

ROSE ROBINSON D.C., L.Ac.

2510 OVERLAND AVENUE

LOS ANGELES, CA 90064

310 559 0525 FAX 310 559 2265

NPI 100 395 7101

Lic# D.C. 18612 AC .3463 Tax ID : 954586431

PATIENT NAME Laura Tull DATE 1-26-08

NEW PATIENT (OFFICE VISIT)

- 99201 Brief Exam _____
- 99202 Limited Exam 100.-
- 99203 Detailed Exam _____
- 99204 Comprehensive Exam _____
- 99205 Complex Exam _____
- 99070 Disposable Needles _____
- 99070 Orthopedic Appliance _____
- 97803 Moxa Therapy _____
- 93000 EKG _____
- 94010 Spirometry _____

ESTABLISHED PATIENT (OFFICE VISIT)

- 99211 Evaluation Minimum _____
- 99212 Evaluation Limited _____
- 99213 Evaluation Expanded _____
- 99214 Evaluation Detailed _____
- 99215 Evaluation Comprehensive _____

- 98940 Spinal Manipulation _____
- 98941 Spinal Manipulation _____
- 97780 Acupuncture ~~XX~~ _____
- 97813 Acupuncture with El Stim. X
- 97012 Intersegmental Traction _____
- 97026 Infrared Therapy _____
- 97014 Electrical Stimulation ~~XX~~ _____
- 97110 Therapeutic Exercises _____
- 97124 Therapeutic Massage _____
- 97010 Hot/Cold Treatment _____
- 97145 Additional 15 minutes _____
- 80050 Comprehensive Lab Work _____
- 83516 Antigen Allergy Testing _____

Diagnosis: _____

Total 100.-
 Discount 11.-
 Paid 89
 Balance Due 0

Signature Rose Robinson
 Rose Robinson, D.C., L. Ac.

Patient Name: Trell, LAURA Employer: ABATU LLC
 Date of Exam: 01/19/2008 Date of Injury: 01/19/2008 Time In: 1230 Time Out: 1430

Diagnosis: _____

Account # P66807

PATIENT STATUS: New Visit Re-Visit Ortho - New Visit Ortho - Re-Visit

Since the last exam, this patient's condition has:
 Improved as expected. improved, but slower than expected. not improved significantly.
 worsened. permanent & stationary. has been determined to be non-work related.

TREATMENT PLAN:

Diagnostic Studies: bilat knees XRAYS

Medications: DT (TRAMS)

Physical Therapy: Daily for _____ days, or _____ times per week for _____ weeks

Consult/Referral: _____

Estimated return to work with no limitations: _____

MUST WEAR: Splint Sling Immobilizer Back Support Brace Crutches Other: _____

WORK STATUS: Regular duty Modified duty Unable to work

CHECK ONLY AS RELATES TO ABOVE CONDITIONS

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|------------------------------------|-------------------------------|------------------------------------|--|------------------------------------|------------------------------------|--------|------------------------------------|------------------------------------|--|------------------------------------|------------------------------------|----------|------------------------------------|------------------------------------|--|------------------------------------|------------------------------------|--|--|--|--|--|------------|--------------|------------|---------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|
| <ul style="list-style-type: none"> <input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met. <input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls. <input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds. <input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds. <input type="checkbox"/> Light Heavy Work. Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds. <input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds. | <ol style="list-style-type: none"> 1. In an 8-hour work day patient may: <table border="0" style="width: 100%;"> <tr> <td>a. Stand/Walk</td> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> 4-6 Hours</td> </tr> <tr> <td></td> <td><input type="checkbox"/> 1-4 Hours</td> <td><input type="checkbox"/> 6-8 Hours</td> </tr> <tr> <td>b. Sit</td> <td><input type="checkbox"/> 1-3 Hours</td> <td><input type="checkbox"/> 3-5 Hours</td> </tr> <tr> <td></td> <td><input type="checkbox"/> 3-5 Hours</td> <td><input type="checkbox"/> 5-8 Hours</td> </tr> <tr> <td>c. Drive</td> <td><input type="checkbox"/> 1-3 Hours</td> <td><input type="checkbox"/> 3-5 Hours</td> </tr> <tr> <td></td> <td><input type="checkbox"/> 3-5 Hours</td> <td><input type="checkbox"/> 5-8 Hours</td> </tr> </table> 2. Patient may use hand(s) for repetitive: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Single Grasping</td> <td><input type="checkbox"/> Pushing & Pulling</td> </tr> <tr> <td><input type="checkbox"/> Fine Manipulation</td> <td><input type="checkbox"/> Double Grasping</td> </tr> </table> 3. Patient may use foot/feet for repetitive movement as in operating foot controls: <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Patient may: <table border="0" style="width: 100%;"> <tr> <td></td> <td>Not At All</td> <td>Occasionally</td> <td>Frequently</td> </tr> <tr> <td>a. Bend</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Twist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. Squat</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d. Climb</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>e. Reach</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> 5. <input type="checkbox"/> Keep affected area clean & dry. 6. <input type="checkbox"/> No work around high speed or moving machinery. 7. <input type="checkbox"/> No operating of mobile equipment. | a. Stand/Walk | <input type="checkbox"/> None | <input type="checkbox"/> 4-6 Hours | | <input type="checkbox"/> 1-4 Hours | <input type="checkbox"/> 6-8 Hours | b. Sit | <input type="checkbox"/> 1-3 Hours | <input type="checkbox"/> 3-5 Hours | | <input type="checkbox"/> 3-5 Hours | <input type="checkbox"/> 5-8 Hours | c. Drive | <input type="checkbox"/> 1-3 Hours | <input type="checkbox"/> 3-5 Hours | | <input type="checkbox"/> 3-5 Hours | <input type="checkbox"/> 5-8 Hours | <input type="checkbox"/> Single Grasping | <input type="checkbox"/> Pushing & Pulling | <input type="checkbox"/> Fine Manipulation | <input type="checkbox"/> Double Grasping | | Not At All | Occasionally | Frequently | a. Bend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. Twist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | c. Squat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | d. Climb | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e. Reach | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Stand/Walk | <input type="checkbox"/> None | <input type="checkbox"/> 4-6 Hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> 1-4 Hours | <input type="checkbox"/> 6-8 Hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Sit | <input type="checkbox"/> 1-3 Hours | <input type="checkbox"/> 3-5 Hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> 3-5 Hours | <input type="checkbox"/> 5-8 Hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Drive | <input type="checkbox"/> 1-3 Hours | <input type="checkbox"/> 3-5 Hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> 3-5 Hours | <input type="checkbox"/> 5-8 Hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Single Grasping | <input type="checkbox"/> Pushing & Pulling | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Fine Manipulation | <input type="checkbox"/> Double Grasping | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Not At All | Occasionally | Frequently | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Bend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Twist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Squat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. Climb | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e. Reach | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

ADINA
 626-1323

DISPOSITION:

Exam & Reevaluation on: _____
 Wound Check: _____ days Suture Removal: _____ days
 Referral to Dr.: _____
 Final Visit, no further care required. Return only if needed.
 Attending Physician's Name: N. KATCHMAN DO
 Signature: [Signature]

COMMENT:

Pacific Orthopedic
if necessary
phone 626 2821600

I hereby acknowledge that I have received the instructions indicated above and on the reverse side of this form, I understand that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as instructed above.

[Signature] X [Signature] 01-19-08

REVIEWED AFTERCARE INSTRUCTIONS WITH PATIENT PATIENT OR REPRESENTATIVE DATE

Patient Name: Tull, Lana Employer: Abarta LLC
 Date of Exam: 01/21/08 Date of Injury: 01.19.08 Time In: 2pm Time Out: 3:00
 Diagnosis: Spain/strain of bilateral knees (R>L) with abrasions
 Account #: 116804 / 116006 (L) handed

PATIENT STATUS: New Visit Re-Visit Ortho - New Visit Ortho - Re-Visit

Since the last exam, this patient's condition has:
 Improved as expected. improved, but slower than expected. not improved significantly.
 worsened. permanent & stationary. has been determined to be non-work related.

TREATMENT PLAN:

Diagnostic Studies: _____
 Medications: OSalmon Patch #20 Q.I. Q.I. 2 Analgene bath #1 tube Q.I.
 Physical Therapy: Daily for _____ days, or _____ times per week for _____ weeks
 Consult/Referral: DMRI: Rt knee to R/O internal derangement (2) orthopedics: consultation & treatment
 Estimated return to work with no limitations: call 310-976-6174

MUST WEAR: Splint Sling Immobilizer Back Support Brace Crutches Other: _____

WORK STATUS: Regular duty Modified duty Unable to work

CHECK ONLY AS RELATES TO ABOVE CONDITIONS

<p><input checked="" type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.</p> <p><input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.</p> <p><input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.</p> <p><input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.</p> <p><input type="checkbox"/> Light Heavy Work. Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.</p> <p><input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.</p>	<p>1. In an 8-hour work day patient may:</p> <p>a. Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 4-6 Hours <input type="checkbox"/> 1-4 Hours <input type="checkbox"/> 6-8 Hours</p> <p>b. Sit <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours</p> <p>c. Drive <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours</p> <p>2. Patient may use hand(s) for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation <input type="checkbox"/> Double Grasping</p> <p>3. Patient may use foot/feet for repetitive movement as in operating foot controls: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Patient may:</p> <table border="0"> <tr> <td></td> <td>Not At All</td> <td>Occasionally</td> <td>Frequently</td> </tr> <tr> <td>a. Bend</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Twist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. Squat</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d. Climb</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>e. Reach</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p>5. <input checked="" type="checkbox"/> Keep affected area clean & dry. 6. <input type="checkbox"/> No work around high speed or moving machinery. 7. <input type="checkbox"/> No operating of mobile equipment.</p>		Not At All	Occasionally	Frequently	a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Not At All	Occasionally	Frequently																						
a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
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e. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						

<p>DISPOSITION:</p> <p><input checked="" type="checkbox"/> Exam & Reevaluation on: <u>T.O. C by orthopedics.</u> <input type="checkbox"/> Wound Check: _____ days <input type="checkbox"/> Suture Removal: _____ days <input type="checkbox"/> Referral to Dr.: _____ <input type="checkbox"/> Final Visit, no further care required. Return only if needed. Attending Physician's Name: <u>MICHAEL LAM MD</u> Signature: <u>[Signature]</u></p>	<p>COMMENT:</p> <p><u>fx of RT knee - arthroscopic repair @ 1997</u></p>
--	---

I hereby acknowledge that I have received the instructions indicated above and on the reverse side of this form. I understand that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as instructed above.

[Signature] **X** [Signature] 1/21/08
 REVIEWED AFTERCARE INSTRUCTIONS WITH PATIENT PATIENT OR REPRESENTATIVE DATE



EMPLOYEE INJURY INCIDENT STATEMENT

Please assist us in determining how to prevent this type of injury/incident in the future and so that we may be able to access any medical records related to a work related injury or illness.

Full Name: Laura Ann Tull Home phone #: 310 936 6154
First, Middle, Last
 Social Security Number: 223 90 2525 Assignment start date: 1 / 19 08
 Company Name: The Books Department assigned to: Background
 Date of injury/incident: 1/19/08 Time 11:49 am/pm Date injury/incident was reported: 1/19/08
 Did you finish your shift? YES or NO Time you left Work: _____

What are your usual shift hours? _____ To _____ Regular work days? M T W T F St Sn

Who is your on site Supervisor? Rodney Who did you report the injury/incident to? PA + Erica

In what department did the injury occur?: Background

Job Description: Background Artist Specify what department, assembly line, equipment #, etc.

Describe what you were doing at the time of the injury/incident: Running with a crowd. It felt like someone knocked my feet out from under me
Specify any equipment, chemicals, or tools related to the injury incident.

What part(s) of your body was affected by the injury/incident: Both knees
Specify exact body parts such as R-ankle, L-index finger, lower back, etc.

Have you ever sustained an injury to this part of your body before now?: YES or NO

If yes please explain Can recall 1997. I have a bad Q angle in my right knee

Did anyone witness the injury/incident? Yes - 200 Background artist
Indicate Name and Phone Number.

How would you prevent this injury/incident from happening again? Accident - I was careful.

<u>LA</u> <small>Initials</small>	I am seeking medical treatment at this time for the above reported injury.
_____ <small>Initials</small>	I am declining medical treatment at this time for the above reported injury. However, I understand that I may request treatment at a later date provided I contact Barrett Business Services, Inc. I further understand that the claims administrator will review future requests before such treatment is authorized.

I certify that the information I have given on this statement is correct and true. I also authorize all medical providers to release any medical records of information to Barrett Business Services only if the above injury/illness is deemed work related.

Laura Tull Employee Signature Fax to: (909)-605-9761 1/19/08 Date

HUNTINGTON ORTHOPEDIC SURGICAL MEDICAL GROUP

Clayton E. Patchett, M.D. • T. Thomas Ackerson, M.D. • George Tang, M.D. • Vahe R. Panossian, M.D.

10 Congress Street, Suite 103, Pasadena CA 91105
Phone: (626) 795-0282 • Fax: (626) 795-0583

WORK STATUS REPORT

Date of Exam: MAR 14 2008

Name: Laura Tull | Sessions Payroll - Barrett Bus

Date of injury/Claim # 1/19/08 CA3116441

THIS PATIENT WAS SCHEDULED TODAY FOR: [] Orthopedic Consultation [] Consultation and Treatment [] Progress Evaluation [] Permanent Disability Evaluation

THE RESULTS OF TODAY'S VISIT:

[] The patient failed his/her appointment Present Disability is: [] work-related [] NOT work-related

[] Found to be Permanent and Stationary as of _____ and is released from care.

[] The patient's disability status is, or is to be changed as follows:

[x] Patient is NOT DISABLED from his/her regular work. Patient may resume his/her regular work [] immediately [x] next shift [] on _____

[] Patient is TOTALLY DISABLED from any work until approximately _____

[] Patient remains TOTALLY DISABLED from any work until approximately _____

[] Patient will probably be released for regular work beginning _____

[] Patient is released to MODIFIED WORK [] immediately [] next shift [] on _____

With the following restrictions:

[] NO lifting or carrying over: [] 10lbs. [] 25lbs. [] 50lbs. [] _____ lbs.

[] NO soiling or wetting of dressing and/or wound or cast

[] Limited use of [] right [] left [] arm [] leg

[] Limited work above shoulder level with [] right arm [] left arm

[] Limited [] twisting and rotating [] gripping [] wrist extension and flexion with the [] right hand [] left hand

[] Limited [] standing [] walking [] sitting [] stooping [] bending

[] Use of crutches at work, but [] may bear weight [] may not bear weight on [] right leg [] left leg

[] Patient must wear his/her back brace [] at all times [] while working

[] Patient should avoid continuous prolonged sitting in bent over position without alternate standing or walking

[] Patient to remain on MODIFIED WORK with the same restrictions described in the previous report. Anticipated duration of modified work status is: _____ days _____ weeks _____ months

[] Patient is not yet permanent and stationary, _____ more month to elapse before patient rating.

[] Residual Disability _____

[] Patient to return for appointment in _____ days _____ weeks [] as needed

FAX INFORMATION

FAX phone number 503-553-5837

Adjuster's Name Brunk, Michelle

Physician Signature:

[] Clayton E. Patchett, M.D. [] George Tang, M.D. [] T. Thomas Ackerson, M.D. [] Vahe R. Panossian, M.D.

State of California
Division of Workers' Compensation

Additional pages attached

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

<input type="checkbox"/> Periodic Report (required 45 days after last report)	<input type="checkbox"/> Change in treatment plan	<input type="checkbox"/> Released from care
<input type="checkbox"/> Change in work status	<input type="checkbox"/> Need for referral or consultation	<input type="checkbox"/> Response to request for information
<input type="checkbox"/> Change in patient's condition	<input type="checkbox"/> Need for surgery or hospitalization	<input type="checkbox"/> Request for authorization
<input type="checkbox"/> Other:		

Patient:

Last TULL First LAURA M.I. _____ Sex F
 Address P.O. BOX 146 City PASADENA, CA State CA Zip 91102
 Date of Injury 01/19/2008 Date of Birth 06/08/1970
 Occupation ACTRESS SS # 223 - 90 - 2525 Phone (310) 936-6154

Claims Administrator:

Name CAMBRIDGE INSURANCE Claim
 Number CA316441
 Address P.O. BOX 7218 City PASADENA State CA Zip 91109
 Phone (626) 296-4828 FAX (_____) _____

Employer name: SESSIONS PAYROLL Employer Phone (_____) _____

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints:

no problem

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

*FROM
WTRP
OSTS*

Diagnoses:

- Resolved Knee Contusion ICD-9 _____
- _____ ICD-9 _____
- _____ ICD-9 _____

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?)

*Fall duties
- [signature]
P.S*

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Work Status: This patient has been instructed to:

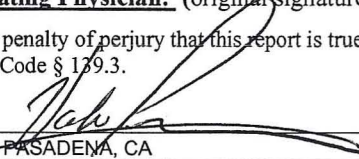
- Remain off-work until _____.
- Return to *modified* work on _____ with the following limitations or restrictions

(List all specific restrictions re/ standing, sitting, bending, use of hands, etc.):

- Return to full duty on 3/14/08 with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp) Date of exam: _____

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 179.3.

Signature:  Cal. Lic. # A066450
Executed at: PASADENA, CA Date: MAR 14 2008
Name: VAHE PANOSSION M.D. Specialty: ORTHOPEDIC SURGEON
Address: 10 CONGRESS ST. # 103 Phone: 626 795-0282

Rose Robinson, D.C., L. Ac.
2510 Overland Avenue
Los Angeles, CA 90064-3333
310 559 0525 Fax 310 559 2265
NPI 100 395 7101

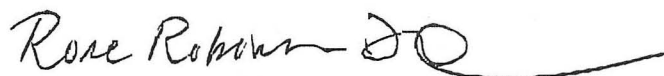
January 28, 2008

RE: LAURA TULL
DOL: January 19, 2008

To Whom It May Concern:

Laura Tull was seen in my office on January 26th, 2008 for injuries sustained in slip and fall accident which occurred on January 19, 2008. She received acupuncture and physical therapy to her injured knees. I have recommended that she continue with care two times per week for approximately four weeks. If you have any questions regarding her condition, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Rose Robinson" followed by a stylized flourish.

Rose Robinson, D.C., L. Ac.

HUNTINGTON ORTHOPEDIC SURGICAL MEDICAL GROUP

Clayton E. Patchett, M.D. • T. Thomas Ackerson, M.D. • George Tang, M.D. • Vahe R. Panossian, M.D.

10 Congress Street, Suite 103, Pasadena CA 91105
Phone: (626) 795-0282 • Fax: (626) 795-0583

WORK STATUS REPORT

Date of Exam: JAN 29 2008
Name: Hull, Laura
Date of injury/Claim # /

THIS PATIENT WAS SCHEDULED TODAY FOR: Orthopedic Consultation Consultation and Treatment
 Progress Evaluation Permanent Disability Evaluation

THE RESULTS OF TODAY'S VISIT:
 The patient failed his/her appointment Present Disability is: work-related NOT work-related
 Found to be Permanent and Stationary as of _____ and is released from care.

The patient's disability status is, or is to be changed as follows:
 Patient is NOT DISABLED from his/her regular work.
Patient may resume his/her regular work immediately next shift on _____
 Patient is TOTALLY DISABLED from any work until approximately _____
 Patient remains TOTALLY DISABLED from any work until approximately _____
 Patient will probably be released for regular work beginning _____

Patient is released to MODIFIED WORK immediately next shift on _____
With the following restrictions:
 NO lifting or carrying over: 10lbs. 25lbs. 50lbs. _____ lbs.
 NO soiling or wetting of dressing and/or wound or cast
 Limited use of right left arm leg
 Limited work above shoulder level with right arm left arm
 Limited twisting and rotating gripping wrist extension and flexion
with the right hand left hand
 Limited standing walking sitting stooping bending
 Use of crutches at work, but may bear weight may not bear weight on
 right leg left leg
 Patient must wear his/her back brace at all times while working
 Patient should avoid continuous prolonged sitting in bent over position without alternate standing or walking

Patient to remain on MODIFIED WORK with the same restrictions described in the previous report.
Anticipated duration of modified work status is: _____ days _____ weeks _____ months
 Patient is not yet permanent and stationary, _____ more month to elapse before patient rating.

Residual Disability _____
 Patient to return for appointment in _____ days 6 weeks as needed

FAX INFORMATION
FAX phone number _____
Adjuster's Name _____

Physician Signature: [Signature]
 Clayton E. Patchett, M.D. George Tang, M.D.
 T. Thomas Ackerson, M.D. Vahe R. Panossian, M.D.

2/11/08
3:15

JAN 29 2008



John St. Cyr
Cell: 661.607.2719
Home: 661.248.1088

Thanks be to GOD Group 1

Huntington Orthopedic Surgical Medical Group
10 Congress Street, Suite 103 Pasadena, CA 91105
(626)795-0282

PHYSICAL THERAPY PRESCRIPTION

Name Louisa Tull Date 4/29/08
Diagnosis (2) knee contusions
Onset Date _____ Frequency/Duration 2 per week for 6 weeks
Precautions/Comments _____
Steven Fleming

COMPLETE PROGRAMS

- | | | |
|---|-----------------------------------|--|
| <input checked="" type="checkbox"/> PT Evaluation | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Elbow | <input checked="" type="checkbox"/> Knee |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Low Back Education | <input type="checkbox"/> Hand | |

Heat:
 Ultrasound/Phonophoresis
 Paraffin Bath
 Other _____

Cold:
 Ice Massage
 Other _____

Traction: Static Intermittent
 Cervical
 Home Instruction

Soft Tissue Mobilization:
Area _____

Hydrotherapy:
 Whirlpool

Electrotherapy:
 Muscle Stim./Re-education
 Iontophoresis
 TENS
 Other _____

Therapeutic Exercise:
 ROM
 Passive
 Active-assistive
 Active
 PRE
 Stretching
 General Conditioning

Gait Training:
 FWB WBAT
 PWB NWB

Other: _____

Parvinder
Physician (please print name)
[Signature]
Physician's signature

GREY'S ANATOMY

293886

Employee ID	Employee Name	Date	Social Sec. No.	Start Period	End Period
293886	LAURA A. TULL	1/18/2007	400-86-0885	1/7/2007	1/7/2007

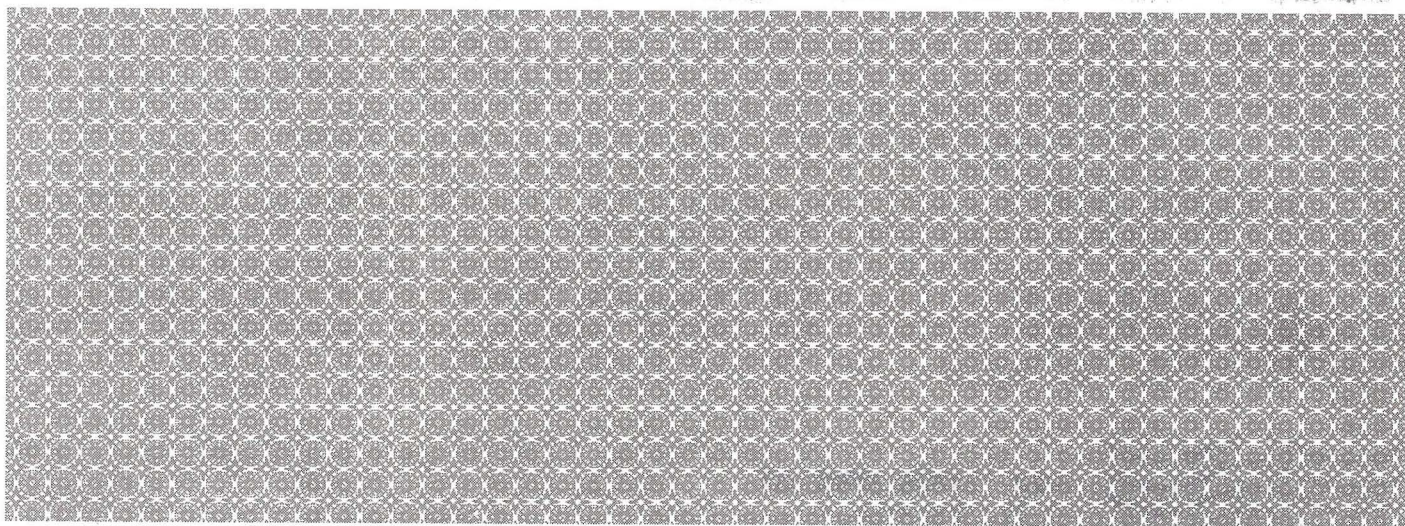
Earnings				Taxes			Deductions		
Code	Rate	Hours	Amount	Code	Withheld	Year-To-Date	Code	Amount	Year-To-Date

MEAL	\$7.50		\$7.50	FICA					
OT1	\$11.25	2.00	\$22.50	Med.	\$1.46	\$6.17			
OT2	\$15.00	0.70	\$10.50	S.S.	\$6.23	\$26.38			
REG	\$7.50	8.00	\$60.00	Federal	\$8.19	\$36.28			
				State	\$0.28	\$2.91			

Local
\$0.80 \$3.40

Gross Year-To-Date	Net Year-To-Date
\$425.50	\$350.36
	Net Pay
	\$83.54

Total 10.70 \$100.50 \$16.96



THE GOODS

395632

Employee ID		Employee Name		Date	Social Sec. No.	Start Period	End Period		
223902525		LAURA A. TULL		1/24/2008	202-00-4526	1/19/2008	1/19/2008		
Earnings				Taxes			Deductions		
Code	Rate	Hours	Amount	Code	Withheld	Year-To-Date	Code	Amount	Year-To-Date
MEAL	8.00		\$8.00	FICA					
OT1	\$12.00	1.30	\$15.60	Med.	\$1.27	\$5.96			
REG	\$8.00	8.00	\$64.00	S.S.	\$5.43	\$25.47			
				Federal	\$5.05	\$30.79			
				CA		\$3.82			
				CASDI	\$0.70	\$3.28			
Total		9.30	\$87.60	Total	\$12.45		Total		

Gross Year-To-Date	
	\$415.80
Net Year-To-Date	
	\$346.48
Net Pay	
	\$75.15

