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# Allevio Experts Team Members Bios – Spring 2016

## MD: Dr. Kevin J. Smith - Anesthesia, Pain Management

* Dr. Smith is our leading Chronic Pain expert and our Medical Director.
* Qualified as an expert witness on Chronic pain in court and has a 10+ year career in the space.
* General Anesthesiology at Rouge Valley Health System, consultant in acute and chronic pain management: particular interest in diagnosis and management of spinal pain.
* Dr. Smith is seasoned, tested, and clear-speaking.

Areas of interest: complex chronic pain conditions, neuropathic pain, spinal pain

## Dr. Mark Friedlander - Anesthesia, Pain Management

* Anesthesiologist actively practicing General Anesthesia at North York General Hospital and Pain Management at Allevio.
* Clinical and Research Fellow in Anesthesia and Pain Management
* Qualified as an expert witness, 8+ years experience.

Areas of interest: chronic pain, neuropathic pain, fibromyalgia

## Dr. Michael Gofeld - Anesthesia, Pain Management

* Staff Anesthesiologist, Department of Anesthesia, St. Michael's Hospital
* Assistant Professor, Anesthesia, University of Toronto
* President and Chairman of Board, American Academy of Pain Medicine Ultrasonography
* Current Headache and Pain Reports (Section Editor) and associate Editor for Pain Practice Regional Anesthesia and Pain Medicine

Areas of interest: complex chronic pain conditions, neuropathic pain, spinal pain

## Dr. Harsha Malempati - Orthopedic Surgery (Spine and General Orthopedics)

* Dr. Malempati collaborates closely with the Allevio Clinical team.
* Appointments at Sunnybrook Health Sciences Centre and MacKenzie Health-Richmond Hill.
* Practice includes orthopaedic trauma, spine trauma, and all adult elective spine pathologies.
* Published author in spine surgery.

Areas of interest: orthopedic injuries, spinal trauma, spinal pain

## Dr. Latham - Orthopedic Surgery (Foot and Ankle)

* Specialist Orthopedic Surgeon; he completed a fellowship in hip and knee surgery in 2007, followed by a fellowship in foot and ankle surgery at Toronto Western Hospital.
* Full-time active staff at the Scarborough Hospital and privileged at Toronto Western Hospital.
* Published author in foot and ankle surgery. Trains fellows from the University of Toronto at Scarborough Hospital.

Areas of interest: foot and ankle injuries

## Dr. Rahul Pathak - Neurology, Interventional Pain Management

* Specialty training in Neurology and Interventional Pain Management.
* Consultant in interventional pain management at Allevio Pain Management Clinic in Toronto

Areas of interest: migraines, chronic pain, neurological / pain complaints

## Dr. Allan Swayze - Psychiatry

* Currently a consultant Psychiatrist at North York General Hospital.
* Assistant Professor of Psychiatry for the University of Toronto since 1977.
* He is an experienced independent medical assessor in both plaintiff and defence work and is trial tested.

Areas of interest: chronic pain, post traumatic stress, depression, anxiety, conversion disorders, CAT

## Dr. Matthew Plant - Plastic Surgeon

* Full time Plastic Surgeon for Orillia Soldiers' Memorial Hospital and a provides emergency coverage at Rouge Valley Health.
* Seminar Leader at the University of Toronto
* Director of Plastic Surgery for the Clearview Institute.

Areas of interest: all hand and wrist injuries, scarring, burns, peripheral nerve injuries, bed sores

For more information or referrals, call Alyssa Cooper at (416)840 5990 ex 24 [alyssa.cooper@allevioclinic.com](mailto:alyssa.cooper@allevioclinic.com)

# Allevio Experts Fees for Services

## Independent Assessment Fees:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Report type | Fee | Loss | Documentation | Pre accident history |
| Basic Chronic  Pain assessment | $3950.00 | MVA < 2  years | Standard | Unremarkable |
| Intermediate  Chronic Pain  assessment | $4725.00.00 | MVA 2+ years | Moderate | Positive but not complex / extensive |
| Complex Chronic Pain assessment | $5775.00 | MVA / CAT  Personal  injury  Med/Mal | Extensive | Significant / complex |
| Minor Injury  Guideline  Report/rebuttal | $950.00 |  |  |  |
| Psychiatry and  Neuropsychology  assessments | $6250.00 + |  |  |  |
| CAT  determination | 7000.00 + |  |  |  |
| Paper review / Addendum/  Other | $500 /hr |  |  |  |

## Treating Physician reports and Integrated Pain Management

|  |  |  |  |
| --- | --- | --- | --- |
| Report type | Fee | Covers | Documentation |
| Treating  Physician  report | $500-$1000 | Treatment  questions | Our clinical notes and record |
| Treating Physician Medical Legal report | $500/hr | Diagnosis, Treatment, Prognosis, Causation, Benefits etc. | CNR’s plus any additional provided documentation |
| MIG report | $950.00 | Minor Injury Guideline | Questionnaire, interview and examination |
| 3 week Pain Management Educational Program | $6200.00 | Education, psychoeducation, support, self management | CNR’s  Outcome measures  Reports |

## Allevio Experts Deposit and Cancellation Policy

1. Unless waived, a deposit of $2000 is required for all regular assessments and paper reviews
2. Deposit is forfeited for cancellation < 5 business days’ notice, or when criteria for credit are not met (see #3).
3. Deposit is credited to next booking, IF following conditions are met:
   * Appointment cancelled with greater than 5 business days’ notice, and
   * Appointment filled by same firm, and
   * Brief and pain questionnaire are available at least 5 business days in advance.
4. Exceptional consideration is given for:
   * Unexpected illness (i.e. too much pain is not an acceptable cancellation)
   * Family or personal emergency
   * At discretion of Allevio Experts

# Dr. Kevin J. Smith – CV

## Kevin J Smith, MD, FRCPC

101-240 Duncan Mill Road

North York, Ontario M3B 3S6

Tel: 416-840-5990 ext. 24

Fax: 647-427-4100

Experts@AllevioClinic.com

### EMPLOYMENT

#### Allevio Pain Management Clinic

Chair Medical Advisory Committee, Medical Director 2011 - Present

#### Rouge Valley Health System - Ajax and Pickering & Centenary

Department of Anesthesia, Active Staff 2004 - Present

#### Ajax Anesthesia Pain Clinic

Director, Chronic pain management 2004 - Present

#### Ontario Shores Mental Health Centre

Department of Anesthesia, Active Staff 2004 - Present

#### The Scarborough Hospitals - General Division

Department of Anesthesia, Courtesy Staff 2003 - 2011

#### Advanced Cardiac Life Support Instructor

Instruct health care providers in the skills of emergency resuscitation 2001 - 2004

### EDUCATION

#### Schulich School of Business

Physician Leadership Development program,   
OMA masters certificate 2012 - 2013

#### The Centre for Clinical Leadership

Anesthesia Leadership Initiative, Peter Minich MD 2010

#### University of Toronto

Physician Leadership Program, Health Policy,   
Management & Evaluation, 2008

#### McMaster University

Department of Anesthesia, Residency Program 1998 - 2003

#### University of Calgary

Faculty of Medicine, Medical Degree 1995 - 1998

#### University of Calgary

Faculty of Management 1994 - 1995

#### University of Alberta

Bachelor of Science, Major - Biological Sciences 1990 - 1994

#### Western Canada High School

Advanced High School Diploma,   
International Baccalaureate Program 1987 - 1990

### PROFESSIONAL AFFILIATION

#### McMaster University, Department of Anesthesia

Assistant Clinical Professor - Adjunct 2011 - Present

#### College of Physicians and Surgeons of Ontario

OHPIP Facility Assessor 2012 - 2013

#### Promed Evaluations

Independent Medical Evaluations, Chronic Pain 2010 - 2013

#### Access Rehab

Independent Medical Evaluations, Chronic Pain 2010 - 2013

#### Allied Med Trauma Evaluations

Independent Medical Evaluations, Chronic Pain 2006 - 2011

#### Regain Health Pain Management Program

Clinical Director 2006 - 2010

#### The Shapero Markham Headache and Pain Treatment Centre

Chronic pain consultant; diagnostic interventional pain management 2008 - 2009

#### The Rehab Centre, Dr. A. Kachooie

Chronic pain consultant 2004

#### The Scarborough Hospital

Independent chronic pain practice 2003 - 2004

### COMMITTEES/INVOLVEMENT

* Physician Payment Review Board, Vice Chair 2014 - Present
* Negotiations Committee, OMA 2013 - Present
* Physician Services Committee, OMA-MOHLTC 2013 - Present
* Chronic Pain Working Group, C-Chair, OMA-MOHLTC 2013 - Present
* Physician Payment Review Board, OMA Member 2012 - Present
* Education and Prevention Committee, Co-Chair,   
  OMA-MOHLTC 2011 - Present
* OMA Section on Anesthesiology, Executive member 2009 - Present
* Surgical Program Clinical Quality Committee, RVHS 2009 - Present
* Negotiations Team 2012, OMA, Interviewee 2012 - 2008
* Flow Improvement Team, Ajax Hospital 2009 - 2006
* OMA Section on Anesthesiology, Tariff Chair 2009 - 2005
* Department of Anesthesia, Treasurer, Ajax Hospital 2009 - 2008
* Physician Services and Payment Committee, OMA-MOHLTC 2003 - 2004
* Director, Acute Pain Service, Scarborough General

### MEMBERSHIP

* American Society of Regional Anesthesia and Pain Medicine
* Canadian Anesthesiologists' Society
* College of Physicians and Surgeons of Ontario
* Ontario Medical Association
* Royal College of Physicians and Surgeons of Canada

### ACADEMIC OPPORTUNITIES

* ACLS, Sunnybrook HSC April 2011 September
* Centre for Clinical Leadership, Peter Minich 2010 October/November
* HPME, University of Toronto 2008 August 2006 June
* Training on Radiofrequency Procedures, Sunnybrook 2006 October 2004
* Dr. Gil Faclier, Sunnybrook,   
  Invasive Chronic Pain Procedures December 2004 2001
* Peripheral nerve blocks, Toronto Western Hospital 2011, 1998 April 1999
* Botox for pain management, Dr. Ian Finkelstein
* ACLS Instructor's Course
* ACLS
* ATLS

### References available upon request

# Dr. Kevin J Smith – Sample Report

Anesthesiology & Chronic Pain Management

240 Duncan Mill Road Suite 101

Toronto, Ontario M3B 3R6

Telephone: (416) 840-5990

Fax: (647) 427-4100

## INDEPENDENT CHRONIC PAIN ASSESSMENT

#### FOR:

Mr. XXX

#### RE:

First Last name

Date of Birth:

Date of Accident:

Date of Assessment:

Date of Report:

#### ASSESSOR:

Dr. Kevin J. Smith, M.D., F.R.C.P. (C) Anesthesiology & Chronic Pain Management

### INDEPENDENT CHRONIC PAIN ASSESSMENT:

Dear Mr. XX

#### PREAMBLE:

This is to certify that I, Dr. Kevin Smith, am a licensed medical practitioner in the Province of Ontario. I am a specialist in Anesthesiology by virtue of a fellowship with the Royal College of Physicians and Surgeons of Canada. I obtained my medical degree at the University of Calgary in 1998 and completed specialty training in Anesthesiology at McMaster University in 2003. In addition to my practice in General Anesthesiology at Rouge Valley Health System, I am a consultant in acute and chronic pain management and have particular interest in the diagnosis and management of spinal pain. I am the Medical Director and a staff consultant of the Allevio Pain Management Clinic, as well as the Ajax Pain Clinic (at Rouge Valley Health), providing the assessment and management of chronic pain conditions. I dedicate 60-80% of my practice towards clinical care and 20-40% towards administrative and political responsibilities and medico-legal assessment.

This third party assessment was performed at the office of Allevio Pain Management, 942 - 275 Slater Street, Ottawa, Ontario, K1P 5H9.

The client understands the nature and purpose of this independent medical evaluation. The assessor/client relationship was explained and was fully understood. Verbal consent for release of this report was obtained. The client’s identity was confirmed with her driver’s license.

The history outlined below was related to me during this assessment. The documentation forwarded to me was also reviewed and is listed in the appendix, with a description of specifically relevant items summarized below under “Summary of Relevant Documentation.”

It should be noted that this report is based upon the presumed truthfulness of the client. If there have been distortions or inaccuracies in the client’s reporting, diagnostic impressions and conclusions could be altered.

The client has been advised that upon request a copy of this report can be forwarded by the client’s lawyer to the primary family physician to consider any medical recommendations made during this assessment.

Please note that the term **possible** in this report is referring to an anticipated outcome or result of less than 50% and the term **probable** is referring to an anticipated outcome or result of greater than 50%.

A signed Form 53 (Acknowledgment of Expert’s Duty) and full CV are attached.

#### INSTRUCTIONS PROVIDED:

I have been instructed to review the documentation forwarded to me, assess this client, and provide a detailed chronic pain report summarizing my findings and opinion.

#### NATURE OF OPINION SOUGHT:

I have been asked to perform this assessment specifically to address the issues of diagnosis, prognosis, whether the client is employable, whether the client requires assistance with housekeeping activities and treatment recommendations as they relate to the motor vehicle accident on the indicated date of loss.

#### DOCUMENTATION PROVIDED:

See appendix

#### DOCUMENTATION REVIEWED:

Affidavit of Documents 1:

1. CNR’s Dr. (GP)

* Regular visits between 2008 and 2011 pre-accident - mostly related to HTN, peri- menopausal symptoms
* October 4, 2010 - back pain, note “LBP 7 months ago”
* January 3, 2011 - MVA, driver struck by a truck passenger side, neck and back pain most of the night.
* January 4, 2011 - X-ray - mild spondylosis C5-6, mild degenerative changes and spondylosis L3-4 and L4-5, with mild facet degenerative L4-5 and L5-S1.
* July 13, 2011 - physiotherapy and massage ongoing, left forearm pain, neck pain,
* September 13, 2011- feels down since MVA, can’t complete previous activities, referral for psychology/CBT
* December 13, 2011 - note indicating that she fell down at home, bruised right forearm and lower back. No more improvement with physio.

1. December 21, 2011 Psychology assessment Dr.

* Complaints of neck pain, left arm pain, low back pain, left leg, headaches, poor sleep.
* Adjustment disorder, rule out depressive disorder and generalized anxiety disorder
* Psychotherapy recommended, Treatment plan for 10 sessions
* Tests results felt to be valid

1. CNR’s Physiotherapy Clinic

* January 19, 2011 intake - lower back pain, wrist pain, neck pain, upper back pain
* February 2, 2011 assessment report - lower back pain, left wrist hand pain, neck pain. Plan - neck and back exercise program, cardio program, education, modalities.

1. Updated CNR’s Dr.

* February 14, 2011 MRI lumbar spine - minimal disc bulges at L4-5 and L3-4
* January 24, 2012 EMG - limited as she refused the nerve conduction, EMG normal.

1. CNR’s Dr. Psychologist - copy of report and treatment plans and handwritten progress notes
2. April 10, 2012 IE Multidisciplinary of Dr. XX (re IRB)

* Complaints were recorded as: lower back, neck pain, numbness in left hand, headaches. FAE results were felt to represent inconsistent effort.
* Psychology results indicate - Pain Disorder, adjustment disorder, vehicle related anxiety. Psychologist felt that she would have difficulty with employment, caregiving and housekeeping as a result of her pain and fatigue but no substantial inability to perform employment.
* Opinion was that she does not suffer a substantial inability to perform pre accident employment.

1. May 22, 2012 IE Physiatry of Dr. XX

* Dr. XX is of the opinion that she remains with a substantial inability with carrying out her job. She is encouraged to use pacing and continue to attempt pre accident

#### Second Supplementary Affidavit of documents:

1. April 4, 2013 Psychology progress report Dr. Psychologist - despite treatment her depression and anxiety continues to be in the severe range - 16 additional sessions recommended.
2. May 30, 2013 IE OT IHA (OCF-18 for assistive devices)

* Assistive device is not felt to be reasonable, as it does not address neck position, a bookstand is recommended. In addition, a pain management program is recommended.

#### Third Supplementary:

1. October 3, 3013 Progress report Physiotherapy (Tab 5) - report indicates that there has been no significant improvement with treatment. An MRI to further investigate symptoms is recommended.
2. Updated CNR’s Dr. XX

* August 13, 2012 General rehabilitation clinic consult report Dr. XX - Clinical impression of myofascial pain with active trigger points in the trapezius muscles, ongoing muscular low back pain, WAD II. Chronic pain. Pain management strategies discussed including medication, swimming, physiotherapy and education.
* August 21, 2013 right big toe x-ray - O A changes

#### Fourth Supplementary:

1. CNR’s Dr. XX Sports Medicine - January 20, 2014 - Ongoing reports of: chronic neck and shoulder pain, low back pain radiating left leg. MRI right ankle, may benefit from cortisone injections in peroneal and post tibial area.
2. january 31, 2014 EMG re left CTS – normal

#### Fifth Supplementary

1. Updated CNR’s Dr. XX

• February 21, 2014 MRI right ankle - Achilles tendinopathy. Synovitis within the retrocalcaneal bursa.

• April 2, 2014 - right ankle pain worse than left, swelling

2. File from The Gym Club - gym membership and visits dates

3. Updated CNR’s The Hospital

• March 27, 2009 ER record - presenting with atypical chest pain

• June 14, 2009 ER record - presenting complaint of upper extremity pain, left hand swelling and pain, ?carpal tunnel

• January 7, 2011 X-rays left forearm, left hand and left wrist

• January 17, 2011 ER record - MVC 2 weeks ago, right forearm injury, x-rays no fracture

• January 17, 2011 X-ray left forearm and wrist - no fracture or dislocation

• February 14, 2011 MRI lumbar spine - minimal disc bulges at L4-5 and L3-4

• May 8, 2013 EMG re numbness in left hand - normal

4. November 26, 2014 OT report

• Ongoing: right lower leg pain and lower back pain

• Recommendation to continue biweekly OT, assistive device personal training, psychology, chiropody

5. CNR’s Independent Case Management Services

6. Updated CNR’s Dr. XX

• June 11, 2014 MRI right ankle - retrocalcaneal lobulated bursal fluid with surrounding soft tissue edema and internal synovitis as well as suspected small erosion anterior to the calcaneal insertion of the Achilles tendon

7. CNR’s Psychological Services

8. Updated CNR’s Dr. XX

• September 11, 2014 MRI cervical spine - small disc protrusion at C4-5, C5-6 and C6-7

9. January 8, 2015 IME Dr. XX

• Documents and treatment summary reviewed in detail

• Dr. XX’s opinion questions role of MVA with forearm pain and hand numbness, documents indicate it was not immediate

• He opinions that knee pain is not accident related as well as left ankle and foot pain

• Conclusion that Chronic pain syndrome triggered by MVA interfering with all aspects of life

Additional documentation:

1. CNR Dr. XX

• 2014-2015 Multiple entries re: right ankle synovitis

• Feb 11, 2015 Synovitis R ankle, possible medial meniscal tear L knee

• Mar 30, 2015 Low back pain, radiation L leg, L ankle, L knee, L ankle tender central plantar fascia

• April 29, 2015 pain L ankle, getting worse on R side; Cervical whiplash, plantar fasciitis, Achilles tendinitis; bone scan relatively normal

• Bone scan April 1, 2015 - minimal increased uptake lower left SI joint, probably represents degenerative bony change, slight increased uptake left knee possible enthesopathy, abnormal moderate increased uptake plantar left calcaneus suggestive of plantar fasciitis, minimal increased uptake posterosuperior right calcaneus suggestive of minimal enthesopathy at achilles tendon insertion

• MRI Left Knee March 26, 2015 - mild chronic MCL sprain, medial and patellofemoral compartment chondropathy, mild strain proximal medial gastrocnemius, lobulated fluid signal likely related to small ganglion or previous capsular injury

• MRI Right Ankle June 11, 2014 - retrocalcaneal lobulated bursal fluid with soft tissue edema and internal synovitis, suspected small erosion Achilles tendon

2. May 14, 2015 OT Update Report - severe increase in pain since last visit, pain and swelling left ankle and knee pain, excruciating pain sole of her left foot prevented from walking safely in her home; cane ordered immediately; recommended OT every 1-2 weeks in home; attending Dr. for psychological and reports benefit; participating in personal training- Dr. put on hold and recommended physiotherapy for increase in pain.

3. Hospital CNR 2008 to present

• Mental Health Department notes

• December 1, 2014 - consultation - diagnosis major depressive episode with anxious features secondary to some significant changes in her life over past 3 years, rule out generalized anxiety disorder.

HISTORY OF PRESENT INJURY AND TREATMENT COURSE:

This client is a XX year-old right-handed woman who was involved in a motor vehicle accident on. She was the seatbelted driver of a Toyota with her two daughters that was struck on the passenger side by a truck in a T-bone fashion. The airbags did not deploy. The car was eventually repaired for several thousand dollars.

The client did not lose consciousness. Immediate symptoms and obvious injuries sustained include dizziness. After paramedics arrived she was found to have elevated blood pressure. Her daughters were quite upset so she preferred to return home to attend to their needs. By that evening she developed neck and back pain with some discomfort in her left arm, so she attended her Family Doctor, Dr. XX, the following day. She was sent for x-rays and referred for physiotherapy, which she initiated about one week later. She explained that the x-ray reported a small fracture on the left wrist, later re-assessed and told there was no fracture.

Since then, the client attended therapy for more than two years overall, with only short-lived benefit.

Dr. XX has managed her medications, including initiation of anti-depressants approximately three years ago. She has struggled with side effects from various medications, but reports that the anti-depressants helped somewhat.

She consulted with several physicians over the subsequent years, including Dr. XX for right ankle pain that developed approximately 1/ years ago. An MRI reported some synovitis, and she subsequently had a cortisone injection that exacerbated the pain. She recently attended a bone scan, but she is unaware of the results.

She then consulted with Dr. XX for the ankle and was informed that nothing could be done, apparently sent for tests for the liver.

She has had personal training at her home twice weekly for the past two years, with some subtle benefit, recently exacerbating her back pain and recently advised to cease training until another MRI is completed to rule out a possible compressed nerve.

She is pending approval for additional physiotherapy based on Dr. XX’s recommendation.

She started seeing Dr. XX for psychotherapy several years ago, reporting some benefit with visits approximately every 2 weeks or as needed. Within the past year she also started seeing a Psychiatrist, Dr., attending approximately every 1-2 weeks for medical management and counseling, with some benefit.

She is currently on the wait list for the Chronic Pain Program at The Ottawa Hospital.

Investigations:

• January 4, 2011 - X-ray - mild spondylosis C5-6, mild degen changes and spondylosis L3-4 and L4-5, with mild facet degen L4-5 and L5-S1.

• January 7, 2011 X-rays left forearm, left hand and left wrist

• January 17, 2011 X-ray left forearm and wrist - no fracture or dislocation

• January 17, 2011 ER record - MVC 2 weeks ago, forearm injury, x-rays no fracture

• February 14, 2011 MRI lumbar spine - minimal disc bulges at L4-5 and L3-4June 11, 2014

• June 11, 2014 MRI right ankle- retrocalcaneal lobulated bursal fluid with soft tissue edema and internal synovitis, suspected small erosion Achilles tendon

• September 11, 2014 MRI cervical spine - small disc protrusion at C4-5, C5-6 and C6-7

• Bone scan April 1, 2015 - minimal increased uptake lower left SI joint, probably represents degenerative bony change, slight increased uptake left knee possible enthesopathy, abnormal moderate increased uptake plantar left calcaneus suggestive of plantar fasciitis, minimal increased uptake posterosuperior right calcaneus suggestive of minimal enthesopathy at achilles tendon insertion

• MRI Left Knee March 26, 2015 - mild chronic MCL sprain, medial and patellofemoral compartment chondropathy, mild strain proximal medial gastrocnemius, lobulated fluid signal likely related to small ganglion or previous capsular injury

The client reports that her overall condition has declined since the accident with newer pain sites developing over time. She indicated that the left knee pain developed perhaps one year after the accident, and the right ankle pain perhaps 1 '/2 years ago, explaining that because of her back pain and left leg radiation she was limping and that may have resulted in the knee and ankle pains. She reports that she has not had anything helpful for the pain per se, even though the depression is somewhat better on treatment.

PREVIOUS ACCIDENT AND PAST MEDICAL HISTORY:

The client reports being involved in no previous motor vehicle accidents and no major injuries. There is an otherwise unremarkable pre-accident medical history, notably without a reported history of chronic pain, depression or anxiety. She has pre-accident hypertension treated with medication and one episode of chest pain and hand pain that occurred in 2009. She explained that she was under a great deal of stress at that time due to concern over her family’s safety in Lebanon and reported that she was likely depressed at the time; she did not require treatment and improved spontaneously, with no documented complaints of depression in Dr. XX’s pre-accident notes. She also explained that prior to presenting to ER for the left arm pain she had been cleaning her son’s room and pushed on his bed and strained the arm, resolving after a couple of days with Tylenol. She denied pre-accident back, neck or arm pain in the year prior to the accident, and she denies any pre-accident restrictions of any kind. She does not smoke and drinks alcohol seldom. Past surgeries include a C-section for her 6th child.

Reported medications include recent Xenical to lose weight, Zopiclone, Naproxen 500 mg OD, Buproprion, Robaxacet or Tylenol ES 6-8 per day, Coversyl and Voltaren gel 1-2 times per day. Previously attempted medications for pain control include Lyrica, discontinued due to stomach upset. Allergies are reported to no medications.

SOCIAL HISTORY:

The client was born in Iran and immigrated to Canada in 1991. She was educated to grade 12 and received 1/2 year of post-secondary education in Law, discontinued when she fled due to war. She lives with her husband of 30 years in their own home. Their relationship is significantly strained since the date of loss due to loss of intimacy due to pain. They have six children, with five living at home. The parental relationship is strained due to feeling short and impatient with them and less interested in participating in activities with them.

Socially, the client was previously active with family and friends. She enjoyed visiting friends often, working and cooking at the family restaurant, walking and participating in religious theatre in their community. Although not regular, she went to the gym on occasion to exercise, but she was very physically active at the gym in approximately 2008. Much of her time was spent managing their large family. Since the date of loss, the social activities have decreased significantly. This is due to persistent pain, loss of interest and feeling like being alone. She spends most of her day at home, feeling anxious and nervous with most activities and “screaming too much,” reporting that that was never her personality prior to the accident.

FUNCTIONAL ENQUIRY:

The client’s weight has increased since the date of loss by 18-20 kilograms. The client’s sleeping habits have worsened since the date of loss. She previously slept 7 restful hours per night, not requiring a sleep aid, but now sleeps 4-5 hours per night, waking 1-2 times due to pain. The client does not feel rested in the morning and spends 1-2 hours during the day resting due to pain. Concentration and memory have been somewhat worse. She does not have nightmares about the accident. She does not still feels scared to drive. The client’s mood is described as sad, nervous, fatigued, irritable, angry, frustrated, unable to cope and wanting to be alone, somewhat improved on medication but still symptomatic. She has undergone extensive psychological counseling with Dr. XX, with some reported benefit, and has been attending a Psychiatrist as well.

ACTIVITIES OF DAILY LIVING:

The client reports usually being independent with self-care, including dressing, bathing and showering, but occasionally has difficult changing her clothes or removing her shirt during flare- ups.

With respect to homemaking duties, she was fully independent prior to the accident without restrictions. She was the primary caregiver of the family and household, “taking care of everything.” Since the accident she has had to rely on her children and husband much more, reporting that two of her children take some time off work in order to help her. She has been provided some assistive devices through her Occupational Therapist, which help her manage chores. She has been getting OT help for approximately 3 years, finding it helpful. She is now capable of managing some dusting, vacuuming, dishes, folding laundry and light cooking. She finds it difficult to stand for long such that she cannot prepare full meals as she had before the accident. She requires frequent breaks in order to pace herself. She requires help with cleaning the bathroom, mopping, lifting laundry, making beds and all outdoor chores such as shoveling, lawn care and gardening.

With respect to care-giving duties, her children are independent, between ages 23 and 11. She reported having the greatest difficulty with her youngest daughter as she was still young at the time of the accident (and present in the vehicle) and the client was unable to maintain the same relationship with her personally or physically, such as being unable to lift or carry her any longer.

OCCUPATIONAL HISTORY/STATUS:

At the time of the accident, the client was working as an owner operator of the family restaurant, working 35 hours per week. They had run the business for more than 14 years. Demands of the employment included managing and assisting with cooking or shopping. Following the accident, the client has been unable to resume this work. She attempted to return to the restaurant on a few occasions to check on things, but she has felt too much pain, anxiety or loss of interest to stay or

help in any meaningful way. Due to financial strain and difficulty finding and affording chefs, they were forced to close the business approximately one year ago.

The client is currently not working. The client reports that she is focusing on trying to get healthier and feel better, hoping to return to work some day. As she feels unable to manage most chores at home without frequent breaks to pace herself, she feels incapable of returning to work.

CURRENT STATUS INCLUDING SYMPTOMS IN ORDER OF SEVERITY:

The American Medical Association (AMA) guides to the evaluation of permanent impairment recommends that assessments for disability due to pain include reproducible methodologies to evaluate the severity of pain, activity restrictions, emotional distress and pain behaviours. Due to the complex interaction of physiological, psychological and social factors associated with musculoskeletal and, specifically, spinal disorders, it is difficult to evaluate these disorders through traditional biomedical techniques. As a consequence of this complexity, and because pain and disability are the most significant issues for injured patients, the evaluation of functional status is essential in the treatment of chronic disabling musculoskeletal disorders [Anagnostis et al]. Patient self-report is one means being increasingly relied upon to evaluate functional status. To incorporate these factors into this assessment, the client completed the following questionnaires:

a. Pain Disability Questionnaire (PDQ)

The PDQ [Anagnostis et al] is a simple and quick methodology for measuring the degree of impact that pain has on a person’s ability to perform essential life activities, including housework, personal care, basic physical activities and social and recreational activities. The level of disability increases as the total point score out of 150 increases. The score can be divided into a physical component (out of 90 points) and a psychological component (out of 60 points).

The client scored the following:

Physical score 60/90 (Items 1-7, 12-13; Score >22/90 is above normal range)

Psychosocial score 50/60 (Items 8-11, 14-15; Score >15/60 is above normal range)

Total score 110/150 (Score > 37/150 is above normal range)

This result suggests a finding consistent with Chronic Disabling Musculoskeletal Disorder (CDMD). Scores consistent with the CDMD group (range 72-120) are associated with a severe level of pain-related disability that has not responded to primary and secondary levels of treatment.

b. Pain Scores

The client reports overall pain levels ranging from 4/10 at its best to 9/10 at its worst, with an average pain score of 7/10.

Reported pain scores of 6-7 are considered moderately severe, 8-9 are considered severe and 10 is considered extremely severe or equivalent to the worst pain ever experienced by the individual. Most people report being able to generally cope with pain intensities up to 5-6, at which point function, quality of life and capacity to cope begin to deteriorate when the average pain is in this range or higher.

The following details the pain sites, in order of severity from worst to least.

• Low back pain

Described as intermittent but nearly daily lower left-sided back pain characterized as sharp, shooting and burning, radiating from the left low back to the left anterior thigh and knee. There is seldom numbness in the left foot. The pain is aggravated by prolonged sitting beyond 1-2 hours (requiring change in position), standing from a seated position, lifting, bending, walking more than 15-20 minutes, standing more than 15-25 minutes (initially only a few moments after the accident), climbing stairs and stress. The pain is alleviated by medication, rest and sleep. There is no associated bowel or bladder incontinence.

• Neck pain

Described as intermittent but nearly daily posterior neck pain characterized as hot/burning, notably with bending or leaning forward with the neck, such as while reading. The pain used to radiate from the neck to the right side of the head with numbness, since resolved and moving to the left side of the head, since resolving approximately 6 months ago. There was some left arm heaviness and pain that resolved approximately one year ago, with intermittent numbness and tingling of the fingers diffusely. The pain is aggravated by looking up, looking down, turning the head, reading and stress. The pain is alleviated by medication, sleep and rest.

• Right ankle pain, recently left ankle pain

Described as sharp and burning, developing perhaps 1 '/2 years ago and diagnosed with synovitis. She then developed some left sided ankle and foot pain, burning on the bottom of the left foot. She is pending a new MRI to rule out nerve compression and has had a bone scan recently to look for sites of inflammation.

• Left knee pain

Described as intermittent left-sided knee pain characterized as sharp, with bending in particular.

c. Neuropathic Pain Questionnaires

a. DN4:

The DN4 questionnaire scored 5/10 based on one point for each of the following items related to neck and left arm pain: ^ burning, O painful cold, O electric shocks, tingling, O pins and needles, |^l numbness, O itching,

hypoesthesia to touch, |^| hypoesthesia to prick, O brushing allodynia.

A score of at least 5/10 is generally consistent with neuropathic pain.

PHYSICAL EXAMINATION:

The client appeared well-groomed with a slightly limping and unsupported gait upon entering the examination room. Reported height was 165 centimetres and weight 80 kilograms. She appeared comfortable while sitting, but shifted approximately every 20-30 minutes, and moved to the examination table with visible discomfort, reporting that the back was very sore. Once standing, she stood for a few moments and stepped carefully, reporting that the pain is always worse until she makes a few steps. The affect appeared somewhat flat. She was extremely well- spoken, cooperative and forthcoming.

Examination of the head and neck revealed a very stiff posture, somewhat forward flexed. The temporalis, frontalis, masseter and occipitalis muscles were nontender. The occipital groove was nontender at the region of the greater and lesser occipital nerve bilaterally. There was tenderness to the trapezius and paracervical muscles on the left primarily (mild on the right), with some hypertonicity of the left trapezius muscle. Parathoracic muscles were tender on the left. Periscapular muscles were tender on the left. Range of motion of the cervical spine demonstrated flexion (chin to chest wall 5-6 cm), extension to 0-5 degrees, leftwards rotation to 45 degrees, rightwards rotation to 20-30 degrees, left lateral flexion to 15-20 degrees and right lateral flexion to 15-20 degrees. Spurling’s maneuver was positive for left neck and trapezius/periscapular pain, not down the left arm. She complained of increasingly numb fingers of the left hand through the examination.

Examination of the upper extremities revealed slightly reduced light touch and normal grip/motor testing to the left arm, with reduced pin-prick diffusely through the left arm from deltoid to fingers compared to normal findings on the right. Biceps reflex was 1+, reduced, on the left, and 2+ on the right. Triceps reflex was 2+, normal, bilaterally. Range of motion of the shoulders was reduced for abduction to 120 degrees actively, 150 degrees passively and restricted mostly on the left due to increasing neck and shoulder pain, and external rotation to 75 degrees on the right and 60-75 degrees on the left. The appearance of the arms was normal, specifically no muscle wasting, swelling or discolouration.

Examination of the back revealed normal alignment and tender paralumbar musculature on the left. Flexion was fingertips to mid thigh, extension was to 0-5 degrees and lateral flexion was to 10-15 degrees bilaterally. Pain was reported with lateral flexion, extension and flexion, worst with extension or trying to bend beyond the thigh. The peri-sacroiliac soft tissue was very tender on the left. Provocative testing of the sacroiliac joints using the FABER maneuver revealed positive findings to the left joint for sacroiliac pain, and contralateral left severe back pain on testing the right joint. The lateral hips were nontender at the trochanters.

Lower extremity neurological examination was normal to light touch, pin prick and motor testing. Knee jerk testing was 2+, normal. Ankle jerk reflex was 2+, normal. Leg raise testing was normal bilaterally, limited by back pain only, associated with negative ankle dorsiflexion sign. The appearance of the legs was normal, specifically no muscle wasting, swelling or discolouration.

The left knee was tender medial to the patella with seemingly unrestricted flexion and extension. The left ankle was tender postero-laterally with seemingly unrestricted range. There was tenderness along the lateral and plantar surface of the calcaneus and the plantar fascia.

This client demonstrated the following observable pain behaviours:

• Facial grimacing with examination

• Holding or supporting the back after examination

• Limping gait

• Frequent shifting of posture or position

• Extremely slow movements and caution putting weight on the left leg after prolonged sitting

In consideration with the general assessment for this client, these pain behaviours are consistent with the diagnoses summarized below.

DIAGNOSIS AND DISCUSSION:

As my opinion is based solely upon information provided in the supplied documentation, the client’s personal report and today’s assessment, I reserve the right to revisit my opinion if further information should become available.

On the basis of the history, physical examination and review of the Medical Brief, this client has the following diagnoses:

• Chronic pain syndrome (with mixed musculoskeletal and neuropathic features) associated with:

o Sleep disruption

o Psychological/emotional disturbance

• Chronic musculoskeletal neck pain due to:

o Mechanical, possible facetogenic, pain o Myofascial pain

o Possible discogenic or radicular pain o Possible left shoulder injury not yet defined

• Chronic musculoskeletal low back pain due to:

o Left sacroiliac joint pain o Mechanical, possible facetogenic, pain o Myofascial pain

• Neuropathic pain - left arm

• Chronic left knee pain, not yet fully defined

• Chronic ankle pain, not yet fully defined

o Probable left plantar fasciitis o Right ankle synovitis with Achilles tendinopathy

The musculoskeletal spinal injuries may involve tearing and disruption of the soft tissues and there is often damage to the discs or facet joints. This type of pathology has been shown in humans and in animal studies. Although reported incidences vary, there is a high incidence of progression from acute whiplash injury to chronic pain. A series of reviews in 2011 concluded that approximately 50% of whiplash patients progress to chronic pain, and 10-20% will develop

moderate to severe pain syndromes. This is probably due to a variety of factors, including facet joint injury, central sensitization (see below), stress response and psychosocial and sociocultural factors. [Jull et al]

There are also features of neuropathic pain characterized by the abnormal neurological findings in the left arm and reported burning pain with numbness and tingling. This will make future care more difficult as this client has both neuropathic pain as well as musculoskeletal pain to treat.

In addition, this client has gone on to develop the features of a chronic pain syndrome. Although definitions vary, a chronic pain syndrome is generally said to exist where the pain has been present for more than 3-6 months (or beyond the expected healing time), is intrusive in nature, is usually associated with sleep disruption and mood changes, and interferes with most of the patient’s activities (usually reflected as a 50% or more reduction in global function).

A chronic pain syndrome starts off with acute pain. As a result of the acute pain impulses, there are secondary changes in the spinal cord and brain that is known as central sensitization. As a result of this, pain becomes more diffuse and typically no longer follows a dermatomal pattern. There is secondary disuse in the musculoskeletal system. There are often associated psychological and emotional difficulties and a characteristic sleep disturbance.

A chronic pain syndrome often causes long-term disability. Adapted from a 2005 report of the American College of Occupational & Environmental Medicine, the Treasury Board of Canada Secretariat reports the probability that employees will return to any form of employment following an absence from work for illness or injury decreases from 50% at 3 months, to 20% after 6 months and 2% or less after 12 months. This is consistent with patients suffering from chronic pain syndrome.

In my opinion this client meets all the features of a chronic pain syndrome, complicated by a co-existing mood disorder.

The client reported a depressed mood since the date of loss and has reported a significant amount of social and emotional upset as a result of this motor vehicle accident. She has been diagnosed and treated for depression and anxiety, both medically and psychotherapeutically. This will have a deleterious effect on social, marital, professional and recreational activities as well as aggravate the severity of chronic pain. In fact, co-existing clinical depression/anxiety is known to adversely affect the quality of chronic pain, the ability to cope with chronic pain as well as the efficacy of treatment. Furthermore, without adequate treatment for depression/anxiety, chronic pain will be permanent despite other treatments discussed. Ongoing psychological and psychiatric treatment is recommended, preferably in association with a multidisciplinary pain management program as summarized below.

As a result of the chronic pain, this client has developed a sleep disruption resulting in a non-restorative and broken sleep pattern. Sleep disorders are known to worsen the degree of chronic pain as well as treatment efficacy in patients with chronic pain.

PROGNOSIS:

Based on the chronicity and severity of the signs and symptoms, the prognosis for recovery to pre-accident levels of function from these diagnoses is poor.

In addition, this client will have permanent chronic pain and associated functional impairments. The chronic pain syndrome involves a combination of both physical injuries as well as a strong psychosocial component in terms of the ability to cope with the development of these injuries and with life with chronic pain. Engaging in high impact physical and recreational activity will be difficult and will aggravate the pain. Social and familial relationships tend to progressively worsen over the years. This is consistent with the client’s reported and documented post¬accident condition.

Q: Are you able to state that “it is more probable than not” that a future event will occur?

Yes, it is probable that a future event will occur, meaning that the client will probably experience either continuous pain or flare-ups in pain due to the accident-related diagnoses.

CAUSALITY:

With some discussion below, these diagnoses are causally related to the motor vehicle accident on the date of loss.

The painful symptoms reported were not present prior to the accident and all developed at the time or soon after the accident, including the left arm pain (x-ray January 7, 2011 to rule out fracture). The injuries are consistent with the mechanism of injury. The persistence and severity of these painful injuries has resulted in the development of the chronic pain syndrome, complicated by a mood disorder.

As the ankle and knee pain developed much later, it is probable that they developed as a result of the chronic limp, which is directly related to the accident-related back pain, notably left sacroiliac joint pain. Therefore the ankle and knee pain are probably indirectly causally related to the accident.

Q: Are there any medical conditions or injuries which existed prior to the motor vehicle

accident which have an effect on the client’s current medical condition? If so, what are the conditions or injuries and what effect do they have on her current medical condition?

No, there were no significant predisposing factors. This client had no meaningful pre-accident symptoms and led an unrestricted lifestyle socially, recreationally and professionally.

She clarified that the left arm symptoms reported in 2009 (see ER visit from June 14, 2009) were likely related to an arm or wrist strain while pushing her son’s bedroom furniture, and the symptoms resolved within a few days with no subsequent pain or restriction. This is consistent with the absence of these symptoms in Dr. XX’s records.

Other than one mention of back pain in Dr. XXr’s clinical records on October, 2010, her pre-accident visits are primarily related to hypertension and peri-menopausal symptoms. Given the presence of mild facet and disc degenerative changes on the x-ray from January, 2011, there was

pre-existing degenerative changes (which are very common and often asymptomatic). At most, these changes possibly resulted in mild pre-disposition to developing back pain from the accident. However, it is highly improbable that she would have spontaneously developed chronic back pain had the accident not occurred. The presence of these degenerative changes are clinically insignificant in many patients, and there is no relationship between these changes and the accident-related left sacroiliac joint pain, which is the predominant cause of her current back pain and referred leg symptoms.

DISABILITY:

Q: Please address the following issues with respect to each impairment: the nature of the

impairment, the permanence of the impairment, the specific function that is impaired, the importance of the specific function to the person, and whether the impairment was directly or indirectly sustained as the result of the accident?

These diagnoses result in impairments that restrict the following important functions: prolonged walking, sitting, standing, repetitive bending/pushing/pulling, heavy lifting, high impact physical activities (for example, running, jumping) and extension, flexion or rotation of the neck. These impairments are serious and permanent and have been continuous since the accident.

The relatively high score on the psychosocial score of the pain questionnaire is consistent with a significant degree of impairment due to ongoing psychosocial changes.

Q: Was the impairment causally related to the accident on the above date of loss?

Yes, see above discussion of causality.

Q: Please provide an opinion with respect to whether the impairment has been continuous

since the accident.

Yes, the impairment has been continuous since the accident.

Q: Please provide an opinion with respect to whether the impairment of function interferes

with the client’s usual activities of daily living?

When considered together in the context of a chronic pain condition, these diagnoses result in impairment that effect the client’s ability to maintain activities of daily living, including personal care (at times requiring her husband’s help to remove shirts), driving (due to pain with prolonged sitting), cooking (due to difficulty standing or bending), leisure/recreational activities and social activities that require the use of the above-noted functions that were normally engaged in at the time of the accident. This includes being unable to return to community theatre.

Q: Please provide an opinion with respect to whether the function impaired is necessary for

the client to provide his own care or well-being?

Yes, the functions impaired are required for the client to provide self-care, including bathing, dressing and self-grooming. Although she sometimes requires her husband’s help to remove shirts, she manages independently with most self-care activities most of the time.

Q: Please provide an opinion with respect to whether the function impaired impacts upon

the client’s ability to engage in homemaking/housekeeping activities?

The client has limitations to perform homemaking duties requiring heavy lifting, repetitive bending and prolonged standing or walking, and she should avoid the heaviest chores such as shoveling and lawn care.

Q: Subject to the client reasonably participating in the recommended treatment of the

impairment, is the impairment expected to improve?

Based on the client’s current condition, and without stabilization of pain and function, it is probable that the condition and resulting impairment will continue to deteriorate. Subject to the client reasonably participating in the recommended treatment (below), it is possible that the client’s symptoms will be better controlled, but it is probable that the impairment will not significantly improve due to the chronicity and severity of the diagnoses.

EMPLOYABILITY:

Q: Please provide an opinion with respect to whether the client’s injuries, sustained in the

motor vehicle accident, prevent her from engaging in any form of employment for which she may be reasonably suited by way of education, training and experience? If you are of the opinion that the client is now limited in vocational options, please state so and discuss the limitations. Please also advise if you believe the client has suffered a loss of competitive advantage in any employment field she may ultimately be able to work in and the types of restrictions she will have on any occupation ultimately chosen.

This client was previously self-employed with her husband in the management and operations of their restaurant. Demands include many of the important functions that are currently restricted. Based on this client’s current restrictions, she will have permanent impairment restricting her ability to maintain working in her chosen profession at pre-accident levels, therefore limiting her vocational options. Given the severe global impact of the chronic pain syndrome with mood disorder on Mrs. Rida, including deconditioning, poor sleep, altered concentration/attention and mood changes, she will be unable to sustain any form of productive employment in the foreseeable future.

She reported, however, maintaining hope of working again if her condition were to improve. While it remains improbable that her symptoms will improve enough to sustain productive employment after this long, additional treatments may provide improved pain severity and stability such that she could consider non-competitive employment or non-vocational activities.

FUTURE MEDICAL TREATMENT AND RECOMMENDATIONS:

Q: Please provide an opinion with respect to whether the client would benefit from any

further testing, examination or treatment?

The following are recommended to attempt to stabilize current pain and function and to possibly delay further deterioration:

• Medical options for the family doctor to consider include multimodal anti-neuropathic analgesia, including: Nortriptyline 10-20 mg nightly; Gabapentin 100 mg to 600 mg. These can help to stabilize the pain and sleep-wake cycle without the side effects of opioid analgesia;

• Aquatherapy, swimming and a supervised low impact aerobic exercise program is recommended for stabilization and long-term management of this pain condition;

• Assistive device:

o Cane to help avoid chronic limping

o Orthotics or proper footwear for plantar fasciitis and Achilles tendinitis

• Referral to an Interventional Pain Clinic to consider interventional treatment options to help stabilize the pain and enable less pain with more rehabilitative efforts, including:

• Diagnostic sacroiliac joint (SlJ)-pain assessment to objectively document SIJ- mediated pain, which can also help determine a possible treatment option to stabilize ongoing mechanical back pain;

Sacroiliac joint pain is often associated with chronic low back pain and tends to remain chronic without further treatment. Diagnostic sacroiliac injections can help to determine if the sacroiliac joints specifically are contributing to the pain. A negative result would imply that the pain generator is more likely from an alternate source, such as myofascial tissue, intervertebral disc, facet joints or neuropathic in nature. Noninvasive treatments include swimming/Aquatherapy and wearing a sacroiliac belt during activity, which helps to stabilize the pelvis and decrease pain. This pain may possibly improve with concurrent treatment of back pain from alternate pain generators. Occasionally sacroiliac injection with corticosteroid, prolotherapy or radiofrequency neurotomy is necessary for control of persistent symptoms. Osteopathic and chiropractic treatment appear particularly beneficial for sacroiliac pain.

• Diagnostic facet-pain assessment to objectively document facet-mediated pain, which can also help determine a possible treatment option to stabilize ongoing mechanical neck and/or back pain;

Based on the characteristics and location of spinal pain, it is possible that the pain is generated from the facet joints of the spine. A diagnostic facet-pain assessment provides a more objective and evidence-based method of determining if the facet joints are the source of pain generation. A diagnostic facet-pain assessment can be valuable in the determination of prognosis for mechanical spinal pain (with respect to symptom control). A negative result would suggest that the pain generator is more likely from an alternate source, such as myofascial tissue, intervertebral disc, sacroiliac joint or neuropathic in nature. In addition, it is useful in providing some direction for possible treatment options for post¬whiplash or strain injuries.

• Lidocaine +/- ketamine infusions for medically-resistant neuropathic pain;

• Possible epidural steroid injections for radicular pain;

Based on the description of ongoing pain radiating down the left arm, supported by physical examination and findings reported on MRI (small herniations), it may be reasonable to consider a trial of fluoroscopically-guided epidural steroid injections. These injections can possibly improve the painful symptoms of spinal pain and limb pain due to underlying disc disease with nerve root impingement or radiculitis. If efficacious, these treatments can be repeated every 3-6 months as required.

• Referral to a multidisciplinary pain management program, addressing physical, psychological and self-management issues concurrently. Multidisciplinary rehabilitation is recommended for the treatment of chronic pain by several authoritative bodies, including the College of Physicians and Surgeons of Ontario, American Society of Anesthesiologists and the International Association for the Study of Pain. Goals of multidisciplinary care include both subjective outcomes as well as objective functional outcomes (e.g. return to work). The physical component would be a reconditioning program that focuses on improving strength, endurance and flexibility of the upper and lower extremities, cervical and lumbar spine regions and core stability as well as lower impact cardiovascular and respiratory conditioning. This needs to be carried out in a supervised and progressive manner in order to be effective. The overall objective is to stabilize both the pain condition and level of function. This client would be a strong candidate for a multidisciplinary pain management program. Unfortunately there are few publically funded multidisciplinary pain management programs in Ontario, but a coordinated effort amongst providers addressing each area of need would be appropriate.

• Physical therapy for various j oint and tendon diagnoses

• Further investigations, if not already complete:

o Left shoulder ultrasound

This concludes the Independent Chronic Pain Assessment on your client. Please feel free to contact my office for clarification of any of the materials presented.

Yours sincerely,

K. Smith, M.D., F.R.C.P. (C)

REFERENCES:

The following references have been used in support of opinions in this assessment. This list is not all-inclusive and may be updated from time to time.

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# Dr. Mark Friedlander – CV

# Dr. Mark Friedlander – Sample Rep

# Dr. Michael Gofeld – CV

# Dr. Michael Gofeld – Sample Report

# Dr. Pat Morley-Forester – CV

# Orthopedic Surgery

# Dr. Harsha Malempati – CV

# Dr. Harsha Malempati – Sample Rep

# Dr. Rajiv Ghandi – CV

# Dr. Rajiv Ghandi – Sample Report

# Dr. W. Latham – CV

# Dr. W Latham – Sample Report

# Chiropractic

# Dr. Mike Lehr