.

25 **MS. TURNER:** I know.

1 **THE WITNESS:** But then he had to remove
2 the teeth for this jaw to start -- well, I guess they
3 were knocked out, though.

4 **BY MS. TURNER**

5 Q. But some of them were knocked out. In
6 that picture some of your teeth had already been
7 knocked out, but they were still -- at that point you
8 still had at least as many teeth as are in that
9 picture after the accident?

10 A. (No verbal response.)

11 Q. Okay. Were those teeth -- did you get to
12 keep those?

13 A. No.

14 Q. Okay. What happened as a part of your
15 treatment to the teeth that were remaining even after
16 the ones that were initially knocked out?

17 A. Once Dr. Fowler done my surgery, there
18 wasn't no teeth left.

19 Q. So they had to pull all of your teeth?

20 A. Yeah.

21 Q. Did they tell you why they had to or do
22 you know why they had to pull all of your teeth out?

23 A. He took out -- he never did -- I don't
24 know. No, I don't. He never said. He just -- all I
25 know is they -- one of the pictures -- I don't know

1 if y'all have it or not. It's right here
2 (indicating) where this hit the -- undoubtedly hit
3 the dock because the bone's showing. And when it
4 broke this (indicating) part, he had to take teeth
5 out to be able to get in and it -- he done the
6 surgery I guess from here (indicating) up.

7 Q. Okay. And you're indicating your lower
8 left jaw?

9 A. Yeah.

10 Q. Okay.

11 A. And I can tell it's there because the
12 nerve damage is -- because a feather can go across it
13 and you can feel it. I know it's there. The wind
14 bothers it even.

15 Q. Okay. And do you still have a scar on
16 your chin bone from the accident?

17 A. I don't know if you can see it but I feel
18 it right there (indicating).

19 MS. TURNER: Okay. I don't know if you
20 would want her to approach the bench so that you
21 could see the scar.

22 THE COURT: I do want to see the scar.
23 Let me walk to you. Show me where it's at.

24 THE WITNESS: Right there (indicating)
25 right where it was -- the bone is showing on the

1 pictures.

2 THE COURT: All right.

3 THE WITNESS: And then right here is where
4 it was broke. And that's where he had -- he had to
5 go back in and -- he took one plate out and then the
6 next one because it -- I called him from Brownsville,
7 Texas and told him it was itching really bad and it
8 was oozing stuff. And when I got back to Greenville
9 I had an appointment with him and a surgery
10 appointment. And he said no, it's got to come out
11 and he said it's infected.

12 THE COURT: All right. Thank you.

13 BY MS. TURNER

14 Q. Okay. Now, were you eventually fitted
15 with a prosthetic with implants or dentures? Tell
16 the Commissioner about what you received in order
17 to -- by way of dentures or implants.

18 A. I got implants. And the reason they -- I
19 can't eat right with them but thank God I'm where I'm
20 at. Because my jaws were not lopsided he had to
21 reline my jaws and with the break made it even worse.
22 And so that's why they went with these because they
23 had to be specially made to try. And they done a lot
24 of trying to try to align my teeth up.

25 Q. Okay.

1 A. And I mean like go to a regular dentist
2 and get implants and you can eat fine. But right
3 here (indicating) this was so sore the rest of my
4 life.

5 Q. Okay. Were you able to get all of your
6 teeth implanted?

7 A. Yes. They on studs. They're on metal
8 studs.

9 Q. Okay. How many actual implanted teeth do
10 you have?

11 A. All of them.

12 Q. Okay. Are some of them removable?

13 A. No. Yeah. I can take the top plate out.
14 I can't --

15 Q. That's what I mean.

16 A. Yeah. I can take this out. I have to to
17 clean it.

18 Q. Okay.

19 A. And these here (indicating), I have to
20 take little brushes and keep them brushed because
21 food gets underneath them and especially on this side
22 here (indicating) because it's raised up higher.
23 Because there wasn't as much bone structure here
24 (indicating) as there was there. Fowler is actually
25 a person that does cosmetic surgery on you too. So I

1 was lucky in that deal.

2 Q. Okay. Now, you said that you can take the
3 top in and out, the top dentures --

4 A. Uh-huh.

5 Q. -- in and out?

6 A. Yes, ma'am.

7 Q. Why weren't those done as implants?

8 A. They don't do the top.

9 Q. Okay.

10 A. And I don't know anyone that's ever had
11 them done that can't take the tops out.

12 Q. Okay. Well, tell the Commissioner about
13 the -- you said you had some nerve damage to your
14 face; is that right?

15 A. Yeah. Well, yeah. Where this bone...

16 Q. What symptoms do you continue to have as
17 far as that's concerned?

18 A. I mean, it hurts but this right here
19 (indicating) is where the nerves are.

20 Q. Okay. Any numbness?

21 A. Feels like you put a lot of bubble gum in
22 them, you know. It's not numb. But, you know, it's
23 hard to sleep on it. So I have to keep -- have to
24 sleep on the couch most of the time. I have to get
25 on the other end.

1 Q. Okay. Do you feel like the injuries to
2 your mouth, teeth and jaws and the nerve damage has
3 affected your speech pattern --

4 A. Yes, ma'am.

5 Q. -- at all? Okay. What's it done as far
6 as your ability to speak clearly?

7 A. It's just hard to talk.

8 Q. Okay. And what about your left shoulder?
9 What were you experiencing right after the accident
10 as far as that's concerned?

11 A. I remember -- like I said, I kept telling
12 him don't -- don't move me. Just don't move me. And
13 it was just on this side (indicating) all the way
14 down. It's not just my shoulder. It's in the
15 muscles more. And they gave me -- I did go to
16 physical therapy the workers' comp place and they had
17 me to rub around. Because I didn't realize it until
18 I got home when I went to put a jug a tea in the
19 refrigerator and I couldn't pick it up.

20 Q. Okay.

21 A. And because at Sonya's they wouldn't let
22 me pick up nothing with my mouth wired shut. I
23 wasn't able to do a whole lot of nothing. And they
24 gave me the physical therapy after the -- they let my
25 mouth open. And, you know, I had to go do the wall

1 and push a sled. It wasn't real heavy. And I done
2 that for a few weeks.

3 Q. Okay.

4 A. And then that was it with them doctors.

5 Q. How about now, Ms. Cox? As we sit here
6 today, are you still having any symptoms? Any
7 painful symptoms in your shoulder?

8 A. Yes, ma'am. I take a CoQ10 for it.

9 Q. Okay. Are there some things that you feel
10 like you were able to do before the accident that
11 you're no longer able to do due to the injuries you
12 had in the accident?

13 A. Yeah.

14 Q. Tell the Commissioner about some of those
15 things that you're not able to do anymore. You
16 mentioned lifting a jug of tea was difficult in the
17 days following the accident. Can you do that
18 anymore?

19 A. It's hard for me to do a whole lot of
20 work. Because I'd get home from a run and I could go
21 out and mow my grass and I felt good. But after
22 this, you know, I've got to stop and either I rub it
23 down with something or, you know, once it gets to
24 hurting. And it hurts really bad.

25 Q. Okay.

1 A. Not just a little bitty hurt. It's a bad
2 one and it'll bring you to tears. But all up in here
3 (indicating) hurts and I do keep stuff to rub on it.

4 Q. Okay. And when you say all up in here
5 (indicating) hurts, you're indicating your clavicle
6 area up into --

7 A. I don't know what you call it. This
8 muscle up in here (indicating) and down this.

9 Q. Yeah. I was just trying to describe it
10 for the court reporter. But okay. The left shoulder
11 area?

12 A. Yeah.

13 Q. Okay. Does the symptoms that you continue
14 to have from the accident, does it affect your
15 ability to sleep at all?

16 A. I take sleep medicine.

17 Q. Okay. And are you able to sleep
18 comfortably on your left side?

19 A. On my right side I am. Not on the left.

20 Q. Why can't you sleep comfortably on your
21 left side?

22 A. Because it's... It's all twisted up.

23 Q. Okay. All right. Now, prior to this
24 accident were you -- and the work that was done on
25 your teeth, were you able -- did you have any

1 restrictions at all on what you were able to eat?

2 Were you able to eat anything that you wanted?

3 A. Yes.

4 Q. You were able to eat anything that you
5 wanted without any restrictions?

6 A. Yes, ma'am.

7 Q. Okay. And are you still able to do that?

8 A. No. No.

9 Q. Typically, what kind of foods are you able
10 to eat now with your prosthetic?

11 A. A lot of soft foods. A lot.

12 Q. Okay.

13 A. I can't -- it's hard to chew steak because
14 it wads up in my mouth when -- I'm afraid I'm going
15 to get chocked on it and I ain't even tried pork.

16 Q. Okay.

17 A. I eat a lot of chicken, baked chicken and
18 grilled chicken.

19 Q. At one point during your recovery and
20 treatment during the course of this litigation do you
21 remember attending what is called work-hardening?

22 A. Yes.

23 Q. Okay. During that process where you were
24 attending work-hardening did you give your very best
25 efforts during that --

1 A. Yes, I did.

2 Q. During that time? Okay. Do you feel like
3 the work-hardening fixed the problems that you were
4 having when you went in?

5 A. Nope.

6 **MS. TURNER:** Okay. Could I have just a
7 moment?

8 **THE COURT:** Certainly.

9 **BY MS. TURNER**

10 Q. Going back to the weeks that followed your
11 accident let's say -- or the time period that
12 followed your accident, did there come a time when
13 you were asking your employer to send you for
14 additional treatment?

15 A. Yes.

16 Q. Okay. And do you remember what time frame
17 that was?

18 A. I don't remember the dates. No.

19 Q. Okay. Did your employer send you up when
20 you requested?

21 A. No.

22 Q. Okay. Did you seek any kind of self-help
23 at that point?

24 A. Yes. I went to the Life Center at
25 Greenville Memorial.

1 **THE COURT:** Say that again, ma'am.

2 **THE WITNESS:** I went to the Life Center.

3 **BY MS. TURNER**

4 Q. And you did that on your own?

5 A. Yes.

6 Q. Okay. Why did you do that?

7 A. Because I was trying to get my strength
8 back.

9 Q. Okay. All right. And was that program
10 helpful?

11 A. Yeah.

12 Q. Did it continue or did you continue to
13 have the benefits of that program after you stopped
14 going?

15 A. No. I had to pay for it out of my pocket.

16 Q. And is that why you stopped going is
17 because it got too expensive?

18 A. No. It was because I didn't get no
19 financial help.

20 Q. Okay. All right. Now, there also came a
21 time when -- or did there come a time when you
22 just -- when you felt like you weren't able to
23 continue working?

24 A. Yeah.

25 Q. Okay. Had you sought any treatment or

1 help from your family doctor at that time, your
2 regular doctor? I think Dr. Ellis is it?

3 A. Yeah.

4 Q. You had?

5 A. No. I hadn't talked to her about nothing.

6 Q. During the entire course of your work?
7 Why did you stop --

8 A. Yeah. She knew I got hurt.

9 Q. I'm sorry?

10 A. She knew I got hurt.

11 Q. Okay. There's been some -- well, never
12 mind. When you stopped going to work, why did you
13 stop going to work?

14 A. I went and seen my doctor and I didn't
15 weigh but 92 pounds. 95 pounds.

16 Q. Okay.

17 A. And that's why I told Palmetto State I
18 couldn't do it.

19 Q. Okay.

20 A. And they said they wouldn't help me.

21 Q. All right. Again, you weren't able to get
22 your employer to send you back to the doctor at that
23 point?

24 A. No, ma'am. He wouldn't send me back.

25 Q. Okay.

1 A. They said workers' comp denied it.

2 Q. All right. One more second. I'm sorry.

3 On and off you worked for a good period of time after
4 your injury; is that right?

5 A. Yes.

6 Q. You did go back?

7 A. I did go back at first. Yeah.

8 Q. Okay. Were there times that were
9 interrupted where you had to go and get surgeries or
10 medical treatment that interrupted your --

11 A. Yes. As a matter fact, Dr Newsom is the
12 one that released me to go back to work. And I told
13 her. I said, "Dr. Newsom, they got more surgeries to
14 do." And she said that's not my problem.

15 Q. Okay. Dr. Newsom treated you for what?

16 A. Really, I don't know. I guess...

17 Q. Was it --

18 A. That's who they sent me to.

19 Q. But Dr. Newsom sent you -- she was
20 treating your shoulder injury; is that -- does that
21 sound right?

22 A. Yeah. She's the one that recommended --
23 sent me to their therapist.

24 Q. Okay. All right. I'm sorry, Ms. Cox. I
25 neglected to ask you this in the beginning. Could

1 you describe for the Commissioner what your job
2 duties consisted of as -- what kind of things you had
3 to do while you were driving for Palmetto State.

4 A. We went to Brownsville twice a week and --

5 Q. Brownsville, Texas?

6 A. Texas. I assume everybody knows where
7 Brownsville is. I'm sorry. And you always got to
8 make sure your load is secure and make sure it's
9 placard. You have to hook them, drop and hook down
10 at the other end at Brownsville. And you got to pull
11 the lever to unhook, roll down the legs when you do
12 that and then opening and closing doors. Sometimes
13 the doors are really hard to shut on some of the
14 trailers that's older or brand new. Because they
15 don't want to get in there tight because they ain't
16 been used. But you have to take a crowbar sometime
17 and raise them up. And a lot of stuff with the
18 freight going on. So it's -- you know, make sure all
19 your tires are pumped up and ready to roll. Pulling
20 the hood over to check or holding stuff in it. So,
21 you know, it's still a job that you're doing.

22 Q. All right. Now, immediately prior to your
23 accident were you able to do all those things?

24 A. Yes, ma'am.

25 Q. Okay. After your accident when you did

1 eventually tried going back to work, were you able to
2 do all those things by yourself still?

3 A. No, ma'am.

4 Q. Okay. How did you manage to get those --

5 A. Well, once the...

6 Q. -- accomplished?

7 A. Once the Brownsville run ended, you run
8 what they call a wild run and you never knew where
9 you were going. And like one of the co-drivers,
10 he -- at the last minute he laid out -- well, he
11 didn't lay out. He just said he had to go because he
12 had had a death in the family. And so they didn't
13 have nobody else to run the California run, so I had
14 to run it by myself.

15 Q. Okay. Just to make sure that the
16 Commissioner understands because I know we've been
17 dealing this case for a long time. But what you're
18 saying is that prior to that time you usually ran
19 with two drivers when you did --

20 A. Yes.

21 Q. -- your runs? You usually ran with two
22 drivers and there came a point when somebody laid out
23 and you had to do what would normally be a two-person
24 run with a single?

25 A. Yes.

1 Q. Just by yourself? Okay.

2 A. They do have single runners that run out
3 there but normally it's a team. And then I really
4 knew that I couldn't do it anymore when I'd run the
5 two New Jersey runs by myself up to Jersey. And I'd
6 run the first one and come back. And they said,
7 "Jennie, we need you to take another one." And I
8 said, "Boys, I'm just wore out. I can't do it." And
9 they kept on and on and I was the one they were
10 calling and people that they depended on and they
11 kept on and on. And I said, okay. I said, I'll run
12 it. And I said but I'm telling you I'm tired. And I
13 got it back because it was another man's truck and he
14 was getting ready to go out on his run. So I had to
15 get the truck back and the trailer so he could go out
16 on his run. And that's -- I was so worn out I
17 couldn't go no more. That was it.

18 Q. How did you manage to get like the hooking
19 and the -- all that physical activity that you were
20 able to do before your accident, how were you able to
21 get that done --

22 A. A lot of time...

23 Q. -- after your accident?

24 A. A lot of times at night when I'd come in
25 there wasn't nobody on the yard. I'd usually get one

1 of the men to pull it for me. But a lot of times --
2 and they shut the doors for me there sometimes
3 because I couldn't get them to shut.

4 Q. Okay.

5 A. So one of the leasing companies up past
6 us, I walked up there and they would come down there
7 and pull the pin for me. And they asked me. They
8 said, "Jennie, why are you doing this?" I said,
9 "Man, I hate not to work." I said, "I really do."
10 And those boys would testify in court that if they
11 come down there and I'd skin my knuckles up. One
12 time I had blood everywhere. But I didn't want to
13 give my job up but I had to.

14 Q. Okay. In any capacity at all have you
15 worked since 2016?

16 A. No.

17 Q. Okay. Do you feel like at this point you
18 would be able to ever work as a truck driver again?

19 **MR. GALLAGHER:** I'm going to object,
20 Commissioner. I don't think it's relevant.

21 **THE COURT:** Ms. Turner.

22 **MS. MIMS:** I certainly think that it's
23 relevant whether she can still do her job or not,
24 but --

25 **THE COURT:** I'll allow it. Please

1 proceed.

2 THE WITNESS: No. I can't.

3 THE COURT: Anything else, Ms. Turner?

4 MS. TURNER: I think that's all. Thank
5 you.

6 THE COURT: Mr. Gallagher.

7 CROSS-EXAMINATION

8 BY MR. GALLAGHER

9 Q. Ms. Cox, you mentioned earlier that the
10 fall actually -- you actually lost some teeth in a
11 fall and then you actually had to have some other
12 teeth extracted later in order to repair your jaw; is
13 that correct?

14 A. I guess because I -- I was so drugged up.
15 No way -- I don't remember none of it. You would
16 have to ask Sonya and Tammy what happened and my
17 sister.

18 Q. To your knowledge did all the teeth that
19 you lost as a result of this accident whether it be
20 teeth that were knocked out from the initial accident
21 or teeth that later had to be extracted to repair
22 your jaw, were those subsequently replaced with
23 implants?

24 A. Yes. There was -- when I came aware of
25 where I was at at Greenville Memorial, I did not know

1 until they got ready to send me home the next day
2 that I didn't have no teeth in here. That he had
3 extracted them all during surgery.

4 Q. And subsequently the doctor replaced all
5 those teeth with implants; correct?

6 A. Yes.

7 Q. And Dr. Cobb was involved with that?

8 A. Yes.

9 Q. Dr. Cobb's records indicate --

10 **MR. GALLAGHER:** This is APA 454 and 455
11 for the record, Commissioner.

12 **BY MR. GALLAGHER**

13 Q. -- that you have implants at 20 and 23,
14 25, 27, and 30, at Number 3, Number 5, Number 6,
15 Number 11, Number 12 and Number 14. That's 11 teeth
16 you have implants. Do you --

17 A. I don't understand that.

18 Q. Is that your understanding was the number
19 of teeth --

20 A. I don't know.

21 Q. -- that you lost?

22 A. I don't know.

23 Q. You mentioned earlier something about 13
24 teeth in the picture and you testified that --

25 **THE COURT:** Mr. Gallagher, that's

1 misrepresentation. She said six. Ms. Turner said
2 13.

3 **MR. GALLAGHER:** Okay. All right. I won't
4 ask that question.

5 **BY MR. GALLAGHER**

6 Q. So Dr. Cobb says you have 11 implants as a
7 result of your accident. Then would you also agree
8 that that's how many teeth you lost as a result of
9 this accident?

10 A. All I know is I didn't have a tooth in my
11 head when I finally -- one night when Sonya and them
12 was asleep I snuck in the bathroom and I opened my
13 mouth a little bit and pulled my lip down and all I
14 seen was something white down here and I panicked and
15 I said, "Oh, God, I got an infection." And so I
16 asked the doctor about it and he said, no, that's got
17 your mouth. He said that's not infection. That's
18 where you're sewed up.

19 Q. Okay.

20 A. So I don't -- I didn't have any teeth --
21 they didn't pull anymore after -- once my mouth was
22 wired shut, nobody else pulled nothing. They done a
23 lot of surgery on the gums. Doctor...

24 Q. You were missing teeth before this
25 accident; correct?

1 A. Oh, yeah. I was missing a few. Not the
2 whole mouth full. I could eat.

3 Q. Okay. I'm just trying to pin down how
4 many teeth you lost as a result of this accident.
5 There seems to not be a real clear answer to that.

6 A. That seems to have been a problem the
7 whole time. But I wish that I could tell you but I
8 can't.

9 Q. Okay. But you would have to defer to what
10 the doctor's notes say about the number of teeth that
11 were actually replaced with implants; correct?

12 A. Yeah. I guess because I got a mouth full
13 of them.

14 Q. Okay. You got a mouth full of implants?

15 A. Yeah, I do. But implants they're not
16 implanted a tooth at time. It's like this whole
17 plate and then there's a certain amount of studs in
18 here that they snap to. Now, the bottom one I
19 couldn't tell you how much. But they had to work
20 around this broken part right here (indicating).
21 Because you cannot put the rod -- it makes sense that
22 you could not put the rod down through this metal
23 right here (indicating) because these will grow
24 probably into my bones now, my jaw bones. Does that
25 make sense?

1 **THE COURT:** Uh-huh.

2 **BY MR. GALLAGHER**

3 Q. Other than the teeth you obviously have an
4 impairment to your jaw with regard to your ability --

5 A. Yeah.

6 Q. -- to chew; correct?

7 A. Yeah.

8 Q. You said earlier you have some facial
9 numbness right there around the site of your --

10 A. It's not numb. It just feels like that --
11 you know, if I pinch it, I can't really tell I'm
12 pinching it. But now I can do like this (indicating)
13 and I can do it to the facial hairs. It's like
14 needles sticking in it.

15 **MR. GALLAGHER:** Commissioner, I didn't
16 hear your description for the record on the scarring.
17 I don't know if you --

18 **THE WITNESS:** Do you want to see?

19 **BY MR. GALLAGHER**

20 Q. But you have some scarring on your chin;
21 is that right?

22 A. Right there (indicating) is where the
23 plates were that he had to remove.

24 **THE COURT:** The scarring to me is barely
25 visible.

1 MR. GALLAGHER: Okay.

2 THE WITNESS: Yeah.

3 BY MR. GALLAGHER

4 Q. Is that a surgical scar or is that from
5 where --

6 A. This is a surgical. This one right here
7 (indicating) is where the bone was showing. Do y'all
8 not have the pictures of the bone right there?

9 Q. So you have two scars? You have scarring
10 from the surgical site and then you have some
11 scarring from the actual injury itself; is that
12 correct?

13 A. Yeah.

14 MR. GALLAGHER: All right. That's all the
15 questions I have of Ms. Cox.

16 THE COURT: Anything further, Ms. Turner?

17 REDIRECT EXAMINATION

18 BY MS. TURNER

19 Q. Ms. Jennie, did you have more than 11
20 teeth before this accident?

21 A. I was pretty sure I did, but I couldn't
22 swear on the bible on it.

23 MS. TURNER: Okay. Thank you.

24 THE COURT: Mr. Gallagher, anything else?

25 MR. GALLAGHER: No, sir.

1 **THE COURT:** You may step down, ma'am.
2 Thank you very much.

3 Any other witnesses on behalf of the
4 claimant? Are you calling anybody else?

5 **MS. TURNER:** We're going to call Ms. Cox'
6 daughter, Sonya.

7 **THE COURT:** And what is the purpose of the
8 testimony?

9 **MS. TURNER:** It will be corroborative of
10 Ms. Cox' testimony regarding her ability to perform
11 and also --

12 **MS. MIMS:** We'd call Sonya Cantrell.

13 **THE COURT:** Mr. Gallagher.

14 **MR. GALLAGHER:** Commissioner, if it's just
15 corroborative, I don't know that it's really
16 necessary or relevant. I mean, I would stipulate she
17 would corroborate what her mother testified to about
18 these injuries.

19 **MS. COX:** Well, she knows more than I do
20 about it.

21 **MR. GALLAGHER:** Well, she may have more
22 knowledge of the history of it, but I'm not sure
23 that's really relevant inquiry here today.

24 **THE COURT:** How is it going to relate to
25 permanency?

1 **MS. TURNER:** That's it. It's just
2 corroborative. It's corroborative testimony. Yes.

3 **MS. MIMS:** Well, she certainly know about
4 her mother's mouth and her teeth. It was more
5 than...

6 **MS. TURNER:** Okay.

7 **MS. MIMS:** I believe it was more.

8 **MS. TURNER:** Yeah. We'll call her then
9 for that purpose. Sorry.

10 **THE COURT:** All right. Let's limit the
11 testimony to that.

12 Raise your right hand, please.

13 **SONYA CANTRELL,**
14 AFTER HAVING BEEN DULY SWORN TO TELL THE TRUTH,
15 TESTIFIED AS FOLLOWS:

16 **THE COURT:** Please state your full name
17 for the record.

18 **THE WITNESS:** Sonya Cantrell.

19 **DIRECT EXAMINATION**

20 **BY MS. MIMS**

21 Q. Ms. Cantrell, what is your relationship to
22 Jennie Cox?

23 A. I'm her daughter.

24 Q. And how old are you, Ms. Cantrell?

25 A. Forty-seven.

1 Q. So I'm assuming you've known her quite
2 some time?

3 A. Uh-huh.

4 Q. And you knew her May 31st, 2012; is that
5 correct?

6 A. Uh-huh.

7 Q. And I believe you went down to --

8 A. Atlanta.

9 Q. -- Atlanta when she got injured?

10 A. Uh-huh.

11 Q. And let me ask you. There's some
12 question. The records are not totally clear. Your
13 mom is not clear. She had teeth in her mouth before
14 this injury; is that correct?

15 A. Yes.

16 Q. Was she being treated for any damage to
17 her teeth or anything like that as you know?

18 A. Not that I'm aware of.

19 Q. And what would be your testimony to this
20 Commissioner as to teeth that she had in her mouth?
21 I mean, do you have any idea how many she lost? Was
22 there any conversation in Atlanta when you went down
23 to Grady Hospital as to the teeth or anything like
24 that?

25 A. Huh-uh. No.

1 Q. And you've seen the pictures. I think you
2 took the pictures of your mother?

3 A. I took the pictures. Uh-huh.

4 Q. And what would be your testimony as to how
5 many teeth she has lost since this injury on
6 May 31st, 2012?

7 A. Guessing or?

8 Q. Based on what your knowledge of your mom.

9 A. By my knowledge? I mean, she had -- she
10 had a good decent amount of teeth in her mouth. I
11 mean, she could eat, talk, you know. I mean, she...

12 Q. Well, did she have any missing teeth in
13 the front --

14 A. Yes.

15 Q. -- her upper? She had missing teeth
16 before the injury?

17 A. Before the accident? No.

18 Q. No. That's my point. What about the
19 lower? Did she have any missing teeth?

20 A. In the front? No.

21 Q. No.

22 A. Huh-uh.

23 Q. Okay. And, of course, you know what your
24 mom has been through I believe through this period of
25 time; is that correct?

1 A. I do.

2 Q. Before the injury on May 31st, 2012, was
3 she healthy as best you know?

4 A. Yeah.

5 Q. As you understand it, she was working; is
6 that correct?

7 A. She was a very hard worker. Yes.

8 Q. And I believe she's a single woman at this
9 point; is that correct?

10 A. Uh-huh.

11 Q. And before the accident do you know of her
12 having any treatment, undergoing any treatment for
13 her mouth or anything?

14 A. No.

15 Q. Just generally she's very soft-spoken and
16 doesn't aggressively speak for herself. What has
17 this journey been like for her since this accident?

18 A. Very emotional. Very emotional.

19 Q. I think she lived with you for a period of
20 time; is that correct?

21 A. Uh-huh. She sure did.

22 Q. And you saw what she's gone through?

23 A. Uh-huh.

24 Q. What do you know about her being able to
25 work during this period after? There's been some

1 records that she worked after the injury. I don't
2 believe she worked the first -- after the accident it
3 was several months; is that correct?

4 A. Correct.

5 Q. Why was that?

6 A. She wasn't able to.

7 Q. Okay. And she had surgery?

8 A. She was not physically and she just was
9 not able to.

10 Q. As she sits here now does she appear to be
11 better than she was back in March of 2016 when she
12 stopped driving?

13 A. Did she appear to be better?

14 Q. Better. That's correct. Physically.

15 A. Physically, no.

16 Q. Has she gained any weight?

17 A. I think she's a gained a little weight
18 back.

19 Q. Do you remember how much weight she lost
20 from the time of the accident in May of 2012?

21 **MR. GALLAGHER:** Objection. Relevance.

22 **THE COURT:** Ms. Mims.

23 **MS. MIMS:** I see it as very relevant as to
24 her condition and what she's gone through as to your
25 determination of permanency.

1 **THE COURT:** But I think we're heading down
2 a path of something that the panel already ruled
3 upon.

4 **MS. MIMS:** Okay. I'm sorry.

5 **BY MS. MIMS**

6 Q. She has lost some weight; is that correct?

7 A. Yeah.

8 **MS. MIMS:** I think that's all I have.

9 **THE COURT:** Anything, Mr. Gallagher?

10 **MR. GALLAGHER:** No, sir.

11 **THE COURT:** All right. You may step down,
12 ma'am. Thank you very much.

13 **THE WITNESS:** Thank you.

14 **THE COURT:** Any other witness on behalf of
15 the claimant?

16 **MS. TURNER:** No.

17 **THE COURT:** Any witnesses on behalf of the
18 defendants?

19 **MR. GALLAGHER:** No, sir.

20 **THE COURT:** All right. That will
21 concludes this proceeding.

22 (WHEREUPON, THE HEARING WAS CONCLUDED AT 2:23 P.M.)
23
24
25

CERTIFICATE OF REPORTER

STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

I, SKYLET KEAN, COURT REPORTER AND NOTARY PUBLIC, FOR THE STATE OF SOUTH CAROLINA, DO HEREBY CERTIFY THAT SAID HEARING TRANSCRIPT IS A STENOGRAPHIC REPORT AND WAS TRANSCRIBED THROUGH COMPUTER-AIDED TRANSCRIPTION; THAT THE FOREGOING TRANSCRIPT CONTAINS A TRUE RECORD OF SAID HEARING.

I FURTHER CERTIFY THAT I AM NEITHER ATTORNEY NOR COUNSEL FOR, NOR RELATED TO NOR EMPLOYED BY ANY OF THE PARTIES CONNECTED TO THE ACTION, NOR AM I FINANCIALLY INTERESTED IN THE ACTION.

WITNESS MY HAND AT COLUMBIA, SOUTH CAROLINA, THIS 16TH DAY OF AUGUST 2019.

SKYLET KEAN, COURT REPORTER
NOTARY PUBLIC FOR THE STATE OF
SOUTH CAROLINA
MY COMMISSION EXPIRES: 07/30/2024