

# PRECISION

## Psychiatric Evaluations

**DR. SANJAY AGARWAL, M.D., Q.M.E.**

**410 TOWNSQUARE LANE,  
HUNTINGTON BEACH, CA 92648**

**(855) 472-3894  
(855) 490-3554 - FAX**

**JANUARY 12, 2022**

Brett Sherry, Esq.  
Koszdin, Fields, Sherry & Katz  
6151 Van Nuys Blvd.  
Van Nuys, CA 91401

Nicolett Ybarra, Esq.  
Law Offices of Muhar, Garbar,  
Av & Duncan  
P.O. Box 7218  
London, KY 40742

**EXAMINER:**

**Sanjay Agarwal, M.D.**  
Psychiatry

EMPLOYEE	:	Mr. Branden Moore
EXAM DATE	:	12/06/2021
DATE OF BIRTH	:	05/12/1990
EMPLOYER	:	Abercrombie Pipeline
D/INJURY	:	05/28/2020
CLAIM NUMBER	:	WC608-W60694-00
PANEL NUMBER	:	2757577
WCAB NUMBER	:	ADJ13339678

## **INITIAL PSYCHIATRIC QUALIFIED MEDICAL EVALUATION**

### **EVALUATION CONCLUSIONS**

My summarized assessment about Mr. Moore's psychiatric status is as follows:

1. Synopsis: Mr. Moore experienced multiple physical injuries while working for the above-named employer.
2. Psychiatric Symptoms: reactive depression and reactive anxiety
3. Primary Axis I: Adjustment Disorder with Mixed Anxiety and Depressed Mood, Chronic (309.28);
4. GAF/WPI: 63 which translates to a WPI score of 11
5. Future Medical Treatment: Comments on future medical treatment will be deferred until Mr. Moore has reached MMI/P&S from a psychiatric perspective.
6. Recommended Treatment: This writer does believe that Mr. Moore's psychiatric symptoms could improve with additional mental health treatment. However, per Title 8, Division 1, Chapter 1, Article 3, §35.5 (Compliance by AMEs and QMEs with Administrative Director Evaluation and Reporting Guidelines), g(2),

*"For any evaluation performed on or after July 1, 2013, and regardless of the date of injury, an Agreed Medical Evaluator or Qualified Medical Evaluator shall not provide an opinion on any disputed medical treatment issue, but shall provide an opinion about whether the injured worker will need future medical care to cure or relieve the effects of an industrial injury."*

Therefore, based on the above, it is this writer's opinion that Mr. Moore would benefit from additional mental health treatment. However, this writer will not provide any specific recommendations for treatment as I am unsure what medical treatment may be in dispute. Of course, upon written request, this writer will be happy to provide specific recommendations for additional mental health treatment to help expedite Mr. Moore reaching MMI/P&S.

7. Causation: On a **preliminary** basis, this writer finds that that Mr. Moore's current psychiatric injury is **predominantly industrial** in nature. Of special note, Mr. Moore states that he has pending QME evaluations, stating that he has a QME in

cardiology with Dr. Jeffrey Caren (cardiology) on 2/4/2022 and a QME in orthopedics with Dr. William Winternitz (orthopedic surgery) on 2/24/2022.

Of special note, this writer noted that Mr. Moore's injury occurred on 5/28/2020, which was approximately 2 months after beginning employment with the subject-employer, Abercrombie Pipeline, in March 2020. Therefore, this writer considered LC 3208.3 (d), which addresses employment of less than 6 months (see below for details).

**Also of very special note, all of my above opinions in regards to causation are subject to change until after this writer has determined Mr. Moore to be MMI/P&S, as, at that time, this writer will be able to take apportionment into account. At that time, this writer will then provide a specific percentage of causation to the industrial portion of Mr. Moore's psychiatric injury versus the potential non-industrial portion of Mr. Moore's psychiatric injury and consequent permanent psychiatric disability.**

8. **Apportionment:** Because causation is being deferred, a formal comment on apportionment will also be deferred at this time.

*Benson:* Given that there is only 1 date of injury, the Benson decision does not apply as 100% of Mr. Moore's industrially-related permanent psychiatric disability would be attributed to the specific date of injury on 5/28/2020.

Of course, this is a **preliminary** opinion and subject to change if additional dates of injury are added in regards to this claim.

9. **Maximal Medical Improvement (MMI)/Permanent and Stationary (P&S):**  
This writer will **defer** commenting on whether Mr. Moore has reached MMI, and whether he can be declared P&S from a psychiatric perspective until after all records including but not limited to the QME reports from Dr. Jeffrey Caren (cardiology) and Dr. William Winternitz (orthopedic surgery) as well as the requested AME or QME in neurology have been received to determine whether either of these physicians recommend additional treatment. This information is quite important as any changes in Mr. Moore's physical status would likely change his psychiatric status.
10. **Temporary Total Disability (TTD)/Permanent Total Disability (PTD):** At no time has this writer found Mr. Moore to be TTD or PTD psychiatrically in regards to this industrial injury from the earliest date of injury in relation to this claim of 5/28/2020 up to and including the date of this evaluation, 12/6/2021. This is a

**preliminary opinion** and subject to change until after this writer has declared Mr. Moore MMI/P&S from a psychiatric perspective and this writer has received all records pertaining to Mr. Moore.

11. **Permanent Psychiatric Disability:** Deferred as Mr. Moore is not declared P&S from a psychiatric perspective at this time.
12. **Factors of Permanent Psychiatric Disability:** Deferred as Mr. Moore is not declared P&S from a psychiatric perspective at this time.
13. **Section 3208.3(b)(2):** Per the examination and after a careful review of the records, this injury is not a direct result of exposure to significant violent acts. Therefore, section 3208.3(b)(2) does not apply.
14. **Section 3208.3(d):** It appears that Labor Code 3208.3(d) **may come into play** as Mr. Moore was not employed for greater than 6 months with the subject employer at the time of injury. This writer would ultimately **defer to the Trier-of-Fact** to determine whether the workplace events leading to Mr. Moore's injuries constitute "a sudden and extraordinary employment condition" as this is a legal determination, not a medical one.
15. **Section 3208.3(e):** The injury does not meet the criteria for a post-termination case. Mr. Moore remains employed by the subject-employer.
16. **Section 3208.3(h):** 3208.3(h) does not apply as Mr. Moore denied that there are substantial personnel actions involved.
17. **Requested Examinations:** After a careful review of the records and a comprehensive examination, I do recommend a Neurology AME or QME evaluation **if not already performed** to answer the following critical questions:
  - A) Are Mr. Moore's neurological injuries and complaints industrial in causation?
  - B) Has Mr. Moore reached MMI and thus been declared P&S from a neurological perspective?
  - C) If not found to be MMI, what treatments are recommended to restore Mr. Moore to his pre-injury level of physical functionality?
18. **Work Restrictions:** Deferred as Mr. Moore is not declared P&S from a psychiatric perspective at this time.

Mr. Branden Moore

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19. Requested Records: During the evaluation, Mr. Moore states that he had his deposition taken in regards to this workers' compensation claim. In addition, he states that he has upcoming OME appointments in cardiology and orthopedics respectively that are scheduled to take place in February 2021. Mr. Moore also was seeing Dr. Paul Liderman, (psychiatry) through the Veterans Affairs (VA) health system; however, this writer only received a few records from him. In addition, Mr. Moore states that he may have had some telephone interactions with Dr. Kenneth Garrett, PhD (psychology) who he was seeing on an industrial basis. This writer would also request that a full copy of the Progress Note dated 3/23/2016 and authored by Dr. Paul Liderman, M.D. (psychiatry) be provided as a portion of this note was missing. This writer would request all of the aforementioned records as well as all other additional and missing records be provided to my office as soon as possible for my review. A supplemental report will be issued with a summary of the records along with my opinion.

**BILLING STATEMENT:**

Usually, this evaluation would fall under ML 201 for an initial psychiatric evaluation with the applicable 2.0 modifier, however, because of the complexity of the evaluation as described below, I believe 5307.6(b) applies. Accordingly, I have billed my usual and customary fee on an hourly basis to account for the total time required to prepare this evaluation.

There are clearly "extraordinary circumstances" relating to the medical condition for which Mr. Moore was evaluated. The best proof regarding the complexity of this evaluation is the substance of the medicolegal report which reflects these complex issues. Some examples of the issues of complexity that are reflected in this evaluation include the following: multiple prior nonindustrial injuries including documented episodes of prior Major Depressive Disorder, Generalized Anxiety Disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, and Panic Disorder; depression, anxiety, panic attacks, and PTSD in conjunction while serving for a prior employer (the US Marines) during his enlistment; a claim with likely highly apportioned concerns in multiple other organ systems including but not limited to orthopedic, neurological, cardiovascular, and internal medicine at both the time of employment and prior to employment contributing to adverse mental sequelae; a review of complex and detailed past medical, surgical and psychiatric histories; a review of complex and detailed family medical and psychiatric histories; a comprehensive review of social and occupational history which included prior conflicts causing mental distress; a review of previous injuries with a previous employer and subsequent disability; a review of the applicant's psychiatric history which predated the subject employer in terms of multiple psychiatric diagnoses per the documentation including depression, anxiety, panic attacks, bipolar disorder, and PTSD; a complex history due to the applicant being a difficult historian; careful review and synthesis of both industrial and non-industrial events in light of a voluminous amount of records received supporting the complexity of this case; a review of medications, allergies, and all current conditions and medical treatments; complex issues of causation being addressed with respect to predominant industrial causation; a review of current activities of daily living in light of other history obtained; and synthesis of a mental status examination and comprehensive psychiatric testing profile with the aforementioned information to arrive at comprehensive and well-reasoned preliminary conclusions based upon reasonable medical evidence.

This Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances included:

1. Face-to-face time with Branden Moore required 4.75 hours.
2. Record review required 20.75 hours for 1419 pages received with an attestation.

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3. Report preparation and editing required 15.5 hours.
4. Psychological Testing required 5.0 hours.
5. Complex psychiatric issues addressed with this comprehensive evaluation.

Date of Report: January 12, 2022. Signed this 12<sup>th</sup> day of January 2022 in San Bernardino, California.

Sincerely,



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Sanjay Agarwal, MD  
Qualified Medical Evaluator  
Diplomate of the American Board of Psychiatry and Neurology

Dear Gentlepersons:

Mr. Branden Moore was seen for a diagnostic psychiatric evaluation, as scheduled on 12/6/2021, and this evaluation took place via Zoom due to the Covid-19 pandemic. This writer was present at his office located at 410 Townsquare Lane, Huntington Beach, CA 92648, and Mr. Moore stated that he was present at his current place of residence located at 292 Finnhorse St., Hemet, CA 92545. Mr. Moore verified that he was alone in the room, and this writer did not notice anyone else in the room with him or anyone communicating with him during the entirety of this evaluation. The evaluation performed and the time spent performing such evaluation was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph (3) of subdivision (J) of section 139.2.

The following report summarizes my findings and my opinion on diagnosis as well as the issues of causation, disability and apportionment, if any, in relation to the alleged injury sustained by Mr. Branden Moore while employed by the subject-employer, Abercrombie Pipeline.

This psychiatric report is confidential and privileged. Some individuals and family members may tend to misunderstand and distort the information enclosed in this report. This may result in significant psychological distress to Mr. Moore or may interfere with the treatment and eventual recovery from illness.

For individuals with self-destructive or assaultive tendencies, the consequences of ill-considered disclosure of this report may be serious. This report is meant for the use of qualified professionals only and those with the need to know by operation of law. Persons breaching the confidential nature of this report assume the risk and liability of doing so.

At the onset of examination, it was explained to Mr. Moore that this report was not confidential and that the information obtained and findings, as well as diagnosis and report completed by the examining physician, would be shared with the insurance company and all other parties involved in this matter. Mr. Moore expressed understanding and agreed.

On 12/06/2021, I conducted an extensive evaluation on the above-named claimant to determine if there was a work-related psychiatric injury. In addition to my face-to-face examination with Mr. Moore, I was able to review the records provided. Other than these records, Mr. Moore is the sole provider of the information from which this report including my assessment, recommendations, and conclusions were prepared.

The interview was conducted in English without assistance from an interpreter.

### **IDENTIFICATION DATA**

Mr. Branden Moore is a 31 year-old African-American male who is currently married, on leave and on disability, and living in Hemet, CA. Also, Mr. Moore last worked for the subject-employer, Abercrombie Pipeline, on 05/28/2020.

Of note, Mr. Moore was a very vague historian at times, often losing his concentration and not paying attention to what this writer was asking of him. He also had a great deal of difficulty remembering the chronology of events as well as many details of his past psychiatric history. As a consequence, this writer had to repeat questions numerous times and constantly clarify and rephrase questions before Mr. Moore would provide an appropriate response. However, Mr. Moore was noted to be calm, pleasant, patient, and cooperative throughout the evaluation day.

### **SUMMARY OF THE INDUSTRIAL EVENTS AS RELATED BY MR. MOORE**

#### Employment Details

Mr. Moore worked for the subject-employer, Abercrombie Pipeline, as a groundman. His main job duties included moving 1000 pound rails, climbing up and down tractors and equipment, loading power lines, moving and stacking steel, and driving forklifts.

Mr. Moore worked full-time (80 hours per week, 6 days per week).

Prior to the date of injury, Mr. Moore denied any significant difficulties performing the normal work duties at the worksite.

Prior to the above-listed date of injury, Mr. Moore denied any previous history of disciplinary actions or conflicts with management or coworkers at the worksite.

Overall, Mr. Moore said he loved his job.

Industrial Events

*Brief Summary*

On the date of injury, Mr. Moore was involved in the usual and customary duties at the worksite.

On 5/28/2020, while working for the subject-employer, Abercrombie Pipeline, Mr. Moore suffered a heat stroke, which led to multiple physical problems including but not limited to kidney failure.

*Full Summary of Events*

Mr. Moore began working for the subject-employer, Abercrombie Pipeline, in March 2020 as a ground man. Overall, Mr. Moore states that he loved his job.

Mr. Moore states that things were going well until 5/28/2020. Mr. Moore began his typical workday at 4:30 AM, and on that day, he was performing a variety of duties that required heavy lifting and extremely strenuous work. Mr. Moore states that it was a very hot day, estimating by noon that it was 115-119°: "Also, I was doing everything. I was just with a lazy group of guys."

Mr. Moore states that at times, he tried to take a break; however, due to the workload, his supervisor kept pushing him to continue working. As the day went on, Mr. Moore began to notice that he was sweating profusely and he also began to experience muscle cramps that progressively intensified as the day went on. He told his foreman about the muscle cramps, was given some Himalayan pink salt, and told to keep working. By 5 PM, Mr. Moore states that he was exhausted and collapsed on sporks of a forklift. By then, a different crew had arrived, and they put Mr. Moore in a truck, put cold water under his arms, and also gave him electrolyte drinks. However, Mr. Moore continued to experience a variety of physical symptoms. Approximately 30 minutes later, his co-workers then drove him to a gas station and continued to try to rehydrate him: "By then, I was in excruciating pain from head to toe. I don't know why they didn't call 911 to begin with." Mr. Moore states that he was going into and out of consciousness, and they then drove him to San Gorgonio Hospital's emergency room: "I was screaming the whole way because of the pain. I never experienced anything like that even in the Marines." At the hospital, Mr. Moore states that he was given several bags of intravenous fluids and muscle relaxers; however, it was determined that he had suffered heatstroke and acute renal failure. Mr. Moore remained at San Gorgonio hospital for 1-2 days and was then transferred to the Veterans Affairs (VA) Hospital located in Loma Linda, CA. Mr. Moore was hospitalized for an additional one and a half days and then discharged. Mr.

Moore states that he experienced a variety of physical symptoms that have continued up to the present time and have prevented him from returning to work since 5/28/2020. Mr. Moore states that the physical symptoms affect his entire body although he has noticed that the left side of his body is worse than his right side. Mr. Moore states that he experiences pain affecting his whole body: "It feels like my whole body is on fire." Mr. Moore also experiences muscle weakness, mental fatigue, a left-sided limp, numbness and tingling affecting all of his extremities, back pain, headaches, and increased sensitivity to sunlight, which causes nausea and profuse sweating. He has also noticed decreased levels of memory and concentration, trouble with his coordination, dizziness, decreased sensation to touch, digestive changes, and sexual dysfunction. Mr. Moore also states that he has ongoing nightmares of being in the back of a truck in excruciating pain that continues to occur on a nightly basis (Please refer to the section entitled, "History of Psychiatric Symptoms after the Industrial Events," for more details about his nightmares and various other psychiatric symptoms).

Overall, at the time of this evaluation, Mr. Moore states that his psychiatric injury is exclusively due to ongoing difficulty coping with the physical limitations and chronic pain caused by his various physical injuries that not only prevent him from returning to work but also affect him in all aspects of his personal and social life such as not being able to be active with his wife and daughter.

Of special note, Mr. Moore states that if he was physically well, he would happily return back to the workforce, performing his normal and customary duties although he would not return back to work for the subject-employer, Abercrombie Pipeline, "Because they are negligent. I am in the union, so I have lots of other options." However, again, Mr. Moore states that his psychiatric injury is exclusively due to difficulty coping with the sequelae of his various physical injuries and not due to any other source including but not limited to personnel actions.

#### Post-Injury Details

After the last day of work for the above-named employer, Mr. Moore attended multiple appointments with various clinicians and had contact with his attorney. Of note, Mr. Moore has not worked in any jobs since the last day of work with the subject employer.

Since the industrial events occurred, Mr. Moore has been treated with pain medications, muscle stimulation, mental health treatment (see below for details), various radiographic tests such as X-rays, and information on self-exercises. In addition, he has tried breathing techniques on his own: "I have tried to do the same things that the VA did for me when I had my nightmares about my cardiac problems." Of note, on a private basis,

Mr. Moore states that he has received muscle stimulation and acquired a cane that he uses daily to compensate for difficulty with the left side of his body

Of note, Mr. Moore states that he was receiving his pain medications, Naproxen and gabapentin, from the VA although he does not currently take these medicines as he does not find them to be effective.

In regards to mental health treatment, Mr. Moore states that he received an intake session with Dr. Kenneth Garrett, PhD (psychology) on 6/4/2021 but denied receiving any sessions of dedicated psychotherapy. Otherwise, Mr. Moore denied receiving any mental health treatment in regards to this workers' compensation claim.

Overall, Mr. Moore believes that he would benefit from additional mental health treatment such as sessions of individual psychotherapy to help him cope with the physical limitations following his heatstroke but does not find it necessary for him to return to the workforce: "I would like to learn to cope with the stress from my life changing so much. Also, I would like to get rid of the nightmares of me yelling in the truck. Honestly, though, if my physical problems got better, I probably would not even need mental health treatment." He also states that he would be open to receiving psychotropic medications, "but the best thing that helped me was the therapy. I don't want to be pumped full of pills. I also have to remember that I can only take medicines that work with my CDL [commercial driver's license]. I can't be on any kind of sedative."

To the best of his knowledge, Mr. Moore states that pending medical appointments and treatments include upcoming appointments with a cardiologist, neurologist, and orthopedic surgeon although he was unsure what their names are or when the appointments would be scheduled.

Overall, Mr. Moore said the physical treatments led to no significant decrease in pain, and he did not find the mental health treatment to be very helpful, "because I only received one session with a psychologist, and that's it. That wasn't even really treatment. It was more of an intake. Everything keeps getting denied."

### **PSYCHIATRIC SYMPTOMATOLOGY**

#### **History of Psychiatric Symptoms before the Industrial Events**

Before the industrial events, Mr. Moore described himself as, "Energetic, fun and active." Prior to the above-stated industrial events, Mr. Moore admitted to an intermittent history of psychiatric symptoms (Please refer to the section entitled, "Past Psychiatric History,"

for more details). Briefly, Mr. Moore developed multiple symptoms of PTSD following a sudden cardiac event in 2012 when he required resuscitation while he was serving in the Marines. However, Mr. Moore states that his symptoms of PTSD and fear of sudden death resolved approximately in 2018 after he took a job at a funeral home to face his fear of death.

#### History of Psychiatric Symptoms after the Industrial Events

Overall, Mr. Moore complained of depression and anxiety. Mr. Moore states that he first started noticing his mood change on 5/28/2020: "It was just crazy. I felt in a haze. Now, my stress is because I am still experiencing all of these physical symptoms, and I don't know when they will go away. I just want to get better and get back to work. This whole process is costing me a lot of money."

Overall, at the time of this evaluation, Mr. Moore states that his appetite has decreased, estimating that he has lost 20-30 pounds since the workplace events occurred on 5/20/2020.

Mr. Moore endorses a decreased level of energy: "I feel exhausted all the time."

Mr. Moore endorses a normal level of motivation: "I definitely want to go back to doing everything I was doing before 5/28/20."

Mr. Moore denies feelings of hopelessness: "I think things can get better, but I need proper treatment."

Mr. Moore endorses feelings of intermittent worthlessness: "I feel that way at times. I just can't get better. I just need proper treatment, but there are so many roadblocks with this system."

Mr. Moore denies feelings of guilt: "I do wish that I didn't take that call, but I did what I had to. It was the beginning of the pandemic so everyone was running around like chickens with their heads cut-off."

Mr. Moore endorses anhedonia as he does not enjoy spending time with his family and friends as well as engaging in his current hobbies, "because my wife and daughter are very active. I can't do anything with them like running. My daughter can just sit next to me on the couch. That's not fun for either of us. Even watering the grass, I can't do that because of all my physical problems. I am extremely sensitive to the sun and heat. I just can't do what I used to be able to do."

Mr. Moore endorses an increased level of irritability with “everybody but my kids. I’m unintentionally short with everyone else like my wife. I’m less patient because of the pain throughout my body.”

Mr. Moore endorses decreased levels of concentration and memory (i.e. takes longer to focus on various tasks, has poor focus when attempting to perform multiple activities concurrently, and is frequently forgetful).

In regards to his sexual habits, prior to the DOI, Mr. Moore would engage in sexual intercourse daily. However, at the time of this evaluation, Mr. Moore endorses a decreased level of sexual libido, engaging in sexual intercourse 1-2 times per month: “It’s hard for me to maintain an erection, because my kidneys start hurting. Sex is very uncomfortable for me now. I don’t enjoy it.” Of note, for comparison, just after the cardiac ablation procedure, which occurred on 4/13/2014, “I was humping like a rabbit.”

In regards to symptoms of anxiety, Mr. Moore states that the main focus of his anxiety is “the fact that I am still having physical ailments. I have an ongoing headache, muscle weakness, the left side of my body hurts, and I’m sensitive to sunlight and heat. It causes me to have nausea.”

In regards to Post-Traumatic Stress Disorder, during this evaluation, Mr. Moore mentioned that he periodically experienced nightmares of being in the back of the pickup truck in excruciating pain: “I just would have dreams like I was in the back of the truck screaming in pain. But, that’s it. I don’t have any other symptoms. Really, all of my problems are because of my physical ailments after the heat stroke.” Thus, Mr. Moore denied any other symptoms of PTSD such as avoidant behavior or increased arousal: “No, nothing like that. I can talk about any of this stuff, and I just want to go back to work as soon as I can.” Thus, Mr. Moore does not appear to meet criteria for PTSD in regards to the events that occurred on 5/28/2020; however, he does appear to have met criteria for PTSD in relation to events that occurred in 2012, which is described in more detail in the section below entitled, “Past Psychiatric History.”

In regards to panic, Mr. Moore denied experiencing any panic attacks. Therefore, Mr. Moore does not appear to meet criteria for any form of panic disorder based on the information available to this writer at this time. Of note, Mr. Moore stated that he has experienced panic attacks in the past prior to working for the subject-employer, which is also described below in the section entitled, “Past Psychiatric History;” however, his panic attacks resolved approximately in 2018 at approximately the same time that his symptoms of PTSD resolved as well.

In regards to his sleep pattern, prior to the industrial events, Mr. Moore achieved 8 hours of sleep per night without any difficulty falling asleep or waking up frequently. After the industrial events and at the time of this evaluation, Mr. Moore achieves an average of 2-3 hours of sleep per night with difficulty falling asleep and he wakes up frequently due to pain and physical discomfort.

Overall, Mr. Moore said that his psychiatric symptoms are not significant enough to prevent him from working, and he wants to return to work: "If I was better physically, I would go back to work tomorrow and you'd never hear from me again."

Of special note, Mr. Moore denies any active or passive suicidal or homicidal thoughts, and he contracts for his own safety as well as the safety of others outside of the evaluation today. In addition, Mr. Moore denies any symptoms of psychosis including but not limited to delusions, paranoia, or hallucinations, or any symptoms consistent with a diagnosis of bipolar disorder.

Of special note, per the records received, there was mention that Mr. Moore would see "hell" at times. During this evaluation, when asked to describe this statement, Mr. Moore stated, "I just meant that I had an out of body experience in 2011 when I passed out and had to be defibrillated. I felt like my consciousness went to hell. If I lied or cheated, I saw the consequences of my actions. It's happened twice. The first was due to the episode in 2011 and the second time was when I passed out in my kitchen around 2014, I think, which is why I decided to have my cardiac ablation. Anyway, I see it as a good thing, because it [seeing "hell"] taught me to be much more careful with how I treated others going forward."

### **NON-INDUSTRIAL FACTORS**

After a careful psychiatric interview and review of records, this writer was able to uncover and address multiple non-industrial factors as described below.

Mr. Moore states that his biological father verbally abused him and his stepmother physically and verbally abused him (Please refer to the section entitled, "Family History," for more details about Mr. Moore's family members, his history of abuse, and his relationship history). However, Mr. Moore denies that this history of abuse contributes to his emotional stress level at this time as they have both since apologized to him and he was able to forge a close relationship with them that has been ongoing up to the present time.

Mr. Moore's first marriage ended in divorce; however, he denies that his history of divorce contributes to his emotional stress level as he has 50/50 legal custody of his son who was a product of this marriage, and he is quite happy with his current marriage.

While serving in the Marines, Mr. Moore witnessed the death of one of his superior officers and found out that 2 of his co-soldiers also died, all of which is described above in the section entitled, "Full Summary of Events." However, Mr. Moore denies that these deaths contribute to his emotional stress level at this time as he has accepted these losses and bereaved them appropriately.

Also, while serving in the Marines, Mr. Moore was diagnosed with a cardiac condition known as Wolff-Parkinson-White Syndrome, which caused Mr. Moore to suffer an arrhythmia and required resuscitation. As a result, Mr. Moore had ongoing fear of sudden death for several years. However, Mr. Moore denies that his cardiac condition, any of his other medical issues, or his fear of sudden death contributes to his emotional stress at this time as he states that following a cardiac ablation in 2014, his cardiac condition has been stable for several years without issue. In addition, Mr. Moore states that by 2018, his fear of sudden death resolved after he "faced my fear of death" after he accepted a job at a funeral parlor.

Also, while serving in the Marines, Mr. Moore developed orthopedic injuries to multiple areas of his body (Please refer to the section entitled, "Occupational History - Previous Work-Related Injuries," for more details). However, Mr. Moore denies that any of his previous orthopedic injuries contribute to his emotional stress level at this time as they have improved and do not limit him in any substantial way.

As a child and adolescent, Mr. Moore states that he witnessed some episodes of violence including being shot at (Please refer to the section entitled, "Social History," for more details about these episodes). However, Mr. Moore denied that his upbringing in a relatively violent area contributes to his emotional stress level as he did not develop any psychiatric symptoms including but not limited to signs or symptoms of PTSD and also states that the violence further motivated him to join the Marines to improve his situation.

Of note, Mr. Moore denied being involved in any motor vehicle accidents or filing for any bankruptcies.

### **CURRENT MEDICATIONS**

While he is being prescribed gabapentin 100mg and naproxen 5mg for pain by Dr. Bas of the VA, Mr. Moore states that he stopped taking both of these medicines due to not experiencing any benefit.

Of note, while he has taken psychotropic medications in the past, Mr. Moore denied that he was taking any psychotropic medications at the time of this interview.

### **ALLERGIES**

Mr. Moore denied any known drug allergies.

### **PAST MEDICAL HISTORY**

In regards to his chronic medical illnesses, Mr. Moore denies any current medical diagnoses although he has been diagnosed with Wolff-Parkinson-White Syndrome approximately in 2012, which Mr. Moore states has now resolved following his cardiac ablation as described below.

Of note, Mr. Moore has a history of testicular pain and a testicular mass; however, during this evaluation, Mr. Moore stated it was a varicocele affecting his left testicle and has since resolved. In addition, Mr. Moore states that he was diagnosed with a sexually-transmitted disease, Chlamydia, which was successfully treated. He believes he contracted it while serving in the Marines or soon afterward. However he denies contracting any additional STDs to the best of his knowledge. There was also mention that Mr. Moore was discharged from the Marines due to various orthopedic injuries per the records received; however, during this evaluation, Mr. Moore stated that while he did suffer some physical injuries while serving, he was honorably discharged due to his cardiac condition and need for treatment.

His main locations of physical pain include his left hip, headaches, "and my whole body feeling like it's on fire. Also, my hands feel like they're being pricked by pins and needles at times."

In regards to his surgical history, Mr. Moore states that he underwent a cardiac ablation due to Wolff-Parkinson-White (WPW) Syndrome on 4/13/2014, which was successful.

### **PAST PSYCHIATRIC HISTORY**

Mr. Moore denied any history of past suicide attempts or psychiatric hospitalizations; however, he did receive mental health treatment prior to the above-stated date of injury, which is described below. Of special note, per the medical records received, there was mention that Mr. Moore attempted to end his own life as a child. During this evaluation, when asked about this documentation, Mr. Moore stated that he was a child when this incident occurred, "Yes, I was very little. My father was going to start working nights at the warehouse. I didn't want to spend time alone with my stepmother because she was mean, so I said I would hold my breath until I died. That didn't work. Honestly, I don't know why they documented that to be a suicide attempt."

He received sessions of individual psychotherapy, a few sessions of group psychotherapy, sessions with a psychiatrist, and he was prescribed psychotropic medications, all of which he received via the VA to treat his various psychiatric symptoms especially PTSD and Panic Disorder, which is described below. Of note, Mr. Moore had difficulty remembering the names of his clinicians, details of his psychiatric disorders, and the psychotropic medications that were prescribed: "It has just been too long. Also, my memory is not very good right now."

Mr. Moore states that prior to 2011, he did not require any form of mental health treatment. However, in 2011, while serving as a Marine, Mr. Moore experienced a cardiac episode due to Wolff-Parkinson-White (WPW) Syndrome, which caused him to lose consciousness and require resuscitation by defibrillation. Since then, Mr. Moore developed multiple symptoms of Post-Traumatic Stress Disorder due to fear of suddenly dying. Of note, prior to the cardiac episode, in 2010, Mr. Moore witnessed his sergeant die during a training exercise when he drowned in a vehicle. In addition, in 2011, Mr. Moore learned that one of his fellow soldiers committed suicide by hanging although he did not witness any aspect of this death including but not limited to being present at the site where his friend died. While Mr. Moore states that these events did trouble him, he states that his symptoms of PTSD began after his cardiac episode requiring defibrillation and subsequent fear of sudden death.

Over the years, Mr. Moore continued to have ongoing concern about sudden death due to his cardiac condition, which led him to developing panic attacks as well. Mr. Moore states that he received sessions of individual psychotherapy, a few sessions of group therapy, and various psychotropic medications, all of which were received through the VA. Mr. Moore was also court-ordered to attend anger management classes as part of the divorce from his first wife, which is described in more detail in the section entitled, "Family History." Of note, Mr. Moore was given a variety of diagnoses per the medical records received at this time including PTSD, panic disorder with agoraphobia,

Generalized Anxiety Disorder, Major Depressive Disorder, and Bipolar Disorder. Of special note, the diagnosis of Bipolar Disorder was only mentioned in one note that was received by this writer, and Mr. Moore states that it was only documented because his wife at that time told the doctor that Mr. Moore suffered from bipolar disorder, which is why it was included in the note: "That was bull crap. My ex-wife mentioned that the doctor just wrote that down. I never needed treatment for that. The diagnosis did not make sense. I did have to go to anger management treatment, but that was because my ex-wife told the court that I had to do that in order to see my son." Otherwise, Mr. Moore denied any history of symptoms consistent with mania, which is the phase assessed to determine whether somebody suffers from bipolar disorder. In addition, Mr. Moore states that he did not experience a great deal of relief from any of the psychotropic medications (including but not limited to clonidine, Ambien, lorazepam, duloxetine, and trazodone per the records) that he was prescribed by the VA: "Some of them would help for a little bit, but if you use them too much, they stop working." Also, when asked about specific psychiatric symptoms in the past, Mr. Moore was unable to recall them. However, Mr. Moore states that his main complaints centered on intense fear of sudden death, which resulted in nightmares and difficulty falling asleep: "Those were really my main complaints. I didn't actually feel depressed. I don't know why they gave me that diagnosis. I think it turned out that I did not have depression or anxiety or anger. I was told it was more the PTSD that caused me to feel that way."

However, by 2018, Mr. Moore states that his psychiatric symptoms substantially improved and resolved after he took a job as a funeral director in 2016. Mr. Moore states that the impetus to take this job was to "face my fear of death." Mr. Moore states that being around death began to desensitize him to dying, and in 2018, he attended a funeral, which substantially changed his outlook. Mr. Moore states that the funeral was for a man who had motivated many others. During the funeral, they all recounted how the deceased man had motivated them and made them do more with their lives: "It was an epiphany. That's when I realized I couldn't keep bitching about my heart. I knew my fear was just in my head. When I faced death, I got over my fear of death, and I realized that I needed to get things done with my life. Also, this whole time, they did not catch anything significant about my WPW on the testing." Mr. Moore states that he left the job as a funeral director soon after, and he did not struggle with his psychiatric symptoms as he did before although he was still being prescribed psychotropic medication by the VA but was not taking them: "I felt better, and that's why I stopped going to mental health treatment around 2018. But, I asked that they [his psychotropic medications] still be prescribed just in case my symptoms came back. A friend of mine named 'Jay' had some similar symptoms, felt better, but his symptoms came back. It took him a year to get back into the VA. I didn't want that to happen to me so I wanted to have the pills as a back-up. Luckily, I didn't need them. Besides, I would not be able to take those medicines in order to get my CDL [commercial driver's license] for driving heavy trucks.

I got that in August 2020.” Thus, Mr. Moore states that he was mentally healthy just prior to beginning his job with the subject-employer, Abercrombie Pipeline.

Of note, Mr. Moore appeared to take some strenuous jobs such as hauling junk as well as taking the job with the subject-employer. When asked why, Mr. Moore stated, “Because I realized that I was healthy and fine. I had my cardiac ablation in 2014 after I had passed out in the kitchen, and I did not have any significant problems since then. In fact, hauling junk was just a trial to make sure I was okay. After that, I took jobs as a groundman, because I was confident I was healthy and would be fine. My fear of sudden death went away.” In addition, Mr. Moore states that his panic attacks had resolved around 2018 as well, “But I can’t remember exactly when.”

Of note, Mr. Moore also states that he has a history of being physically and verbally abused by his stepmother, verbally abused by his father, he grew up in a rough neighborhood where he saw others being hurt and shot and was even shot at once himself; however, he denies developing any psychiatric symptoms due to these events, and they are all described in more detail in the sections entitled, “Family History,” and, “Social History.”

Since the industrial events occurred, Mr. Moore denies receiving any mental health treatment in regards to this workers’ compensation claim aside from he an intake session with Dr. Kenneth Garrett, PhD (psychology) that occurred on 6/4/2021, but Mr. Moore denied receiving any sessions of dedicated psychotherapy. Otherwise, Mr. Moore denied receiving any other mental health treatment in regards to this workers’ compensation claim.

Currently, Mr. Moore states that he is not seeing any mental health clinicians. Overall, Mr. Moore did not find that the mental treatment that he received after the workplace events occurred was helpful, “because I only received one session with a psychologist, and that’s it. That wasn’t even really treatment. It was more of an intake. Everything keeps getting denied.”

Overall, Mr. Moore does not believe additional mental health treatment is necessary at this time for him to return to work: “I think that it would be helpful to help me learn how to cope with what my life has become. But, shoot, if I felt better physically, I would go back to work tomorrow, and I would not need any mental health treatment. If I was fine physically, I would walk out the door, go back to my life, and you would never hear from me again.”

### **FAMILY HISTORY**

Mr. Moore denied any known family history of suicide, substance abuse, or psychiatric disorders. Of note, there was mention in the medical records received that his biological mother suffered from excessive alcohol and drug use; however, Mr. Moore stated, "That is just what my dad said. Her family said that she never did any of that stuff. I was told that she did have an unhealthy diet though."

Mr. Moore's biological parents were married; however, in 1992, at the age of 40 years old, Mr. Moore's mother passed away due to cancer. Mr. Moore was approximately 22 months old at the time of his mother's death.

Mr. Moore's father then remarried within one year; however, Mr. Moore states that his stepmother was very condescending, making negative remarks towards Mr. Moore on a daily basis: "She would say things like I would never be anything, and she hated me." In addition, Mr. Moore states that she would spank him for discipline, "But she did that a lot. It was multiple times per week." Mr. Moore states that his father was working nights at a warehouse so he did not see all of the abuse occurring in the household. However, Mr. Moore states that his father was also verbally abusive, often making condescending remarks towards Mr. Moore: "He was just a negative person. He would say things like I would not be anything." However, at the time of this evaluation, Mr. Moore denies that the aforementioned abuse contributes to his emotional stress level or psychiatric injury at this time: "It was hurtful at the time, but I learned from it. I know how to treat my kids and also how not to. Also, about 4-5 months ago, I was thinking about it, so I called them and talked to them. I told them about all the stuff that they had done when I was growing up, and they were both surprised that I could remember everything that had happened even when I was a little child. They both apologized, and I forgave them. We're good now. They are still living in Michigan. I think the reason I called was because I was tired of being walked on. Right now, I feel the same way, because I'm not getting the treatment I need to get better and get back to work. They are both injustices." In addition, Mr. Moore states that he maintains a relatively close relationship with his father and stepmother, speaking to them on an average of once per month: "I have always tried to keep a relationship. I know I just have my dad left. The Bible tells us to love each other unconditionally." Of note, per the records received, there was mention that Mr. Moore's stepmother was an alcoholic; however, Mr. Moore denied this documentation stating, "No, my stepmom was not an alcoholic. She would just have a drink or two with my dad, but it was never excessive."

Mr. Moore has a total of 4 siblings, a half-sister, 2 half brothers, and one stepbrother with an age range between 36-54 years old. Mr. Moore states that no siblings have passed away, they are all in good health, and he is on good terms with all of them.

Mr. Moore has been married twice, is currently married, divorced once, and has 3 biological children, one son from his first marriage and two children from his second marriage (see below for details).

In 2014, Mr. Moore married, "Kacee;" however, in 2016, they decided to divorce: "She actually filed the divorce, but it was because I found out she was having an affair." Mr. Moore states that the divorce proceedings were quite contentious, and he alleges that she made false accusations against him such as physically abusing their son. However, Mr. Moore states that those allegations were found to be unfounded: "I had spanked my son 3 times for hitting a girl at daycare. I didn't want him to learn that hitting girls was okay. The defense attorney looked into it and said that I didn't abuse my son. He found it was "within due bounds."" However, Mr. Moore was still court-ordered to attend anger management, and after 3 weeks, he successfully completed the program: "The lady running it told me that I don't have any problems and to give the certificate to the court." Mr. Moore states that he continues to pay child support to her up to the time of this evaluation. Overall, Mr. Moore denies that this divorce contributes to his emotional stress level as he is quite happy with his current marriage, which is described below.

As a product of his first marriage, Mr. Moore has a 7-year-old son, and Mr. Moore has 50/50 legal custody of him although his ex-wife has physical custody of him. Mr. Moore speaks to his son 1-3 times per week.

Approximately in June 2020, Mr. Moore married, "Monica," and he describes his marriage as, "Very good. I love my wife." Mr. Moore denies that they have required any couple's counseling or marital therapy: "No, we're good. Our marriage has been strained because of what happened with Abercrombie though."

They have 2 children together, a 6-month-old son and a 1 ½-year-old daughter who are both described to be in good health and live with Mr. Moore and his wife.

### **SUBSTANCE USE HISTORY**

Mr. Moore denied any current or past use of alcohol or illicit drugs (including marijuana, amphetamines, cocaine, heroin, IV drug use, or prescription drug abuse); however, he does endorse rare tobacco use as well as use of marijuana derivative products as described below.

Mr. Moore denies current or past alcohol use: "I don't like alcohol. It makes me dizzy." However, Mr. Moore endorses rare tobacco use, stating that he occasionally smokes a

cigarette or cigar: "Really, I have smoked a cigarette or a cigar 30 times in my life altogether. Most of those times were in the Marines, because that was the only time we could get a break. I did smoke afterwards when I was stressed, but that was not very often."

In regards to drug use, Mr. Moore states that he began using CBD drops or other THC products in 2018 or 2019 mainly to help with his residual psychiatric symptoms such as insomnia: "I was just tired of taking the pills from the VA."

Of note, per the records, there was mention that Mr. Moore uses marijuana; however, during this evaluation, Mr. Moore denied smoking marijuana. In addition, he has not used any marijuana products since August 2020 when he obtained his Commercial Driving License (CDL) to operate trucks.

Mr. Moore denied any history of substance abuse treatment.

Also, Mr. Moore denied any history of medical (i.e. history of alcohol poisoning, blackouts due to excessive alcohol intake, seizures or tremulousness within days of stopping alcohol use) or legal complications (i.e. DUIs, incarceration) from excessive alcohol or illicit drug abuse.

### **SOCIAL HISTORY**

Mr. Moore was born and primarily raised by his father and stepmother in Detroit, MI. When asked to describe his childhood, Mr. Moore replied, "Alright I guess. It wasn't good, but I have seen others go through way worse." As a child and adolescent, Mr. Moore states that he lived in a dangerous area, and he witnessed episodes of violence as described below.

When Mr. Moore was a child, he witnessed an attack: "There was this guy at a carwash, and these 2 guys attacked him. I was really young; I was in a car seat. They shot him."

As a young adult, Mr. Moore states that he was shot at: "My cousin, Leon, and I were pulling up to a party hall, and these kids were fighting outside. They thought we were going to jump in so they started shooting at us. We just turned around and left. No one was injured, but that's when I definitely decided to join the Marines. I was already getting ready to join, but that confirmed it. I wanted to get out of that place. If I'm going to die, I want it to be for something worthwhile." Of note, Mr. Moore denied developing any psychiatric symptoms including but not limited to signs or symptoms of PTSD in relation to either of these events.

In regards to religious affiliation, Mr. Moore states that he is a Freemason of the Masonic Lodge. Mr. Moore is of the Christian faith. His highest level of education is a high school degree with some college. At the present time, Mr. Moore's main source of income is from the Veterans Affairs (VA). He receives \$1975 per month. In contrast, Mr. Moore earned \$8000 per month while actively working for the subject-employer, Abercrombie Pipeline.

Currently, Mr. Moore lives in a house in Hemet, CA with his wife and 2 children. In addition, Mr. Moore is heterosexual, endorsed military experience (see below for details), endorsed a history of physical and verbal abuse throughout his childhood but denied any sexual abuse (see below for details), and denied any history of learning disorders or special education. Mr. Moore denied any legal history as he denied any history of arrests, jail time, probation, prison time, parole, bankruptcies, or DUIs. Of note, Mr. Moore states that his ex-wife tried to put a restraining order on him, but it was denied. Otherwise, he did attend an anger management course for 3 weeks successfully in order to gain 50/50 custody of his son: "She [the mediator of the course] said I did not have any problems."

In regards to his military history, Mr. Moore served in the Marines from 2010 until October 2012 when he was honorably discharged for medical reasons due to his cardiac condition. Per the medical records received at this time, he suffered orthopedic injuries including his left elbow, left knee, and left shoulder; however, he does not believe these injuries had any bearing in regards to being discharged in the Marines or affected him functionally after his discharge: "They still hurt at times, but they don't stop me from doing anything." Mr. Moore denies being involved or witnessing any combat; however, he did witness one of his superior officers drown in a vehicle in 2010, heard that one of his fellow soldiers committed suicide by hanging in 2011, and another friend died after falling off a building while they were deployed in Japan in 2012 after Mr. Moore's cardiac event had already occurred. Of note, Mr. Moore developed symptoms of PTSD and panic after suffering a cardiac episode in 2011 in which he required resuscitation, and he then harbored fear of sudden death for several years. However, his fear of sudden death, symptoms of PTSD, and panic attacks resolved approximately in 2018 after he no longer feared death following a job working at a funeral parlor.

## **OCCUPATIONAL HISTORY**

### **(Job History)**

From 03/2020-05/28/2020, Mr. Moore worked as a groundman for Abercrombie Pipeline and stopped working, because he was injured.

From 2019-2020, Mr. Moore worked as a groundman for EPC and stopped working, because he quit to pursue another job.

From 2018-2019, Mr. Moore worked as a junk removal specialist from for J-dog Junk Removal and stopped working because he quit to pursue school.

From 2016-2018, Mr. Moore worked as a funeral director for Preferred Cremation Burial and stopped working because he quit to pursue another job.

From 2010-2012, Mr. Moore worked as an 1833 assault crewman for Marine Corps and stopped working, because he was honorably discharged for medical reasons.

From 2005-2007, Mr. Moore worked as a busboy for International House of Pancakes (IHOP) and stopped working, because he quit to pursue another job.

At the present time, Mr. Moore is unable to work because of the physical limitations and chronic pain associated with his heat stroke that occurred on 5/28/2020.

### **(Previous Work-Related Injuries)**

Prior to this current claim, Mr. Moore denied any previous workers' compensation claims; however, while serving in the Marines, he did suffer work-related injuries and developed psychiatric symptoms as described below.

While serving in the Marines, Mr. Moore states that he did suffer multiple orthopedic injuries affecting his left elbow, left knee, and left shoulder due to repetitive motion and the rigor of the training; however, he denied any substantial functional limitations from these orthopedic injuries especially after he was discharged.

However, in 2011, Mr. Moore suffered a cardiac episode related to Wolff-Parkinson-White (WPW) Syndrome, which required that Mr. Moore be resuscitated via cardiac defibrillation. Following this episode, Mr. Moore developed various psychiatric symptoms of PTSD and panic, which are described above in the section entitled, "Past Psychiatric History." In addition, Mr. Moore witnessed the death of one of his superior

officers by drowning, heard about one of his fellow soldiers committing suicide by hanging in 2011, and heard about one of his fellow soldiers who died in 2012 after falling off of a building. Mr. Moore states that he is currently 80% disabled via the VA but is unsure how much of that disability is due to his past psychiatric symptoms and how much is due to his cardiac condition. He does not believe that his orthopedic injuries led to any of his disability rating.

### **ACTIVITIES OF DAILY LIVING**

Mr. Moore is able to cook, bathe and groom himself, go places alone, manage money, and gets along with others, including family, friends as well as coworkers.

### **REVIEW OF RECORDS**

Records delivered were reviewed. Relevant records for determination of psychiatric impairment are summarized below (Please refer to the section entitled, "Review of Medical Records," found towards the end of this report for a complete summary of all the records received at the time of this interview and synthesis of this report).

On 4/24/2013, per a Mental Health Intake note, Dr. Erica Moses, PhD (psychology) diagnosed Mr. Moore with Anxiety Disorder NOS versus Chronic Adjustment Disorder with Anxiety and Insomnia with an Axis V (GAF) of 60.

On 5/14/2013, per a Psychology Medicine Consult, Dr. Anne Nisenzon, PhD (psychology) diagnosed Mr. Moore with Psychological Factors (anxiety) Affecting General Medical Condition (GMC).

On 5/14/2013, per a Progress Note, Dr. Mohammed Siddiqui, M.D. (psychiatry) diagnosed Mr. Moore with Anxiety Disorder Not-Otherwise-Specified (NOS) and Insomnia with an Axis V (GAF) of 60.

Per Progress Notes dated 5/22/2013 and 5/29/2013, Dr. Nisenzon diagnosed Mr. Moore with Psychological Factors (anxiety) affecting GMC.

On 3/13/2014, per a Progress Note, Dr. Nisenzon documented diagnoses of rule/out PTSD and WPW pattern.

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On 11/2/2015, per a Progress Note, Dr. Emmanuel Espejo, PhD (psychology) diagnosed Mr. Moore with Insomnia, PTSD, Panic Disorder, Agoraphobia, Generalized Anxiety Disorder (GAD), and Major Depressive Disorder (MDD), Recurrent.

Per Progress Notes dated 1/15/2016, 1/22/2016, 1/29/2016, 2/5/2016, 2/26/2016, and 3/4/2016, Dr. Espejo documented the evolution of Mr. Moore's psychological symptoms while receiving cognitive processing therapy.

On 3/11/2016, per a Call Note, Dr. Espejo documented that Mr. Moore failed to attend regularly scheduled appointments and was staying with a friend while attempting to cope with a separation from his wife.

On 3/23/2016, per a Progress Note, Dr. Liderman documented some of Mr. Moore's ongoing psychiatric symptoms; however, the rest of this note was missing.

On 4/1/2016, per a Progress Note, Dr. Espejo diagnosed Mr. Moore with Insomnia, PTSD, Panic Disorder, Agoraphobia, GAD, and MDD Recurrent.

On 4/15/2016, per a Progress Note, Dr. Natalie Castriotta, PhD (psychology) diagnosed Mr. Moore with Insomnia, PTSD, Panic Disorder, Agoraphobia, GAD, and MDD, Recurrent.

On 5/6/2016, per a Progress Note, Dr. Liderman diagnosed Mr. Moore with Bipolar Disorder, PTSD, and Panic Disorder, determined an Axis V (GAF) of 60, and prescribed Mr. Moore the psychotropic medication, Seroquel 50 mg.

On 4/13/2017, per a BHIP Orientation Group note, Mr. Vincent Marquez, LCSW (licensed social worker) documented a diagnosis of Anxiety Unspecified.

On 4/17/2017, per a Progress Note, Mr. Richard Schulz, PMHP-BC diagnosed Mr. Moore with PTSD, MDD, Recurrent, Moderate, and rule/out GAD. He also documented that Mr. Moore was being prescribed the psychotropic medication, risperidone 0.5 mg.

On 5/1/2017, per a Call Note, Mr. Schulz advised Mr. Moore to reduce his dose of risperidone due to side effects of difficulty concentrating and daytime grogginess.

On 5/8/2017, per a Call Note, Mr. Schulz documented that Mr. Moore was still having nightmares and added the psychotropic medication, trazodone 50-100 mg, to Mr. Moore's psychotropic medication regimen.

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Per Progress Notes dated 6/30/2017 and 7/31/2017, Mr. Schulz diagnosed Mr. Moore with PTSD, MDD, Recurrent, Moderate, and Rule/out GAD.

On 11/7/2017, per a Call Note, Mr. Schulz documented that Mr. Moore called and said that Family Court was requiring him to attend anger management courses.

Per Psychiatry Group Counseling Notes dated 1/10/2018, 1/17/2018, 1/24/2018, 1/31/2018, 2/7/2018, 2/14/2018, 2/21/2018, 3/1/2018, and 3/7/2018, Ms. Eileen Holman, LCSW (licensed social worker) documented Mr. Moore's progress and stated per her note dated 3/7/2018 that Mr. Moore successfully completed his 8 week course in anger management and that no further sessions were required.

On 8/15/2018, per a Phone Note, Mr. Schulz documented that Mr. Moore had called indicating increased symptoms of PTSD, anxiety attacks, and nightmares, and Mr. Moore continued on his psychotropic medications of clonidine 0.2 mg and trazodone 200 mg.

On 10/29/2018, per a Progress Note, Dr. Geraldine Kuo, M.D. (psychiatry) diagnosed Mr. Moore with PTSD.

On 10/5/2020, per a Letter, Ms. Holman documented that Mr. Moore had not been seen by her or BHIP Mission Valley Health for 2 years, he was being discharged from the clinic, and if he wished to return, he would have to have a new consult for psychiatry/therapy.

On 6/4/2021, per a Psychological Evaluation, Dr. Kenneth Garrett, PhD (psychology) diagnosed Mr. Moore with Major Depressive Disorder, Generalized Anxiety Disorder with Panic, Chronic Sleep Deprivation, Chronic Issues with His Kidneys, Bladder, and Intestines Due To Episode One Year Ago, and recommended additional psychological treatment.

The non-mental health records documented Mr. Moore's various physical injuries and complaints throughout the years including but not limited to his cardiac condition. There were also many non-mental health clinical notes documenting that Mr. Moore had a history of various psychiatric symptoms including Generalized Anxiety Disorder, Post-Traumatic Stress Disorder, Panic Disorder with Agoraphobia, and was prescribed various psychotropic medications prior to the workplace events occurring although by 2019, there were several notes documenting that Mr. Moore denied psychiatric symptoms such as depression, anxiety, and memory loss although he may have exhibited some of these symptoms from time-to-time. The non-mental health records also documented the workplace events leading to this workers' compensation claim in regards to his various ongoing physical complaints following his heatstroke that occurred on 5/28/2020.

AME/QME Evaluations

On 12/16/2020, per an Initial Internal Medicine PQME Report, Dr. Stanley Majcher, M.D. (internal medicine) determined that Mr. Moore was TTD and that causation was 100% industrial.

On 4/20/2021, per a Supplemental PQME Report, Dr. Majcher recommended that Mr. Moore undergo an evaluation by a cardiologist for Mr. Moore's history of chest palpitations and other cardiovascular issues as well as an evaluation by a psychiatrist for Mr. Moore's psychiatric injury.

On 7/8/2021, per an Internal Medicine PQME Re-Evaluation, Dr. Majcher stated no changes from his prior report and recommended an orthopedist to determine WPI since per the AME Guides, that is required for muscle injuries. Upon receipt of the orthopedic report, Dr. Majcher stated that he would issue a supplemental report.

**MENTAL STATUS EXAMINATION**

Appearance

Mr. Moore appeared his stated age, had good grooming, and had a self-reported height of 6'0" as well as a self-reported weight of 150 pounds. He had brown eyes and black hair. Mr. Moore wore casual clothing. During the interview, Mr. Moore denied wearing any braces or using any equipment to assist with gait as he conducted the interview from his bed.

Behavior

Mr. Moore was cooperative, able to communicate effectively, and did not display any psychomotor agitation or retardation. Physical discomfort was evident. He rated the pain as 8 out of 10 and admitted to taking no medications before the interview.

Speech

Mr. Moore's speech had a normal rate, volume, and clarity.

Mood

When asked to describe current mood, Mr. Moore replied, "I feel like shit. I have a headache, my left arm is twitching, and my left hip is hurting." During the interview, Mr. Moore's mood was depressed and anxious.

Affect

Mr. Moore had a restricted, and often worried, range of affect.

Thought Process

Mr. Moore's thought processes were linear, logical, and goal-directed. Thought integration and reality orientation were normal.

Perceptual Disturbances

Mr. Moore denied any auditory or visual hallucinations during the interview.

Thought Content

There were no known delusions, paranoia, suicidal ideation (intent or plan), or homicidal ideation (intent or plan).

Insight

Good (understands the nature of physical and psychological symptoms)

Judgment

Good (will pursue the necessary treatment).

Cognitive Exam

Orientation- Alert and oriented to time, person, place, and situation.

Registration- Able to remember three words immediately.

Concentration- Mr. Moore was asked to do the serial 7s (subtract 7 continuously from 100), Mr. Moore was unable to do this activity, but was able to correctly spell the word, "WORLD," backwards as "D-L-R-O-W."

Recent Memory- Mr. Moore was able to recall two out of three words after about five minutes.

*Of note, the mental status exam (MSE) is meant to record signs exhibited during the actual interview. There may be differences between the subjective report stated elsewhere in this report and the observations made during the MSE. These differences may be due to, but not limited to, the intermittent nature of certain symptoms, some symptoms are more prominent in one's natural environment (as opposed to an office setting), and certain individuals may mask symptoms in order to appear well in front of the interviewer.*

### **PSYCHIATRIC DIAGNOSTIC TESTING**

All tests were conducted on the above exam date and exam location. There were no observed difficulties during the administration of the exams.

### **MINNESOTA MULTIPHASIC PERSONALITY INVENTORY -2 (MMPI-2)**

The Minnesota Multiphasic Personality Inventory -2 (MMPI-2) is the most widely used and researched test of adult psychopathology. An MMPI-2 was done by Mr. Moore and evaluated by Pearson. Mr. Moore denied any significant difficulty understanding the test items. There were some atypical responses. In regards to validity, Mr. Moore's profile stated:

*"This client endorsed a number of psychological problems, suggesting that he is experiencing a high degree of stress. Although the MMPI-2 clinical scale profile is probably valid, it may show some exaggeration of symptoms."*

With this in mind, the profile was determined to be valid overall. Malingering was not suspected. In regards to Diagnostic Considerations, his profile results suggest that he reported a number of specific physical and psychological symptoms that need to be considered in a diagnostic formulation. Although organic problems need to be ruled out, his personality make-up is consistent with a psychological basis to his symptoms.

### **EPWORTH SLEEPINESS SCALE: score: 17 – Significant Daytime Sleepiness**

The Epworth Sleepiness Scale (ESS) is a self-report questionnaire designed to measure daytime sleepiness. The higher the score, the higher the self-rating by the subject as a measure of daytime sleepiness. The correlation between the score range and the intensity/severity of Mr. Moore's subjective severity of daytime sleepiness is depicted below:

0 – 9	No significant daytime sleepiness
10	Borderline daytime sleepiness
<b>11+</b>	<b>Significant daytime sleepiness.</b>

Mr. Moore scored 17 out of 24, which suggests excessive daytime sleepiness.

**BECK DEPRESSION INVENTORY-II (BDI-2): score: 40 - Severe Depression**

The Beck Depression Inventory II (BDI-2) is a 21-question multiple choice self-report inventory, which asks Mr. Moore to choose from a hierarchy of levels of depressive symptomatology for each question. This test is a self-rating device to delineate the nature, intensity and frequency of depressive symptomatology. It is one of the most widely used instruments for measuring the severity of depression.

Each question is scored from zero to three, with a maximum score of 63 for the test. The higher the score, the higher self-rating by Mr. Moore as a measure of depressive symptoms.

0 - 13	Minimal depression
14 – 19	Mild depression
20 – 28	Moderate depression
<b>29+</b>	<b>Severe depression</b>

Mr. Moore scored 40 out of 63, which suggests severe depression.

**BECK ANXIETY INVENTORY: score: 55 – Severe Anxiety**

The Beck Anxiety Inventory is a 21-question multiple-choice self-report inventory, which asks Mr. Moore to choose from a hierarchy of levels of anxiety-related symptomatology for each question. This test is a self-rating device to delineate the nature, intensity and frequency of anxiety-related symptomatology. Each question is scored from zero to three, with a maximum score of 63 for the test. The higher the score, the higher the self-rating by Mr. Moore as a measure of anxiety-related symptoms.

The following is a description of apportionment correlation of range of scores on the Beck Anxiety Inventory to levels of subjective anxiety:

0 – 21	Mild Anxiety
22 – 35	Moderate Anxiety
<b>36+</b>	<b>Severe Anxiety</b>

Mr. Moore scored 55 out of 63, which suggests severe anxiety.

**INSOMNIA SEVERITY INDEX: score: 26 – Severe Insomnia**

The Insomnia Severity Index (ISI) is a 7-item self-report instrument to briefly measure insomnia.

The following is a description of apportionment correlation in regards to the range of scores the Insomnia Severity Index to levels of subjective insomnia:

0 – 7	No Significant Insomnia
8 – 14	Mild Insomnia
15 - 21	Moderate Insomnia
<b>22 – 28</b>	<b>Severe Insomnia</b>

Mr. Moore scored 26 out of 28, which suggests severe insomnia.

**KATZ ADL SCALE: Mr. Moore was found to be fully independent in his ADL's**

The Katz Basic Activities of Daily Living Scale (ADL) scale is a common self-report instrument to assess the functional status as a measurement of one's ability to perform the activities of daily living independently. Mr. Moore marked "independent" when asked about bathing, dressing, toileting, transferring, continence, and feeding.

**REVIEW OF SYSTEMS (ROS):**

A general review of symptoms was done. Mr. Moore listed the following items: sweats, fatigue, recent unexpected weight loss, trouble sleeping, blurred or double vision, eye pain, sensitivity to light, ringing in ears, chest pain (but not at the time of examination), palpitations, shortness of breath on exertion (but not at the time of examination), chronic shortness of breath, persistent nausea or vomiting, diarrhea, constipation, change in appearance in stool, chronic abdominal pain, increased frequency of urination, urinating more than twice a night, difficulty getting or maintaining an erection, and decreased desire for sexual intercourse.

## DISCUSSION

### Subjective Summary

Mr. Branden Moore is a 31 year-old African-American male, with a significant but intermittent psychiatric history prior to the above-stated date of injury, who participated in a diagnostic psychiatric evaluation with this writer on 12/6/2021 to discuss his psychiatric reaction to a workplace injury.

On 5/28/2020, while working for the subject-employer, Abercrombie Pipeline, Mr. Moore suffered a heat stroke, which led to multiple physical problems including but not limited to kidney failure and chronic physical discomfort.

Since the above-stated date of injury, Mr. Moore has experienced the symptoms of reactive depression and reactive anxiety with the associated symptoms (Please refer to the section entitled, "History of Psychiatric Symptoms after the Industrial Events," for more details).

Overall, Mr. Moore said that his psychiatric symptoms are not significant enough to prevent him from working, and he wants to return to work: "If I was better physically, I would go back to work tomorrow and you'd never hear from me again."

### Objective Analysis

In addition to the subjective information provided above, there were multiple objective sources of information (Please refer to the section entitled, "Psychiatric Diagnostic Testing," for more details).

The mental status exam showed that Mr. Moore had good grooming, observable physical discomfort, a depressed and anxious mood, a restricted, and often worried, range of affect, mild concentration difficulties, and mild memory difficulties.

Mr. Moore's self-tests suggest excessive daytime sleepiness, severe insomnia, severe anxiety, severe depression, and complete independence in performing his Activities of Daily Living (ADL's).

Mr. Moore's MMPI-2 profile results suggest that he may be suffering from a variety of physical and psychological problems, which appears to be consistent with his narrative as he describes a variety of physical complaints that have precipitated his psychiatric complaints.

While the self-tests and MMPI-2 suggest moderate to severe psychiatric symptoms, the functional impairment from these symptoms is still considered mild since Mr. Moore stated that his psychiatric symptoms are not significant enough to prevent him from working, he would immediately return back to the workforce if he was physically able to perform his job duties, and he did not present clinically with moderate or severe psychiatric symptoms.

#### Diagnostic Assessment

In regards to ***Diagnoses***, Mr. Moore states that his psychiatric injury is specifically due to ongoing difficulty coping with the physical limitations and chronic pain caused by his various physical injuries that he developed after suffering a heat stroke and acute kidney failure. Given that Mr. Moore's psychiatric symptoms appear to be linked to a specific stressor, he currently meets criteria for Adjustment Disorder with Mixed Anxiety and Depressed Mood, Chronic. Of note, the modifier, "Chronic," is added to indicate that Mr. Moore's symptoms of reactive anxiety and reactive depression have lasted longer than 6 months.

Of note, Mr. Moore has a history of Panic Disorder without Agoraphobia, Post-Traumatic Stress Disorder, Major Depressive Disorder, and Generalized Anxiety Disorder; however, Mr. Moore states that the symptoms improved and resolved prior to the workplace events occurring. Therefore, they are only being mentioned for the sake of completion at this time although his past psychiatric history will be taken into account when this writer determines apportionment.

In regards to ***Causation***, it appears that Mr. Moore's current psychiatric injury is due to difficulty coping with the physical limitations and chronic pain caused by his various physical injuries. Based on the records received, it appears that Mr. Moore did sustain a variety of physical injuries affecting various organ systems that are consistent with some of his complaints. Therefore, on a **preliminary** basis, this writer finds that that Mr. Moore's current psychiatric injury is **predominantly industrial** in nature. Of special note, Mr. Moore states that he has pending QME evaluations, stating that he has one in cardiology with Dr. Jeffrey Caren (cardiology) on 2/4/2022 and a QME in orthopedics with Dr. William Winternitz (orthopedic surgery) on 2/24/2022.

Of special note, this writer is aware of Mr. Moore's substantial psychiatric history in the past following a cardiac episode in 2011 that appears to have led Mr. Moore to developing a variety of psychiatric symptoms including but not limited to PTSD, panic disorder, anxiety, and depression, primarily due to ongoing fear of sudden death due to his cardiac condition. His symptoms required a variety of different modalities of

treatment that he received through the VA. However, Mr. Moore states that by 2018, he no longer feared sudden death due to his cardiac issues and his psychiatric symptoms substantially improved and resolved. Mr. Moore's mental health remained stable, and he eventually took a job with the subject-employer. This writer also notes that if Mr. Moore had ongoing cardiac concerns, he likely would not have taken a job that was so physically intensive. It was not until the workplace events leading to this workers' compensation claim occurred that appears to have caused Mr. Moore to develop various symptoms of depression and anxiety mainly due to both difficulty coping with the physical limitations and chronic pain caused by his physical injuries and concern when his physical symptoms will improve. Otherwise, Mr. Moore denied experiencing any panic attacks in the last few years and the only symptom of PTSD linked to the workplace events are nightmares of being in the back of a truck while in extreme pain. Upon review of the records received at this time, from 2012-2018, his intense fear of dying, falling asleep, and having nightmares appeared to constitute the majority of his psychiatric issues during that time period. Thus, his past psychiatric symptoms especially in regards to panic and PTSD due to concern of sudden death appears to be quite different from his current psychiatric symptoms of depression and anxiety due to difficulty coping with the sequelae of his various physical injuries. Therefore, the aforementioned psychiatric formulation is the rationale behind this writer finding that Mr. Moore's current psychiatric injury and impairment is predominantly industrially-related based on the information available to this writer at this time although this writer will certainly take Mr. Moore's past psychiatric history into account when eventually determining apportionment.

Of special note, this writer noted that Mr. Moore's injury occurred on 5/28/2020, which was approximately 2 months after beginning employment with the subject-employer, Abercrombie Pipeline, in March 2020. Therefore, this writer considered LC 3208.3 (d), which addresses employment of less than 6 months (see below for details).

As mentioned above, it appears that Labor Code 3208.3(d) does come into play. In abbreviated form, it states, "Notwithstanding any other provision of this division, no compensation shall be paid pursuant to this division for a psychiatric injury related to a claim against an employer unless the employee has been employed by that employer for at least six months. The six months of employment need not be continuous. This subdivision shall not apply if the psychiatric injury is caused by a sudden and extraordinary employment condition."

Ultimately, this writer would **defer to the Trier-of-Fact** to determine whether the workplace events leading to Mr. Moore's injuries constitute "a sudden and extraordinary employment condition" as this is a legal determination, not a medical one.

Also of very special note, all of my above opinions in regards to causation are subject to change until after this writer has determined Mr. Moore to be MMI/P&S, as, at that time, this writer will be able to take apportionment into account. At that time, this writer will then provide a specific percentage of causation to the industrial portion of Mr. Moore's psychiatric injury versus the potential non-industrial portion of Mr. Moore's psychiatric injury and consequent permanent psychiatric disability.

At the time of this evaluation, it appears that Mr. Moore will undergo additional QME or AME evaluations and has undergone a QME evaluation in the field of cardiology with Dr. Jeffrey Caren on 2/4/2022 and a QME evaluation in the field of orthopedic surgery with Dr. William Winternitz on 2/24/2022. This writer will **defer** commenting on whether Mr. Moore has reached ***Maximal Medical Improvement (MMI)***, and whether he can be declared ***Permanent and Stationary (P&S)*** from a psychiatric perspective until after all records including but not limited to the aforementioned reports from Dr. Caren and Dr. Winternitz as well as the requested AME or QME report in neurology (see below) have been received to determine whether any of these physicians recommend additional treatment. This information is quite important as any changes in Mr. Moore's physical status would likely change his psychiatric status.

In regards to ***Recommended Treatment***, this writer does believe that Mr. Moore's psychiatric symptoms could improve with additional mental health treatment. However, per Title 8, Division 1, Chapter 1, Article 3, §35.5 (Compliance by AMEs and QMEs with Administrative Director Evaluation and Reporting Guidelines), g(2),

*"For any evaluation performed on or after July 1, 2013, and regardless of the date of injury, an Agreed Medical Evaluator or Qualified Medical Evaluator shall not provide an opinion on any disputed medical treatment issue, but shall provide an opinion about whether the injured worker will need future medical care to cure or relieve the effects of an industrial injury."*

Therefore, based on the above, it is this writer's opinion that Mr. Moore would benefit from additional mental health treatment. However, this writer will not provide any specific recommendations for treatment as I am unsure what medical treatment may be in dispute. **Of course, upon written request, this writer will be happy to provide specific recommendations for additional mental health treatment to help expedite Mr. Moore reaching MMI/P&S.**

In regards to ***Disability***, Mr. Moore states that at no point has his mood or psychiatric symptoms been significant enough to prevent him from working. Therefore, on a ***preliminary*** basis, this writer does not find Mr. Moore has had any periods of TTD from the DOI of 5/28/2020 up to and including the date of this evaluation, 12/6/2021. Again,

this is a **preliminary** opinion and subject to change until after Mr. Moore has reached MMI/P&S from a psychiatric perspective.

At the time of this evaluation, Mr. Moore states that he is scheduled to undergo QME evaluations in cardiology and orthopedics. However, he denies undergoing a QME or AME evaluation in the field of neurology to evaluate his various physical symptoms of paresthesias, headaches, and potentially other symptoms of his heat stroke. Given that many of his complaints appear to be neurologically based and he was diagnosed with a heat stroke, in regards to ***Additional AME or QME Evaluations***, this writer would recommend that Mr. Moore undergo a QME or AME evaluation in the field of neurology **if not already performed** to answer the following questions:

- A) Are Mr. Moore's neurological injuries industrial in causation?
- B) Has Mr. Moore reached MMI and thus been declared P&S from a neurological perspective?
- C) If not found to be MMI, what treatments are recommended to help restore Mr. Moore to his pre-injury level of physical functionality?

Of special note, Mr. Moore is unsure if there are other QME or AME evaluations that have been requested for him to undergo. This writer would request that this writer be informed if any other additional QME or AME evaluations are scheduled to take place aside from the ones mentioned above and all reports be forwarded to my office as soon as possible for my review.

In regards to ***Requested Records***, during the evaluation, Mr. Moore states that he had his deposition taken in regards to this workers' compensation claim. In addition, he states that he has upcoming QME appointments in cardiology and orthopedics respectively that are scheduled to take place in February 2021. Mr. Moore also was seeing Dr. Paul Liderman, (psychiatry) through the Veterans Affairs (VA) health system; however, this writer only received a few records from him. In addition, Mr. Moore states that he may have had some telephone interactions with Dr. Kenneth Garrett, PhD (psychology) who he was seeing on an industrial basis. This writer would also request that a full copy of the Progress Note dated 3/23/2016 and authored by Dr. Paul Liderman, M.D. (psychiatry) be provided as a portion of this note was missing. This writer would request all of the aforementioned records as well as all other additional and missing records be provided to my office as soon as possible for my review. A supplemental report will be issued with a summary of the records along with my opinion.

Because Mr. Moore is not declared psychiatrically Permanent and Stationary (P&S), this writer will defer commenting on Work Restrictions, Psychiatric Permanent Disability, Factors of Psychiatric Permanent Disability, Future Medical Treatment, and

Apportionment at this time. I will complete my opinions on these topics after I have declared Mr. Moore to have reached MMI, and he is declared P&S.

*GAF/WPI determination:*

According to the DSM-IV TR, Axis V (the Global Assessment Functioning scale or GAF) reports the clinician's judgment of an individual's current overall level of functioning.

The current global assessment of function of Mr. Moore is given as a result of my objective observations and Mr. Moore's subjective reports.

At this time, given the longevity, Mr. Moore's psychiatric symptoms would certainly not be considered transient, and thus, the GAF score would fall below 71 (Please refer to "Explanation of GAF Ratings" below for further information about the GAF ranges).

Mr. Moore's psychiatric symptoms would not be considered moderate in intensity as he does not present with a flat affect and is able to communicate appropriately. He is also linear, logical, and goal-oriented during this interview. Finally, given that Mr. Moore states his psychiatric symptoms do not prevent him from working, he would happily return to the workforce immediately if he was able to perform his job duties, and he is maintaining multiple, meaningful, interpersonal relationships, the impact of Mr. Moore's psychiatric symptoms in relation to the occupational impairment (the primary focus of a workers' compensation psychiatric assessment) is deemed mild, which would place him on the GAF range from 61-70, described as:

*"Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functions (e.g. occasional truancy, or theft within the household) but generally functioning pretty well, has some meaningful interpersonal relationships."*

However, during this evaluation, Mr. Moore endorsed many active psychiatric symptoms during the narrative portion of this evaluation and endorsed many significant psychiatric symptoms per the self-tests. Therefore, this writer finds that Mr. Moore's overall psychiatric functionality and intensity of psychiatric symptoms would fall towards the lower half of the aforementioned GAF range from 61-70.

**Based on the interview, the psychiatric diagnostic testing utilized, the medical records provided thus far, Mr. Moore's clinical presentation, and Mr. Moore's anamnesis, I believe Mr. Moore currently expresses a Global Assessment**

**Functioning scale (or “GAF”) of 63, which according to the AMA Guides 5th edition, translates to a WPI of 11.**

Of course, given that Mr. Moore has not been declared Permanent and Stationary, the aforementioned GAF and WPI are considered **preliminary** and are subject to change after Mr. Moore has reached Maximal Medical Improvement (MMI), and he is declared Permanent and Stationary (P&S) from a psychiatric perspective.

I believe this is a very adequate description of Mr. Moore’s current symptomatic and functional state. Symptomatic and functional status as the basis for the global assessment of function, according to page 46 step two, is as stated:

*“keep moving down the scale until the range that best matches the individual’s symptoms severity or the level of functioning is reached, whichever is worse.”*

Having performed this procedure, I believe that I have adequately and correctly utilized the scale to rate Mr. Moore’s Global Assessment of Function in the most accurate fashion based upon the information I currently have.

Of note, in consideration of Mr. Moore’s condition and Guzman II, I note that psychiatric conditions are rated using a GAF scale. WPI is determined from this scale. GAF scoring is already outside of the four corners of the AMA guidelines and I cannot understand how additional impairment can be added to psychiatric claims. Thus, I do not feel that an additional amount of whole person impairment is indicated for difficulty with ADL’s, sleep disorders, chronic pain, sexual dysfunction or difficulty with treatment as I have already considered these factors in my GAF scoring, and I do not feel any additional WPI is indicated.

Of note, as compared to the most recent Axis V (GAF) of 60 as determined by Dr. Paul Liderman, M.D. (psychiatry) per his progress note dated 5/6/2016, Mr. Moore appears to have improved overall. This makes sense given that Mr. Moore states that his psychiatric symptoms that he was experiencing substantially improved and resolved by 2018. However, he then developed various psychiatric symptoms related to difficulty coping with the physical limitations and chronic pain caused by the heat stroke that he suffered while working for the subject-employer, which has led to this workers’ compensation claim. Of course, it is also important to note that there is a degree of subjectivity to GAF scores and can vary between clinicians.

### **DIAGNOSTIC IMPRESSION**

#### **Axis I (Primary Psychiatric Diagnosis)**

Adjustment Disorder with Mixed Anxiety and Depressed Mood, Chronic (309.28);

#### **Axis II (Personality or Developmental Disorders)**

Deferred (799.9).

#### **Axis III (General Medical Conditions)**

See past medical history.

#### **Axis IV (Psychosocial Stressors)**

Chronic pain, occupational impairment, and financial difficulties

#### **Axis V Global Assessment of Functioning Scale (GAF)**

63 which translates to a WPI score of 11

#### **Explanation of GAF Ratings:**

- |         |   |
|---------|---|
| 91-100  | Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.  |
| 81 – 90 | Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members). |
| 71 – 80 | If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational or general functioning (e.g. temporarily falling behind in school work).                   |
| 61 – 70 | <b>Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functions (e.g. occasional truancy, or theft within the household) but generally functioning pretty well, has some meaningful interpersonal relationships.</b>                      |

- 51 – 60      Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or coworkers).
- 41 – 50      Serious symptoms (e.g. suicidal (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).
- 31 – 40      Some impairments in reality testing or communications (e.g., speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relationship, judgment, thinking, or mood (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant in home and is failing at school).
- 21 – 30      Behavior is considerably influenced by delusions or hallucinations OR serious impairments in communication or judgment (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day, no job, home or friends).
- 11 – 20      Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent; manic excitement) OR occasionally fails to main minimal personal hygiene (e.g. smears feces) OR gross impairment in communication (e.g. largely incoherent or mute).
- 1 – 10      Persistent dangerous of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
- 0              Inadequate information.

### **LEVELS OF PERMANENT MENTAL IMPAIRMENT**

As identified in Table 14-1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

- Class 1. No Impairment
- Class 2. Mild Permanent Impairment
- Class 3. Moderate Permanent Impairment
- Class 4. Marked Permanent Impairment
- Class 5. Extreme Permanent Impairment

**D    Deferred until MMI**

#### **1. Activities of Daily Living**

D	Self-care personal hygiene (urinating, defecating, brushing teeth, combing hair, dressing oneself, bathing, eating, preparing meals, and feeding oneself)
D	Communication (writing, typing, seeing, hearing, speaking)
D	Physical activity (standing, sitting, reclining, walking, climbing stairs)
D	Travel (driving, riding, flying)
D	Nonspecialized hand activities (grasping, lifting, tactile discrimination)
D	Sexual function (orgasm, ejaculation, lubrication, erection)
D	Sleep (restful, nocturnal sleep pattern)

#### **2. Social Functioning**

D	Gets along well with others
D	Initiates social contacts
D	Communicates clearly with others
D	Interacts and actively participates in group activities
D	Cooperative behavior, consideration of others, and awareness of others' sensitivities
D	Interacts appropriately with the general public
D	Asks simple questions or requests assistance
D	Accepts instructions and responds appropriately to criticism from supervisors
D	Gets along with coworkers and peers without distracting them or exhibiting behavioral extremes
D	Maintains socially appropriate behavior
D	Adheres to basic standards of neatness and cleanliness

### **3. Memory, Concentration, Persistence, and Pace**

D	Comprehends, Persistence, and Pace
D	Works with or near others without being distracted
D	Sustains an ordinary routine without special supervision
D	Ability to carry out detailed instructions
D	Maintains attention and concentration for specific tasks
D	Makes simple work-related decisions
D	Performs activities within a given schedule
D	Maintains regular attendance and is punctual within customary tolerances
D	Completes a normal workday and workweek without interruptions from psychologically based symptoms

### **4. Deterioration or Decompensation in Complex or Work Life Settings (Adaptation to Stressful Circumstances)**

D	Withdraws from the situation or experiences exacerbation of signs and symptoms of mental disorder
D	Decompensates and has difficulty maintaining performance of activities of daily living (ADL's), continuing social relationships, or completing tasks
D	Able to make good autonomous decisions/exercises good judgment
D	Performs activities on schedule
D	Interacts appropriately with supervisors and peers
D	Responds appropriately to changes in work settings
D	Aware of normal hazards and takes appropriate precautions
D	Able to use public transportation and can travel to and within unfamiliar places
D	Sets realistic goals
D	Makes plans independent of others

### **OVERALL PERMANENT IMPAIRMENT RATING: Deferred until MMI**

### **PROGNOSIS**

Prognosis is good. From a psychiatric standpoint, Mr. Moore can return to the usual and customary duties performed at the time of injury in his previous workplace environment.

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**THE ASSESSMENT OF MR. MOORE'S  
LEVEL OF IMPAIRMENT IS AS FOLLOWS:**

***Deferred*** until Mr. Moore has been declared MMI/P&S

**CONCLUSION STATEMENT**

This concludes my psychiatric evaluation of Mr. Branden Moore. Please do not hesitate to contact my office with any questions about this report.

**SPECIAL COMMENTARY**

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including Mr. Moore's direct anamnesis.

Thank you for the opportunity of serving as qualified medical examiner in the specialty of Psychiatry for this most interesting case and condition.

**SOURCE OF ALL FACTS AND DISCLOSURE**

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge." I attest that I have no financial conflict of interest in this case. Payment not received within 60 days of receipt of this report will be charged interest and penalties according to Labor Code 4603.2. I declare under penalty of perjury that I have not violated Labor Code Section 139.3, and that the information contained in this report and its attachments, including billing, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Dr. Sanjay Agarwal, MD, conducted the history, the mental status exam, reviewed the records, wrote the psychiatric report, and with the exception of the MMPI-2, which was interpreted by Pearson Assessments, Dr. Agarwal administered and interpreted the psychiatric diagnostic testing utilized during this evaluation. Assistance with the clerical preparation of this report was provided by Charlie Helton. The medical records were

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compiled, organized, and extracted by myself and Charlie Helton, medical historian, after which I reviewed them and produced the above conclusions.

Date of Report: January 12, 2022. Signed this 12<sup>th</sup> day of January 2022 in San Bernardino, California.

Sincerely,



---

Sanjay Agarwal, MD  
Qualified Medical Evaluator  
Diplomate of the American Board of Psychiatry and Neurology

cc. **Via First Class Mail**  
Ashlyn Laskey  
Liberty Mutual  
P.O. Box 779008  
Rochlin, CA 95677

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#### REVIEW OF MEDICAL RECORDS

A record index was provided by Applicant's counsel and checked against with no discrepancies found.

#### **PSYCHIATRIC RECORDS**

DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
4/24/2013	VA Medical Center	Erica Moses, Ph.D. (psychology)	<p><u>MENTAL HEALTH INTAKE</u> – This evaluation stated Axis I diagnoses of Anxiety disorder NOS vs. chronic adjustment disorder with anxiety; and Insomnia with Axis V of 60.</p> <p>Pt c/o insomnia. He passed out and doesn't know if he died but he stated he went to hell. Pt described after-death experience of going to hell and reports was real. He stated when he came to, he had a defibrillator on his chest. Pt's had sleep problems since because he's afraid of it happening again. Pt stated it last happened on Nov. 4<sup>th</sup>. He just can't sleep. Pt stated that sometimes in the middle of the day he has to take a nap and it's inconvenient. He doesn't like taking pills because he doesn't want to become dependent on medicine. Pt reports he has been diagnosed with insomnia and WPW. He feels like he is always apprehensive and on alert. Pt has lots of thoughts running through his mind at night and not dying again. He doesn't want to go back to hell. Pt's girlfriend reports that he will kick and yell in his sleep but he can't recall nightmares.</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>Pt has a history of heart difficulty starting in June 2011. His sleep difficulties began immediately after he left the hospital and was in recovery.</p> <p>Pt denied any difficulties with substances. He rarely drinks alcohol and never at a higher level than now. He reports occasional cigarette when stressed out in order to help him settle to rest.</p> <p>Pt reports a period of depression in childhood due to verbal and physical abuse sustained as a child. He reports it remitted when he moved out with his brother.</p> <p>Pt has some concerns of being in large crowds with onset after military service.</p> <p>Pt appears to be experiencing clinically significant anxiety which are better accounted for by a fear of dying based on medical concerns related to his ongoing WPW rather than a prolonged stress response to the specific trauma of the cardiac episode in 2011 and primarily in response to trying to sleep rather than throughout the day.</p> <p>Pt saw a man killed prior to the military, was shot at in Detroit prior to the military. He was most bothered when he had LOC and saw hell and then was revived while in the</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>military.</p> <p>Pt has recurrent intrusive dreams nightly when trying to sleep. He avoids going to parks, walking up hills, and exercise that make his heart race. He has been told not to exercise by the doctor in the military. Pt used to do numerous athletic activities that he can no longer due.</p> <p>Pt has trouble wanting to connect with others which has been ongoing since childhood due to abuse. He reports feeling reserved but not emotionally numb, he feels for others.</p> <p>Pt has difficulty concentrating, hypervigilance, and states his most distressing symptoms are related to sleep.</p> <p>Pt's worry is solely related to dying and going to hell. He denied Panic attacks.</p> <p>Pt is afraid of falling asleep due to his cardiac episode but denied trying to keep himself awake. He had SI when he was little once and tried to hold his breath to die but it did not work.</p> <p>Pt has no mental health treatment history.</p> <p>Past and current medical problems include WPW, insomnia,</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>and knee/elbow/back pain</p> <p>Pt has a history of alcoholism with his uncle.</p> <p>Pt grew up in Detroit. His mom died of cancer when he was 2 and his dad remarried. He stated they would not allow him to have any individuality, voice his own opinion. He received poor grades until he moved in with his brother at 18 y/o. He described his childhood as hell. He stated physical and verbal abuse by his stepmom and verbal abuse by his dad. Pt didn't want to come home. He lived in a tough neighborhood, people killed and seen others killed and be shot at.</p> <p>Pt has a high school degree.</p> <p>Pt was in the Marines from 2010-October 2012 and honorably discharged for medical reasons.</p> <p>Pt has a girlfriend and helps raise her 2 young kids. He has some difficulties with sexual functioning since 2/20/13. He reports less interested in sex due to varicose veins which caused pain during sex (had to go to the hospital for pain). He lives with his girlfriend.</p> <p>Pt's income is VA compensation and unemployment.</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>MENTAL STATUS EXAM noted he is cooperative; good eye contact; oriented to person, place, time, and situation; mood is good; affect is euthymic; speech is normal; no SI; no AH/VH; and insight is good.</p> <p>DX IMP –</p> <p>Axis I: Anxiety disorder NOS vs. chronic adjustment disorder with anxiety; and Insomnia</p> <p>Axis II: Deferred</p> <p>Axis III: WPW; chronic knee/elbow/back pain</p> <p>Axis IV: recent cardiac episode, loss of grandmother</p> <p>Axis V: 60</p> <p>Pt has clinically significant anxiety with symptoms accounted for by fear of dying based on medical concerns as stated above. He has not been recently evaluated by a cardiologist to determine actual probability of an additional life-threatening cardiac episode and appropriate behavioral limits. It's unclear if he meets criteria for anxiety disorder NOS or a chronic adjustment disorder as the stressor of WPW and its consequences are ongoing. He has difficulty with sleep exacerbated by his fear of dying. He reports poor behavioral habits which may have thrown off his sleep cycle and he may benefit from an intervention to target those behaviors.</p>
5/14/2013	VA Medical Center	Anne Nisenzon, Ph.D.	<u>PSYCHOLOGY MEDICINE CONSULT</u> – Pt reported having a lot of anxiety and difficult sleeping since his first

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
		(psychology)	<p>tachycardia episode in June 2011. He reported that he was diagnosed with WPW syndrome and since has had one similar episode in November 2012. Pt described symptoms of rapid heartbeat, lightheadedness, and occasional fainting. He reported he only had 2 full tachycardiac events but occasionally has heart palpitations and sensations of skipping a beat. Pt reported flashes of himself in the hospital and cardiac defibrillator on his chest which makes him anxious leading him to avoid hospital. He noted after his second episode he had very poor sleep and he responds to the falling feeling with anxiety and it jerks him awake. He reports only getting 2-3 hours of sleep per night and it is often broken. Pt has limited all physical activity until he consults with cardiology and receives the proper treatment.</p> <p>Objective findings note he is oriented x3, speech normal, mood euthymic and affect appropriate to mood, thought process linear and goal-directed, thought content free of psychotic processes, no SI/HI, no AH/VH, and insight/judgment are good.</p> <p>DX – Psychological factors (anxiety) affecting GMC</p> <p>Pt will continue with mindfulness based stress and anxiety reduction.</p>
5/14/2013	VA Medical Center	Mohammad	<u>PROGRESS NOTES – This evaluation stated Axis I</u>

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		Siddiqui, M.D. (psychiatry)	<p><i>diagnoses of Anxiety disorder NOS and Insomnia with Axis V of 60.</i></p> <p>Pt has been having issues with sleep since 2011 after his first tachycardia, WPW, and he has vivid dreams of what happened including getting put into the back of an ambulance, waking up with the defibrillator, and waking up in a cold sweat. He gets about 4 hours of sleep on average per night and his anxiety is having palpitations again and passing out. He is afraid to die. Pt reports that he doesn't feel anxiety during the day, it's at night. He reports loss of interest in previously enjoyable activities. He is no longer able to do sports. He has loss of energy or fatigue. His appetite is not too bad. Pt feels tired. He denied SI/HI. Pt reports flashbacks of the incident.</p> <p>Pt denied any prior psychiatric treatment history. He denied any history of abuse.</p> <p>Pt will have a cigarette to calm himself down.</p> <p>Pt grew up in Detroit and his mom died of cancer when he was 2. His dad remarried. He received poor grades until he moved in with his brother at 18. He described his childhood as hell. Pt reported physical and verbal abuse by stepmom and verbal abuse by his dad. He lived in a tough</p>

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			<p>neighborhood and saw people killed or shot at.</p> <p>Pt has a high school diploma.</p> <p>Pt served in the Marines from 2010-2012. He was medically discharged. He suffered knee, back, and elbow injuries while enlisted.</p> <p>Pt has a girlfriend and helps raise her 2 young children. He has some sexual functioning difficulties with less interest due to varicose veins which cause pain.</p> <p>MSE noted he is cooperative; normal speech; mood is okay and affect is appropriate and congruent; and no SI/HI.</p> <p>DX –</p> <p>Axis I: Anxiety disorder NOS and Insomnia</p> <p>Axis II: deferred</p> <p>Axis III: WPW, chronic knee/elbow/back pain</p> <p>Axis IV: recent cardiac episode, and loss of grandmother</p> <p>Axis V: 60</p>
5/22/2013	VA Medical Center	Anne Nisenzon, Ph.D. (psychology)	<p><u>PROGRESS NOTES</u> – This evaluation stated diagnosis of psychological factors (anxiety) affecting GMC.</p> <p>Pt reported panic symptoms continue with chest tightness, SOB, and sensations of choking especially at night. HE</p>

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			<p>doesn't remember his dreams or any particular triggers for his panic. Pt occasionally has anxiety during the day and they are triggered by anger and usually spurred by someone misunderstanding him or labeling him as being condescending. Pt reported that he tends to bottle up and shutdown when experiencing the psychological sensations of anxiety and anger and steps away.</p> <p>Objective findings notes he was oriented x3, normal speech, euthymic mood, affect appropriate to mod, thought process linear and coherent, and no SI/HI/AH/VH.</p> <p>DX – psychological factors (anxiety) affecting GMC</p>
5/29/2013	VA Medical Center	Anne Nisenzon, Ph.D. (psychology)	<p><u>PROGRESS NOTES</u> – This evaluation stated diagnosis of psychological factors (anxiety) affecting GMC.</p> <p>Pt reported he has not had any anxiety attacks or difficulty falling asleep the past week. He was in LA over the weekend and was busy the whole time. He reported crashing at night and did not have any trouble with falling asleep. Pt also did not have any concern over his heart condition.</p> <p>Objective findings notes he was oriented x3, normal speech, euthymic mood, affect appropriate to mod, thought process linear and coherent, and no SI/HI/AH/VH.</p>

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3/13/2014	VA Medical Center	Anne Nisenzon, Ph.D. (psychology)	<p>DX – psychological factors (anxiety) affecting GMC</p> <p><u>PROGRESS NOTES</u> – This evaluation stated diagnoses of r/o PTSD and WPW pattern.</p> <p>Pt believes he has PTSD following an event in 2013 when he had sudden heart failure and was brought back to life by heart defibrillators. He learned he developed a heart condition that could lead to sudden death in the future. He now re-experiences that event every night in the form of intense nightmares. Pt fears going to sleep and often doesn't return to sleep after awaking from a nightmare. He reports high level of agitation and physical reactions throughout the day with frequent irritability and angry outbursts that are out of his nature, numbing of emotions, feelings of distance from wife and son. He also reported anhedonia, hypervigilance, and high startle response. Pt avoids many situations including anywhere with crowds and places with bright lights that remind him of the hospital that he was taken to. He expressed sadness that he is no longer able to be physically active as he once was due to the danger to his heart. Pt smokes cigarettes as a coping behavior for his anxiety. He reported frequent cognitions/thoughts that he could have prevented this heart condition if he had not joined the military and that his life will never be the same again. He would like treatment to reduce the frequency of his nightmares and reduce the level of agitation and irritation he feels throughout the day and</p>

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			<p>help him reconnect with his family.</p> <p>Pt reported these symptoms began soon after the traumatic event in 2012. He believes the symptoms have continued to exacerbate and may have recently spiked due to the stress related to getting married and his wife's pregnancy with their 2<sup>nd</sup> child.</p> <p>Pt was evaluated for PTSD in April and given a diagnosis for anxiety related to a general medical condition. He reported that treatment did not address his nightmares.</p> <p>Pt prefers treatment closer to home.</p> <p>Objective findings note he is alert and oriented x3, mood euthymic and affect appropriate to mood; no psychomotor agitation; speech normal; thought process normal; no psychotic process; no SI/HI and no AH/VH.</p> <p>DSM 5 DX – R/o PTSD and WPW pattern</p>
11/2/2015	VA Medical Center	Emmanuel Espejo, Ph.D. (psychology)	<p><u>PROGRESS NOTES – This evaluation stated Axis I diagnoses of Insomnia; PTSD; Panic disorder; Agoraphobia; GAD; and MDD, recurrent.</u></p> <p>Pt seen today for psychiatric intake. He meets criterial for insomnia stating it takes him longer than 30 minutes to fall</p>

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			<p>asleep at night and he is awake longer than 30 minutes in the middle of the night and wakes up more than 30 minutes earlier than he would like in the morning. Pt has frequent nightmares nearly every night between 3:30 am and 5 am that are around the same traumatic event he experienced in 2011 when he collapsed and his heart stopped. Pt has a fear of dying since then and a fear of falling asleep at night due to fear of having a nightmare. His wife tells him that he moves around in his sleep during the nightmare and he wakes up in a cold sweat.</p> <p>Pt meets criteria for PTSD stating when he was deployed to Japan in 2011 he collapsed and knew his heart stopped beating. He had to be revived and has had a fear of dying. He also witnessed a sergeant drown in a tank while deployed to Japan. He re-experiences symptoms, avoidance of reminders, and intense reactions when reminded of the events. He reported in the past month that his feelings have been negative and he has lost interest and he feels detached from others, irritable, nervous, easily startled, difficulty concentrating, and difficulty sleeping.</p> <p>Pt meets criteria for panic disorder stating he has panic attacks where he suddenly feels anxious with a racing heart, sweating, shaking, choking sensation, chest pressure, stomach problems, chills, tingling/numbness, feeling strange,</p>

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			<p>fear of losing control, and fear of dying. He has concerns over these attacks and their consequences and has changed his behavior by staying home more often. He stated some of these attacks are unexpected but others are triggered by him being outside his home and around others where he feels uncomfortable or in unplanned situations.</p> <p>Pt meets criteria for agoraphobia. He endorsed anxiety in situations where it might be difficult to escape or get help, including being in crowds or standing in line, in an enclosed space, when alone, traveling in a bus or car, or public transportation. He tries to avoid them and considers the anxiety to be excessive.</p> <p>Pt meets criteria for GAD stating he worries excessively about many areas of his life including leaving his house, his health, his marriage, and being successful. He reported his worries are present most day and he has difficulty controlling his worry. Pt endorsed feeling on edge, muscle tension, feeling tired, difficulty concentrating, irritability, and difficulty sleeping.</p> <p>Pt met criteria for Major depressive disorder, recurrent, with depressed mood most of the day, nearly every day, anhedonia, decreased appetite, difficulty sleeping, fatigue/lack of energy, and difficulty concentrating. He</p>

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			<p>reported more than one episode of depression but not sure how many.</p> <p>Pt reported his symptoms began around 2011 after he collapsed during his deployment in Japan requiring a defibrillator to restart his heart. His fear of dying began after that incident and he stated his nightmares are related to that incident. After his medical discharge from the military in 2012, he began having depressive and anxiety symptoms. Pt stated it has been on and off since then. His panic attacks are at least 4 per month and his last one was yesterday while out of his home. His symptom have increased over time and he has been avoiding his symptoms and trying to make himself feel more comfortable which has resulted in him limiting his activities and his life. His sleep difficulties and nightmare have worsened in the past year. Pt reported he becomes triggered in unpredictable environments, when away from home and when he doesn't like how his wife interacts with him.</p> <p>Pt denied any prior SI. He denied any prior mental health treatment.</p> <p>Pt drinks around one beer every couple of days.</p> <p>Past medical history includes WPW pattern, pain in testicle,</p>

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			<p>and anxiety.</p> <p>Pt considered himself an infrequent smoker but stated his nightmares and sleeping difficulties have increased over the year so his smoking has increased to around 4 cigarettes per day.</p> <p>Pt denied allergies.</p> <p>Pt denied family psychiatric history.</p> <p>Pt is from Detroit, Michigan and stated his mom died of cancer when he was a young child. His father remarried 6 months later. He has 4 older siblings. He stated his stepmom was verbally and physically abusive growing up and his father worked nights which is when his stepmom engaged in abusive behaviors. He described living with her felt like being in prison. He currently has a relationship with his father but not his stepmom.</p> <p>Pt is a full time college student currently. He has 10 classes left before graduating. He is working on his music career with a goal to have a record contract.</p> <p>Pt served in the Marines in 2010-2012 and had one deployment to Japan after the earthquake in 2011.</p>

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			<p>Pt has been married for about 2 years. They have a 1 ½ y/o son and his wife has a 5 y/o from a prior relationship. He described his relationship as stressful at times and he becomes irritated with her when she speaks to him in a manner he doesn't like.</p> <p>Pt is most concerned with his sleep difficulties and nightmares.</p> <p>Pt spends a large amount of time at home. He speaks with his wife, kids, siblings, and 2 people in his motorcycle club.</p> <p>MSE noted he is cooperative; oriented to person, place, and time; mood is dysphoric; affect is appropriate; no SI/HI; speech is normal; and thinking process is coherent.</p> <p>DSM-5 DX: Insomnia; PTSD; Panic disorder; Agoraphobia; GAD; and MDD, recurrent</p>
1/15/2016	VA Medical Center	Emmanuel Espejo, Ph.D. (psychology)	<p><u>PROGRESS NOTES</u> – Pt in for cognitive processing therapy. He reports nightmares and symptoms of PTSD following tachycardic incident with stroke symptoms in 2012.</p> <p>PHQ9 = 18; PC=60.</p> <p>MSE he is oriented x4, insight and judgment good, full range</p>

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			affect and congruent with mood, thought processes linear and coherent and goal directed; no SI/HI; and no AH/VH.
1/22/2016	VA Medical Center	Emmanuel Espejo, Ph.D. (psychology)	<u>PROGRESS NOTES</u> – Pt in for cognitive processing therapy.  PHQ9 = 18; PC=58.  MSE he is oriented x4, insight and judgment good, full range affect and congruent with mood, thought processes linear and coherent and goal directed; no SI/HI; and no AH/VH.
1/29/2016	VA Medical Center	Emmanuel Espejo, Ph.D. (psychology)	<u>PROGRESS NOTES</u> – Pt in for cognitive processing therapy.  PHQ9 = 18; PCL=62.  MSE he is oriented x4, insight and judgment good, full range affect and congruent with mood, thought processes linear and coherent and goal directed; no SI/HI; and no AH/VH.
2/5/2016	VA Medical Center	Emmanuel Espejo, Ph.D. (psychology)	<u>PROGRESS NOTES</u> – Pt in for cognitive processing therapy.  PHQ9 = 17; PCL=60.  MSE he is oriented x4, insight and judgment good, full range affect and congruent with mood, thought processes linear and coherent and goal directed; no SI/HI; and no AH/VH.
2/26/2016	VA Medical Center	Emmanuel Espejo, Ph.D. (psychology)	<u>PROGRESS NOTES</u> – Pt in for cognitive processing therapy.  PHQ9 = 18; PCL=60.

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			MSE he is oriented x4, insight and judgment good, full range affect and congruent with mood, thought processes linear and coherent and goal directed; no SI/HI; and no AH/VH.
3/4/2016	VA Medical Center	Emmanuel Espejo, Ph.D. (psychology)	<u>PROGRESS NOTES</u> – Pt in for cognitive processing therapy.  PHQ9 = 17; PCL=64.  Pt denied SI/HI/AH/VH.  MSE he is oriented x4, insight and judgment good, full range affect and congruent with mood, thought processes linear and coherent and goal directed; no SI/HI; and no AH/VH.
3/11/2016	VA Medical Center	Emmanuel Espejo, Ph.D. (psychology)	<u>CALL NOTES</u> – Pt failed to attend regularly scheduled appointment. He reported he had gotten into a series of disagreements with wife and they have separated. He is staying with a friend. He reported the situation sucked but he's trying to cope.
3/23/2016		Paul C. Liderman, M.D. (psychiatry)	<u>PROGRESS NOTES</u> – <i>Handwriting is mostly illegible.</i>  Pt with PTSD and vivid dreams of dying. Hard to fall asleep. Flashback secondary to earthquake. Mood swings. PTSD. Racing thoughts. High energy and depressed. Birth mom died when he was 2 y/o. He has 4 older siblings.  Pt is an ex-marine.

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			<p>Meds include Lorazepam 1mg</p> <p>Wife asked for separation. He has one son and is living with a friend.</p> <p>Denied SI/HI.</p> <p><i>Missing rest of note.</i></p>
4/1/2016	VA Medical Center	Emmanuel Espejo, Ph.D. (psychology)	<p><u>PROGRESS NOTES</u> – This evaluation stated diagnoses of insomnia; PTSD; Panic disorder; agoraphobia; GAD; and MDD, recurrent.</p> <p>Pt attended first session in past several weeks following separation from his wife and starting to see psychiatrist in the community. He reported receiving a bipolar diagnosis from psychiatrist and expressed concern about this. Stated his wife is unwilling to attend treatment and he is leaning towards asking for a divorce and finalizing their separation. Discussed recent ER visit following panic attack and his concern it was a heart attack.</p> <p>Objective findings noted he is oriented x4, insight and judgment good, full range affect and congruent with mood, thought processes linear and coherent and goal directed; no SI/HI; and no AH/VH.</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			DX – insomnia; PTSD; Panic disorder; agoraphobia; GAD; and MDD, recurrent
4/15/2016	VA Medical Center	Natalie Castriotta, Ph.D. (psychology)	<p><u>PROGRESS NOTES</u> – This evaluation stated diagnoses of insomnia; PTSD; Panic disorder; agoraphobia; GAD; and MDD, recurrent.</p> <p>Pt reported feeling upset following negative interaction with himself and his soon to be ex-wife. He indicated he was in the parking lot and agreed to come in for his session. He reported that he will likely go home to Michigan in May to get support from his family and friends. He reported difficulty committing to treatment with his upcoming trip. Pt reports problems with sleep and nightmares reduced over the past few weeks. He would like to take a break from treatment at this time.</p> <p>Objective findings noted he arrived late, oriented x4, insight and judgment appeared good, full range affect, tearful at times, mood improved, and no SI/HI/AH/VH.</p> <p>DX – insomnia; PTSD; Panic disorder; agoraphobia; GAD; and MDD, recurrent</p>
5/6/2016		Paul C. Liderman, M.D. (psychiatry)	<p><u>PROGRESS NOTES</u> – Handwriting is mostly illegible.</p> <p>Axis I: Bipolar D, PTSD; and panic disorder</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>Axis V: 60</p> <p>RX – Seroquel 50mg</p> <p>4/13/2017 VA Medical Center Vincent Marquez, LCSW (licensed social worker) <u>BHIP ORIENTATION GROUP</u> – Pt would like assistance with anxiety, depression, severe mood swings, anger management, traumatic experiences, improving sleep, relationship problems, and chronic physical pain/serious medical attention. He is not concerned with housing. Pt quit smoking in the past year.</p> <p>PHQ9 = 22 (severe depression). PTSD = 4. PCL-C = 91</p> <p>Pt is interested in medication and individual therapy for anxiety and sleep difficulty.</p> <p>MSE noted his mood appeared anxious and affect was congruent; thoughts linear and goal directed, he has not slept well and it's effecting his daily functioning, no SI/HI, and no evidence of psychosis.</p> <p>DSM5 DX – Anxiety unspecified</p>
4/17/2017	VA Medical Center	Richard W. Schulz, PMHP-BC	<p><u>PROGRESS NOTES</u> – This evaluation stated Axis I diagnoses of PTSD; MDD, recurrent, moderate; and r/o GAD.</p> <p>Pt c/o not being able to sleep. He presents after disengaging</p>

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			<p>from treatment in 2016 due to his divorce stating he was overwhelmed through it, depressed, isolated himself, and did not seek treatment. Pt would like to re-engage to focus on his insomnia and mood symptoms. He reports difficulty since 2012 when he went into dysrhythmia, became unconscious and had to be resuscitated with defibrillation. Pt was stationed in Japan on IED training exercises and they had to don MOPP gear (nuclear biologic chemical protective clothing and masks) and perform various physical activities. He became dehydrated and possible heat injury. The next morning he had weakness and altered LOC eventually passing out. Pt was taken to medical and resuscitated. Since then he has been fearful of dying and concerned of his medical condition. Pt first presented to mental health for treatment in 2013. Pt has sleep maintenance disruption, generalized anxiety (fatigue, on edge, palpitations, anxiety attacks, jitteriness, insomnia, worrying about generalized things), depression (fatigue, depressed, no motivation, little enjoyment except for time with his son, loss of appetite and weight loss) and trauma related symptoms (re-experiencing, angry outbursts, negative mood, hypervigilance, hyperarousal, and nightmares every night).</p> <p>Pt reports rare alcohol use. He denied recreational drugs.</p> <p>Pt initially presented in April 2012 with anxiety disorder</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>NOS, insomnia, and referred for therapy but did not engage at that time. HE returned for an evaluation in March 2014 with diagnosis to r/o PTSD but did not return again until December 2015 at which time he was diagnosed with PTSD, panic disorder w/agoraphobia, GAD, and MDD. He underwent 8 sessions of CPT before disengaging.</p> <p>Pt has taken Ambien, Seroquel, and lorazepam.</p> <p>Pt's medical history includes pain in testicle, WPW pattern, and anxiety reaction.</p> <p>Current RX – Dicyclomine 10mg, Ranitidine 150mg and ascorbic acid 500m</p> <p>Pt was born and raised in MI. His mother died when he was 22 months old. His father remarried and he lived with both parents and 4 older siblings.</p> <p>Pt has 2 ½ years of college. He joined the USMC after graduating high school. He denied combat. Pt was part of the amphibious assault crew. He had a near death experience in 2012. Post-trauma military adjustment has been difficult.</p> <p>Pt reports his failed marriage was due to his spouse's infidelity. He is currently living with his girlfriend.</p>

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			<p>Pt is currently in school for business management.</p> <p>MENTAL STATUS EXAMINATION noted he is cooperative; oriented to person, place, and time; memory good; mood is exhausted; affect is euthymic; no SI/HI; normal speech; coherent; thought content is excessive fear of dying from arrhythmia; good insight; and intact judgment.</p> <p>Pt's symptoms are consistent with PTSD. His depression is less severe than last 6 months due to divorce but still has persistent depressed mood, anhedonia, low energy significant weight loss of 40lbs, insomnia, and diminished ability to focus.</p> <p>DSM-5 DX: PTSD; MDD, recurrent, moderate; and r/o GAD</p> <p>Pt is stable.</p> <p>RX – risperidone 0.5mg</p>
5/1/2017	VA Medical Center	Richard W. Schulz, PMHP-BC	<p><u>CALL NOTES</u> – Pt reported initial side effects with risperidone including difficulty concentrating and daytime grogginess.</p> <p>DX – PTSD</p>

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5/8/2017	VA Medical Center	Richard W. Schulz, PMHP-BC	<p>Reduce Risperidone to 0.5mg</p> <p><u>CALL NOTES</u> – Pt still having nightmares; will add trazodone 50-100mg.</p>
6/30/2017	VA Medical Center	Richard W. Schulz, PMHP-BC	<p><u>PROGRESS NOTES</u> – This evaluation stated Axis I diagnoses of PTSD; MDD, recurrent, moderate; and r/o GAD</p> <p>Pt reports starting yoga, lavender tea, incense, reduce lights and walking. He could not tolerate risperidone due to side effects with cognitive symptoms and dizziness. He has early morning awakening.</p> <p>ROS is negative.</p> <p>MSE noted he is cooperative, normal motor, normal speech, no SI/HI, no obsessions/delusions, affect is stable and mood euthymic, fair insight and intact judgment.</p> <p>DSM-5 DX – PTSD; MDD, recurrent, moderate; and r/o GAD</p> <p>RX – clonidine 0.1mg, trazodone 200mg, and venlafaxine 150mg</p>
7/31/2017	VA Medical Center	Richard W. Schulz, PMHP-BC	<p><u>PROGRESS NOTES</u> – This evaluation stated Axis I diagnoses of PTSD; MDD, recurrent, moderate; and r/o GAD</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>Pt is divorced male presenting with ongoing trauma related symptoms, chronic disrupted sleep pattern, anxiety, and depressed mood since 2012 following a near death experience from arrhythmia and worsened by subsequent divorce due to spouse's infidelity. He is here for further treatment related to his PTSD; MDD, recurrent moderate, and GAD.</p> <p>Pt presents with his girlfriend who requested to join to better understand his diagnosis and share what she has noticed. Pt reported stopping clonidine and venlafaxine because he was not experiencing an increase in anxiety, jitteriness, and nausea that was not tolerable. He tolerated increase in trazodone and is able to get more sleep but still has frequent nightmares. Pt's girlfriend described symptoms consistent with what he reported in session. She indicated difficulties with communication and conflict resolution.</p> <p>Pt denied any psych ROS.</p> <p>MSE noted he is cooperative, normal gait, no psychomotor agitation, normal speech, stable affect, mood still anxious a lot, no SI/HI, no obsessions/delusions, coherent and attentive, no hallucinations or illusions, fair insight, and intact judgment.</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			DSM-5 DX – PTSD; MDD, recurrent, moderate; and r/o GAD  RX – trazodone 200mg, venlafaxine 150mg, and clonidine 0.1mg
11/7/2017	VA Medical Center	Richard W. Schulz, PMHP-BC	<u>CALL NOTES</u> – Pt called stating Family Court is requiring him to attend anger management courses.
1/10/2018	VA Medical Center	Eileen Holman, LCSW (licensed social worker)	<u>PSYCHIATRY GROUP COUNSELING NOTE</u> – Pt attending anger management group. NO SI/HI. Issues related to Veteran's expression of anger.
1/17/2018	VA Medical Center	Eileen Holman, LCSW (licensed social worker)	<u>PSYCHIATRY GROUP COUNSELING NOTE</u> – Pt attending anger management group. He denied SI/HI and participated in group process, sharing relevant personal history.
1/24/2018	VA Medical Center	Eileen Holman, LCSW (licensed social worker)	<u>PSYCHIATRY GROUP COUNSELING NOTE</u> – Pt attending anger management group. He denied SI/HI.
1/31/2018	VA Medical Center	Eileen Holman, LCSW (licensed social worker)	<u>PSYCHIATRY GROUP COUNSELING NOTE</u> – Pt attending anger management group.
2/7/2018	VA Medical Center	Eileen Holman, LCSW (licensed social worker)	<u>PSYCHIATRY GROUP COUNSELING NOTE</u> – Pt attending anger management group. He left group early today for another appt, he was in pain.
2/14/2018	VA Medical Center	Eileen Holman, LCSW (licensed	<u>PSYCHIATRY GROUP COUNSELING NOTE</u> – Pt attending anger management group. Pt is a pleasure to teach

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
2/21/2018	VA Medical Center	Eileen Holman, LCSW (licensed social worker)	<p><u>social worker)</u> and is open to ideas, communicating effectively. NO SI/HI.</p> <p><u>PSYCHIATRY GROUP COUNSELING NOTE</u> – Pt attending anger management group. He is actively participating and listening. No SI/HI.</p>
3/1/2018	VA Medical Center	Eileen Holman, LCSW (licensed social worker)	<p><u>PSYCHIATRY GROUP COUNSELING NOTE</u> – Pt attending anger management group. He has learned a lot from groups he has been going to and is not showing anger.</p>
3/7/2018	VA Medical Center	Eileen Holman, LCSW (licensed social worker)	<p><u>PSYCHIATRY GROUP COUNSELING NOTE</u> – Pt in for mood group for issues related to Veteran's expression of anger. He shows insight and good judgment.</p> <p>Pt has completed 8 week course in anger management. No further sessions required.</p>
8/15/2018	VA Medical Center	Richard W. Schulz, PMHP-BC	<p><u>PHONE NOTES</u> – Pt reports increase in PTSD symptoms, anxiety attacks, and nightmares. He was last seen a year ago and was on clonidine and trazodone. He still has another bottle of trazodone and would like to restart the clonidine.</p> <p>DX – PTSD</p> <p>RX – clonidine 0.2mg and trazodone 200mg</p>
10/29/2018	VA Medical Center	Geraldine P. Kuo, M.D. (psychiatry)	<p><u>PROGRESS NOTES</u> – <i>This evaluation stated diagnosis of PTSD.</i></p> <p>Pt reports no improvement since resuming medication. He just moved into a new apartment and would like a letter to</p>

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			<p>allow emotional support animal per landlord's request. Pt reports improvements in trauma related symptoms, sleep, anxiety, and stress. He denied SI or substance use.</p> <p>ROS is negative for psych symptoms.</p> <p>MSE noted he is cooperative, normal speech, normal motor, affect stable and mood is "a little bit better," no SI/HI, no obsessions or delusions, coherent and attentive, no hallucinations, fair insight, and intact judgement.</p> <p>Pt is a divorced male with symptoms from disrupted sleep pattern, anxiety, and depressed mood since 2012. HE had a prior psychiatric history of PTSD, MDD, and GAD. Pt initially presented to MH in 2013 and has been treated with individual therapy in 2015 (8 sessions of CPT) but disengaged due to marital distress and now returns for treatment. There is a predisposition for substance abuse (mother alcoholism). His psychosocial history is significant for a near death experience from his dysrhythmia and failed marriage due to his wife's infidelity. MSE is significant for worrisome thoughts of dying from medical condition. His medical history is significant for WPWP.</p> <p>Pt's symptoms are consistent with PTSD as evidenced by criteria which include near death event, recurrent nightmares</p>

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			<p>every night, persistent avoidance of social and physical interactions, persistent negative mood and conditions, hyperarousal, and persistently present for past 4 years. His depression is less severe than prior 6 months due to divorce but still has persistent depressed mood, anhedonia, low energy, significant weight loss of 40lbs, insomnia, diminished ability to focus but denied SI. Unsure if he meets criteria for GAD at this time as most of the session was focused on trauma related symptoms and psychosocial stressors.</p> <p>Pt did not respond well to risperidone and d/c prior to f/u appointment. Switched to clonidine but needs further titration to determine response. Initiated venlafaxine but lost to follow up and stopped taking it. He was recently placed on duloxetine 20mg which he is tolerating well. Recommend increase to 60mg for effect.</p> <p>DX – PTSD</p> <p>RX – clonidine 0.2mg, trazodone 200mg, duloxetine 20mg</p>
10/5/2020	VA Medical Center	Eileen L. Holman, LCSW (licensed social worker)	<u>LETTER</u> – Pt has not been seen by this social worker for more than 2 years and has not been seen by BHIP Mission Valley Health in the same number of years. He is being d/c from this clinic. If he desires to return to General Mental Health Clinic, a new consult for psychiatry/therapy will need

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6/4/2021		Kenneth Garett, Ph.D. (psychology)	<p>to be completed.</p> <p><u>PSYCHOLOGICAL EVALUATION</u> – This evaluation stated probable diagnoses of Major depressive disorder; Generalized anxiety disorder with panic; Chronic sleep deprivation; and Chronic issues with his kidneys, bladder, and intestines due to episode of one year ago. Additional psychological treatment is recommended.</p> <p>Pt was injured at work on 5/28/20. He passed out while working on a forklift. He was suffering from dehydration and indicated he had been working 10 hour days consecutively for the past 6 days. He was taken to San Gorgonio Hospital and then transferred to the veterans hospital where he remained for 3 days. Pt experienced physical damage to his kidney, bladder, and intestines and has been suffering chronic physical weakness and has not returned to work. Pt also reports experiencing severe difficulties coping with heat along with severe sleep deprivation and ongoing palpitations.</p> <p>Pt lives with his wife and 1 y/o daughter. He also has a 7 y/o son from a prior relationship. Pt was born in Detroit where he graduated high school and then joined the Marine Corps. He completed a full tour of duty in the Marines and when he left, he had some stressors which required brief follow up with counseling but he has not been in any mental health treatment since that time. Pt stated that his mother died when he was a</p>

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			<p>young child and he was raised by his father and stepmother. Pt has 4 older siblings. He denied any abuse or mental health issues in his childhood.</p> <p>Pt denied any history of alcohol, drugs, or other related criminal issues.</p> <p>Pt states his marriage is quite supportive. His wife is pregnant with their 2<sup>nd</sup> child.</p> <p>Pt reported that prior to the incident, he performed heavy work which demanded physical activity with heavy equipment. He worked as a funeral home director for some time and in trash management as well. Pt had only been working with the company for a number of months when this episode of dehydration and passing out occurred. Pt stated he was in the hospital and received fluid for a number of days but has never been able to regain his sense of wellbeing and is currently under medical care including naproxen and gabapentin for his muscular pain and general discomfort.</p> <p>OBSERVATIONS noted he was cooperative with c/o extreme fatigue along with episodes of anxiety which he did not have prior to the incident at work. He has had financial problems and other emotional setbacks as he has always been a good provider and experiences a sense of loss that he is at</p>

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			<p>home and unable to function effectively at this time.</p> <p>TESTING – Zung Self-Rating Depression Scales. Forer Sentence Completion Test.</p> <p>Pt is currently experiencing psychological symptoms significant enough to warrant psychological care. Recommend 6 psychological sessions to reduce his panic episodes primarily and also request that his physician consider providing some form of sleep medications to help him as clearly chronic sleep deprivation further exacerbates his mood.</p> <p>PROBABLE DX – Major depressive disorder; Generalized anxiety disorder with panic; Chronic sleep deprivation; and Chronic issues with his kidneys, bladder, and intestines due to episode of one year ago.</p>

#### DEPOSITIONS

*None provided.*

#### MEDICAL RECORDS

DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
1/12/2012	VA Medical Center	Luke Hiller, M.D.	X-RAY RIGHT SHOULDER – mild sclerosis seen in

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		(radiology)	horizontal facet of the grater tuberosity, nonspecific in nature, otherwise normal  <u>X-RAY LEFT KNEE</u> – proximal right fibular lobulated cortical irregularity and pedunculated osseous excrescence with intramedullary connection in the distal left lateral femur
1/12/2012	VA Medical Center	Raja Ramaswamy, M.D. (radiology)	<u>X-RAY RIGHT KNEE</u> – proximal right fibular lobulated cortical irregularity and pedunculated osseous excrescence in the distal left lateral femur, both with intramedullary continuation are suggestive of osteochondromas
2/10/2013	Palomar Health	Jack Wilson, M.D. (emergency medicine)	<u>ER VISIT</u> – Pt c/o large mass on left testicle when he stands up with left testicular pain for past 3 days.  ROS is positive for anxiety.  PE noted psychiatric exam revealed he is anxious.  DX – epididymitis and probable varicocele
3/25/2013	VA Medical Center	Michael Hose, M.D. (internal medicine)	<u>PROGRESS NOTES</u> – Pt in to establish care. He has 6 month history of mass in left testicle with one month of testicular pain. His stepmom thinks its varicocele. The testicular pain worsened when he had staph infection in his armpit. His stepmom is a doctor and put him on Bactrim. He has a history of WPW diagnosed in the military with 5-6 syncopal episodes with one a month ago following an argument with his girlfriend. He will get a thud in his heart.

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			Pt also has occasional headaches.  Past medical history includes WPW; knee pain; <b>anxiety disorder</b> ; history of chlamydia; left testicular pain; and <b>insomnia (sits up all night)</b>  <b>Taking Ambien 5mg for sleep.</b>  DX – testicular pain; <b>anxiety causing insomnia</b> ; WPW; and HM
5/8/2013	V.A Medical Center	Paul Krug, RN	<u>ER VISIT</u> – Pt c/o left testicular pain and mass for past 4 months which is radiating to upper abdomen and lower back.  DX – abdominal/chest pain with diarrhea and varicocele
5/30/2013	V.A Medical Center	Rajeev Joshi, M.D. (cardiac electrophysiology)	<u>PROGRESS NOTES</u> – Pt with <b>anxiety</b> and WPW diagnosed in 2011. Since then he's had several episodes of palpitations associated with dizziness lasting an hour with near syncopal episodes. He usually lies down until the episode subsides. He is seeking ablation option.
6/7/2013	V.A Medical Center	Linda Ottley, M.D. (urology)	<u>PROGRESS NOTES</u> – Pt seen in ER in May for left testicular pain radiating to abdomen and lower back for past 5 months. He had been told he had varicocele in the past but scrotal US was negative.  DX – history of varicocele vs. chronic prostatitis/chronic pelvic pain syndrome

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7/1/2013	VA Medical Center	Fiona Cassidy, M.D. (radiology)	<u>ECHOGRAM SCROTUM</u> – unremarkable
3/13/2014	VA Medical Center	Michael Hose, M.D. internal medicine)	<p><u>PROGRESS NOTES</u> – Pt in for annual exam. He was evaluated for WPW and they were planning a special procedure for cryoablation but the cardiology department ws waiting for special catheter to arrive. He has not heard back yet. Pt c/o insomnia and PTSD. He is having nightmares and gets very anxious at night when he gets ready to lay down. His wife shakes her head in agreement. He has recurrent dreams of his gunny driving him down a hallway and he sees lights flashing. Pt was having palpitations going in and out of consciousness and when he gets in the room he blacks out and then wakes up. His wife tells him that he jumps up gasping for breath. Other times he can't sleep and sits at the edge of the bed. They are not sleeping in the same bed. Pt's wife also noticed he grinds his teeth a lot. Pt had TMJ before related to this. E does it right before falling asleep. Fear of going to sleep is a trigger.</p> <p>Pt is still taking flecaidade.</p> <p><b>Pt gets agitated and angry.</b> He has a toddler at home and his wife is pregnant. Pt can't be short-fused.</p> <p>Pt wants nicotine gum to quit smoking. He doesn't smoke</p>

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			<p>much. He will stop for a few days and then needs one for stress. Seems like more used for stress and not due to addiction. Prior behavioral medicine clinic didn't help.</p> <p>DX – Anxiety/possible PTSD causing insomnia; smoking cessation; WPW; and HM</p>
4/12/2014	Sharp Grossmont Hospital	Peter Colaprete, M.D. (emergency medicine)	<p><u>ER VISIT</u> – Pt brought in by ambulance. He was cooking when he felt lightheaded and possibly passed out, falling into the arms of his wife. He felt very tired and had some sharp chest pain intermittently. Medics were called and brought him in. Pt just feels weak without any chest pain at this time.</p> <p>DX – syncope vs. presyncope; history of Wolff-Parkinson-White, possible cardiac arrhythmia; and acute chest pain, rule out coronary ischemia</p>
4/13/2014	Sharp Grossmont Hospital	Alborz Hassankhani, M.D., Ph.D. (cardiac electrophysiology)	<p><u>PROCEDURE NOTE</u> – EP Study with Radiofrequency Catheter Ablation of 2 Accessory Pathways</p>
7/24/2014	VA Medical Center	-	<p><u>PROGRESS NOTES</u> – Pt is 3 months status post cryoablation of his paraseptal accessory pathway and doing very well with minimal palpitations. He still has some residual chest burning and a stress test is recommended.</p>
5/4/2015	VA Medical Center	Michael Hose, M.D. (internal)	<p><u>PROGRESS NOTES</u> – Pt in for annual exam reporting heart rhythm is not fast now but gets pauses and then abnormal</p>

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		medicine)	<p>which worries him. He still has ongoing PTSD but not being followed by mental health. Pt has nightmare and anxiety related to fear of sudden death from episode he had in military. Pt needs a note stating it's okay for him to have a service dog to help with PTSD. He is going to be trained to be a service dog in case he has an issue with his heart and the dog will pick up on it. Dog is also an emotional support animal. Pt still has some tender swelling around abdomen.</p> <p><b>DX – anxiety/possible PTSD causing insomnia and affecting relationship with wife; smoking cessation; WPW status post ablation; hydrocele; folliculitis; and HM</b></p>
3/18/2016	VA Medical Center	Scott Thomson, M.D. (emergency medicine)	<p><u>ER VISIT</u> – Pt was sitting in his car this morning when he was overcome by jitters, numbness/tingling, and sense he could not get air. He drove home and stayed in the car outside, called 911 and was taken to Sharp but ER line was too long so he left without being seen and came here. <b>He interviewed in the presence of his wife and vaguely endorsed worse-than-usual life stress without providing details.</b></p> <p><b>Pt tested strongly positive at October 2015 psych intake for insomnia, PTSD, panic disorder with agoraphobia and GAD. The panic manifestations of panic described are severe like what occurred today. He has been followed</b></p>

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			<p><b>regularly in anxiety disorder clinic but is not medicated. Pt reported he had gotten into a series of disagreements with his wife and they just separated.</b> He is staying with a friend. They have a 1 y/o child and a 5 y/o step child.</p> <p><b>DX – panic attack with somatic manifestations, predisposed by underlying GAD, anxiety, agoraphobia, exacerbated by recent relational trouble with his wife.</b></p> <p><b>RX – Ativan 1mg</b></p>
10/29/2016	VA Medical Center	Yuko Nakajima, M.D. (emergency medicine)	<p><u>ER VISIT</u> – Pt c/o left flank pain for one day with fever, chills, malaise, nausea, and one episode of vomiting. He c/o chest pain and SOB currently.</p> <p><b>DX – gastroenteritis</b></p>
10/29/2016	VA Medical Center	Paul Stark, M.D. (radiology)	<p><u>X-RAY CHEST</u> - Normal</p>
3/17/2017	VA Medical Center	Paul Krug, RN	<p><u>ER VISIT</u> – Pt c/o persistent chest pain since he was last year a year ago that has never gone away since his ablation. He reports some tingling in his fingers and knows that is associated with hyperventilating. <b>Pt endorses anxiety about a new symptom he feels in his ribs with popping.</b></p> <p>Pt left without being seen.</p>
3/17/2017	VA Medical Center	Kathleen Jacobs M.D. (radiology)	<p><u>X-RAY CHEST</u> – No evidence of acute cardiopulmonary disease</p>

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4/16/2017	VA Medical Center	Logan Vidal, D.O. (emergency medicine)	<u>ER VISIT</u> – Pt c/o sore throat, abdominal pain, and rectal pain for past week with fever, nausea/vomiting, and diarrhea. He woke up this morning with a white spot and swollen tonsils.  DX – abdominal pain and gastritis
5/25/2017	VA Medical Center	Joshua Bollan, M.D. (internal medicine)  Alan Maisel, M.D. (cardiology)	<u>CARDIOLOGY CONSULT</u> – Pt with history of WPW status post ablation in 2014 diagnosed in 2011 after a syncopal episode, <b>anxiety disorder, PTSD</b> , presented to ER for palpitations. He woke up this morning with chest pain and palpitations. His chest pain feels like popping and is worse when he moves his arm. It is left-sided and goes to his shoulder and is unrelated to activity. Palpitations do not feel like the ones he had prior to his ablation but feel like the palpitations he has been having a few times a week ever since his ablation in 2014 where he feels like his heart is going to stop. Pt came to ER and elsewhere for this multiple times. He is frustrated despite all the testing, no one can come up with an answer. When he has these episodes, he will also feel tingling in his fingers, nauseated, and lightheaded. He has been asked to schedule an echocardiogram and Holter which he has not done yet.  Current RX – <b>Risperidone 1mg, Trazodone 100mg</b>  Pt's medical history includes WPW; <b>PTSD; panic disorder;</b>

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			<p>and generalized anxiety disorder</p> <p>Pt lives with his girlfriend.</p> <p>Pt used to smoke 3 pack a year. He quit in 2015. <b>Pt occasionally smokes MJ for his anxiety.</b></p> <p>Pt's mom died when he was 2 y/o from lung cancer (heavy smoker and ETOH use). His father is living and healthy.</p> <p>Pt called the cardiology clinic on 5/17 for the same issue and advised to get Holter monitor and echocardiogram which he has not done yet. His symptoms have been present for 3 years regularly so it is unlikely this represents ACS. <b>He has several symptoms which suggest that he may be experiencing panic attacks such as paresthesias. He does carry a diagnosis of panic disorder.</b> He does not have exertional chest pain and his blood pressure is normal. Pt has not had a syncopal episode since his ablation. Pt will get a Holter today.</p>
5/25/2017	VA Medical Center	Jeffrey McMenomy, M.D. (emergency medicine)	<p><b>ER VISIT</b> – Pt c/o feeling off with nausea, tingling in fingertips, pain in left 1<sup>st</sup> toe, palpitations, and chest pain. He thinks it may be related to starting <b>Risperdal and Trazodone</b>. He states sometime between midnight and 2 he had palpitations that woke him from sleep and he felt as if his heart was beating irregularly. Pt reported a history of WPW</p>

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			with ablation. He also reports intermittent pain and swelling in the left 1st IP joint.  <b>Current RX – Trazodone 100mg and Risperidone 1mg</b>  <u>IMP – subjective palpitations and toe pain</u>
5/25/2017	VA Medical Center	Luke Hiller, M.D. (radiology)	<u>X-RAY LEFT FOOT</u> – No abnormality
5/25/2017	VA Medical Center	Geraldine Chang, M.D. (radiology)	<u>X-RAY CHEST</u> – normal
5/26/2017	VA Medical Center	Rana Ram, M.D. (emergency medicine)	<u>ER VISIT</u> – Pt c/o syncopal episode that occurred at 5 pm today witnessed by his wife. He reports just prior he had palpitations (chronic for the past 3 years). He hit his head on the heard floor mostly left sided and now has headaches not associated with visual changes.  DX – Syncope; history of WPW status post ablation; palpitations; and closed head injury
5/26/2017	VA Medical Center	Alex Pearce, M.D. (internal medicine)	<u>HISTORY &amp; PHYSICAL</u> – Pt reports walking to the bathroom when he felt palpitations, left-sided chest pain radiating to his left arm, mild nausea, vison narrowed and then he passed out. He hit his head and woke up on the ground. Pt's girlfriend noted he was mildly confused for 2-5 minutes afterwards. Pt also reports episodes once monthly since his ablation in 2014 where he feels palpitations like his heart skipping a beat and feels like he is going to pass out

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			<p>with associated mild chest pain. He was wearing his Holter monitor when the episode occurred today.</p> <p>Pt reports the chest pain is brief and only just prior to his syncopal episode. He reports getting palpitations when he works out so he will take it easy. <b>Sometimes he wakes up in the middle of the night SOB but attributes this to his PTSD. He also reports a history of anxiety attacks but states his symptoms are different, usually his anxiety attacks present with numbness and tingling in the hands and lips and his mind will race.</b></p> <p>Current RX – <b>Trazodone 100mg and Risperidone 1mg</b></p> <p>DX – syncope; atypical chest pain; <b>Anxiety</b>; FEN; and VTE ppx</p> <p>Pt is admitted to ward with telemetry.</p>
5/26/2017	VA Medical Center	Sreenath Naray, M.D. (radiology)	<u>CT HEAD</u> – no acute intracranial hemorrhage, mass effect or hydrocephalus
5/27/2017	VA Medical Center	Paul Stark, M.D. (radiology)	<u>X-RAY CHEST</u> - Normal
7/26/2017	VA Medical Center	John Hankey, M.D. (emergency medicine)	<u>ER VISIT</u> – Pt c/o left ear pain/muffled sounds. He admits he may have gotten water in his ear. Pain is affecting his work.
			Current RX – <b>Clonidine 0.1mg (for PTSD), Trazodone</b>

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			<p>100mg (for sleep), Venlafaxine 150mg, and ascorbic acid 500mg.</p> <p>DX – right otitis media</p> <p>RX – Claritin 10mg and Augmentin 875mg</p>
7/31/2017	VA Medical Center	Ali Parand, M.D. (internal medicine)	<p><u>PROGRESS NOTES</u> – Pt in to establish care. He reports continued intermittent palpitations, severe episodes associated with near syncope once a month, often provoked by exercise, lasting 1-2 minutes and milder episodes with milder lightheadedness that occurs daily lasting a few seconds. <b>Pt reports anxiety is under control but still has frequent nightmares.</b> Pt went to ER last week for right ear pain and diagnosed with otitis media which has improved with medicine but still has throat pain. Pt also reports left testicular pain since 2012. He has a history of chlamydia one time that was treated. Pt has chronic left knee pain and takes Ibuprofen daily for pain control.</p> <p>Past medical history includes knee pain, <b>anxiety disorder/PTSD</b>, history of chlamydia, left testicular pain, and <b>insomnia</b>.</p> <p>Past surgical history includes paraseptal accessory pathway ablation (April 2014).</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>Pt is divorced and lives with his girlfriend. He has a 3 y/o son that lives with him 2 weeks out of the month and he works for a mortician.</p> <p>Pt quit smoking in 2015. He denied drugs and alcohol.</p> <p>Pt was in the Marines from 2010-2012 and d/c for medical reasons. No combat experience.</p> <p>Pt's biological mom died of lung cancer.</p> <p>Current RX – Amoxicillin 875/Clav K 125mg, Clonidine 0.1mg (for PTSD), Loratadine 10mg, Trazodone 100mg (for sleep), Aspirin 81mg, and Ibuprofen 400mg.</p> <p>DX – WPW syndrome, persistent symptoms; anxiety; chronic left knee pain; painful left varicocele, and recent acute otitis media, symptoms improving.</p>
8/12/2017	VA San Diego	David Krummen, M.D. (cardiac electrophysiology)	<u>PROCEDURE</u> – complete transthoracic echocardiogram
8/14/2017	VA Medical Center	Patricia Hlavin, M.D. (emergency medicine)	<u>ER ISIT</u> – Pt treated last week for ear ache but noted this week he had a lot of dizziness and felt he was sliding off the bed when he wasn't. Pt has mild photophobia but eyes do not hurt when he moves them. Perception feels off and his vision is blurry.

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			Current RX – Amoxicillin 875/Clav K 125mg, <b>Clonidine 0.1mg (for PTSD)</b> , Menthol/M-Salicylate 10-15% topical cream, Loratadine 10mg, <b>Trazodone 100mg (for sleep)</b> , Aspirin 81mg, and Ibuprofen 400mg
8/23/2017	VA Medical Center	Mark Strickland, M.D. (emergency medicine)	<u>ER VISIT</u> – Pt c/o abdominal pain for past 2 days. He is a mortician and was struck with a dirty blade two weeks ago and would like to be evaluated for possible exposure. He cut his finger on a dirty scalpel in a sharps container at work from an unknown corpse.  Current RX – Amoxicillin 875/Clav K 125mg, <b>Clonidine 0.1mg (for PTSD)</b> , Menthol/M-Salicylate 10-15% topical cream, Loratadine 10mg, <b>Trazodone 100mg (for sleep)</b> , Aspirin 81mg, and Ibuprofen 400mg  DX – healthcare related scalpel; abdominal injury resolved
12/10/2017	VA Medical Center	John Hankey, M.D. (emergency medicine)	<u>ER VISIT</u> – Pt c/o dizziness upon waking his morning with abdominal pain, diarrhea, and vomiting with anal burning the past few days. He reports 2 weeks history of intermittent midepigastric abdominal pain, pins and needles feeling in stomach and this morning woke up nauseated and vomited. He had some perirectal discomfort on and off for several days. Pt also felt lightheaded before coming to ER.  Current RX – <b>Clonidine 0.1mg (for PTSD)</b> , Menthol/M-

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>Salicylate 10-15% topical cream, <b>Trazodone 100mg (for sleep)</b>, Aspirin 81mg, and Ibuprofen 400mg</p> <p>DX – rectal discomfort; nausea/vomiting; and abdominal pain</p> <p>RX – Hydrocortisone, famotidine 20mg</p>
3/1/2018	Sharp Grossmont Hospital	Subhash Viswanathan, M.D. (emergency medicine)	<p><u>ER VISIT</u> – Pt c/o sternal chest pain that has been ongoing for one year, worse with inspiration, radiating to right shoulder. He was laying down and had sudden onset of left sided head numbness that lasted 30 minutes and became diaphoretic.</p> <p>Pt's history includes current smoker, kidney infection, <b>PTSD, anxiety</b>, stroke, and WPW.</p> <p>DX – costochondritis; and benign headache</p>
3/7/2018	VA Medical Center	Karen Chen, M.D. (radiology)	<u>X-RAY LEFT HAND</u> – no abnormality
3/27/2018	VA Medical Center	Jasmin Lyons	<u>CALL NOTES</u> – Pt would like to be <b>tested for sleep apnea</b> , his girlfriend states he stops breathing and wakes up in the middle of the night.
4/2/2018	V.A Medical Center	Roana Aminbakhsh, M.D. (internal medicine)	<u>PROGRESS NOTES</u> – Pt in to establish PMD.  Pt's mom passed away from lung cancer. His father is living and healthy.

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>Pt uses marijuana for sleep. He lives with his girlfriend.</p> <p>Pt denied alcohol and tobacco.</p> <p>Current RX – <b>Trazodone and Clonidine</b></p> <p>DX – nausea/vomiting; chest wall pain; history of elevated amylase/lipase; and <b>anxiety/insomnia on trazodone and clonidine</b></p>
4/9/2018	VA Medical Center	Joshua Fierer, M.D. (infectious disease)	<p><u>CHART REVIEW</u> – PCP asked for need to treat Pt for MRSA isolated from throat swab done because he has pharyngitis. That isolate had nothing to do with his medical complaint and by lab policy should not have been reported. There is no documented MRSA in his chart. In 2016, he went to Detroit ER for abscess on the dorsum of his hand w/o prior trauma that drained after soaking and was given Augmentin. It healed without complications. That is not enough to eradicate carriage, which is present in less than 20% of the population. If he develops MRSA infection in the future, Evaluator will reconsider that decision. Not every S. aureus is a potential pathogen.</p>
5/8/2018	VA Medical Center	Joanne Jacalan, NP	<p><u>PROGRESS NOTES</u> – Pt in for left hand xray results after falling two weeks ago when he got dizzy and tried to catch himself on the left hand. He is wearing hand brace still with slight pain. Pt has to push/pull for job as a mortician.</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			Current RX – <b>Clonidine 0.1mg (for PTSD)</b> , Menthol/M-Salicylate 10-15% topical cream, <b>Trazodone 100mg (for sleep)</b> , Aspirin 81mg, and Ibuprofen 400mg  DX – left hand sprain status post fall
5/18/2018	VA Medical Center	Bienvenido Chan Siy-Hian, M.D. (internal medicine)	<u>PROGRESS NOTES</u> – Pt c/o left ear pain in the last few days, feels like it is swollen and hurts when he chews or opens his mouth with some headache.  Current RX – <b>Clonidine 0.1mg (for PTSD)</b> , <b>Trazodone 100mg (for sleep)</b> , Menthol/M-Salicylate 10-15% topical cream, Aspirin 81mg, and Ibuprofen 400mg  DX – TMJ syndrome, left
5/23/2018	VA Medical Center	Eileen Apfel, OTR (occupational therapy)	Occupational therapy session
6/28/2018	VA Medical Center	Jon Bas, M.D. (internal medicine)	<u>CONSULT REQUEST</u> – Pt is not satisfied with cardio service at VA. He would like to go Dr. Williams for evaluation for his heart stop beating for a few seconds and being symptomatic with it. He c/o heart stopping for a few seconds daily with symptoms. He has been going to ER for same. Pt is status post RF ablation for WPW in 2014.  Pt's rated disabilities are <b>anxiety disorder (70%)</b> ;

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			<p>ventricular arrhythmias (30%), limited motion of arm (20%), limited flexion of each knee (10% each), and tinnitus (10%).</p> <p>Current RX – Clonidine 0.1%, Menthol topical cream, <b>Trazodone 100mg (for sleep)</b>, Aspirin 81mg, and Ibuprofen 400mg</p>
6/28/2018	VA Medical Center	Bienvenido Chan Siy-Hian, M.D. (internal medicine)	<p><u>PROGRESS NOTES</u> – Pt has WPW syndrome and had RF ablation in 2014. He has not had palpitations since but complains of heart stopping for a few seconds several times a day every day since 2014. He feels like blacking out or things closing in and sweating. Pt has had Holter monitors done. He would like nonVA cardio consult. Pt's TMJ problems resolved about 2 weeks after being seen.</p> <p>Pt is divorced and unemployed at this time. He quit tobacco in 2016.</p> <p>Current RX – <b>Clonidine 0.1mg (for PTSD)</b>, Menthol/M-Salicylate 10-15% topical cream, <b>Trazodone 100mg (for sleep)</b>, Aspirin 81mg, and Ibuprofen 400mg</p> <p><i>Missing last page of visit</i></p>
7/7/2018	VA Medical Center	Merri Finchem, M.D. (emergency medicine)	<p><u>ER VISIT</u> – Pt c/o congestion, cough, and subjective wheezing along with night sweats.</p> <p>DX – bronchitis/URI with mild reactive airways</p>

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7/8/2018	VA Medical Center	Justin Ly, M.D. (radiology)	<u>X-RAY CHEST</u> – Normal
7/13/2018	VA Medical Center	Bienvenido Chan Siy-Hian, M.D. (internal medicine)	<u>PROGRESS NOTES</u> – Pt c/o right shoulder and left knee. He works in mortuary and he lifts heavy bodies at times. He is putting a strain on his shoulder. Pt also has a history of left knee injury while in active duty while running. He rides motorcycles for his mode of transportation. He has occasional pain when going up stairs and pops occasional and also locks.  Current RX – Albuterol 90mcg, DM10/Gaifensen 100mg, Menthol/M-Salicylate 10-15% topical cream, Aspirin 81mg, and Ibuprofen 400mg  DX – left knee pain and right shoulder pain, probably from muscle strain
7/13/2018	VA Medical Center	Matthew Sharp, M.D. (radiology)	<u>X-RAY LEFT KNEE</u> - Normal
8/24/2018	VA Medical Center	Jisha Joshua, M.D. (pulmonary)	<u>SLEEP CONSULT</u> – Pt with past medical history of <b>anxiety, PTSD</b> who has been referred to pulmonary clinic for evaluation of OSA. He has been having insomnia. Pt has been going to bed at 8 pm but only falls asleep at 1 am. He then has episodes of chocking and apneas witnessed by his girlfriend. Pt wakes up around 3-4 pm after he gets nightmares and then feels fatigued and sleepy throughout the day. He also has snoring and a headache upon

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			<p>waking.</p> <p>Pt's medical history includes community acquired MRSA; tricuspid regurgitation; pain in testicle; Wolff-Parkinson-White pattern; and <b>anxiety reaction</b></p> <p>Pt denied tobacco, alcohol, and illicit drugs.</p> <p>Current RX – Clonidine 0.1mg, Aspirin 81mg, and Ibuprofen 400mg</p> <p><b>Pt is referred to sleep clinic for evaluation. ESS – 6. Will test for OSA.</b></p>
8/24/2018	VA Medical Center	Philippe Montgrain, M.D. (pulmonary and critical care medicine)	<p><u>SLEEP MEDICINE CONSULT</u> – Pt with past medical history of anxiety and PTSD. He has insomnia. He has been going to bed at 8 pm but only falls asleep at 1 am. He has episodes of choking and apneas witnessed by his girlfriend. Pt wakes up around 3-4 pm after he gets nightmares and then feels fatigued and sleepy throughout the day. Pt also has snoring and headaches upon waking up. ESS = 6.</p> <p>Current RX – <b>Clonidine 0.1mg (for PTSD)</b>, Aspirin 81mg, and Ibuprofen 400mg</p> <p>Pt will undergo home sleep test.</p>

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8/31/2018	VA Medical Center	David Bryman, M.D. (emergency medicine)	<p><u>ER VISIT</u> – Pt /co history of migraines and woke up today with photophobia, nausea, and headaches. He has not been sleeping well and has had this several times in the past along with right-sided chest pain worse with moving “not cardiac” and since has resolved. He woke up at midnight with sudden onset of right sided headache followed by nausea, cold sweats, left chest pain, and left arm tingling.</p> <p>Current RX – <b>Clonidine 0.1mg (for PTSD)</b>, Aspirin 81mg, and Ibuprofen 400mg</p> <p>DX – classic migraine</p>
8/31/2018	VA Medical Center	Jennifer Frances-Feneis, M.D. (radiology)	<p><u>X-RAY CHEST</u> – No evidence of acute cardiopulmonary disease</p>
9/10/2018	VA Medical Center	Mike Eskander, M.D. (cardiac electrophysiology)	<p><u>ARRYTHMIA CLINIC</u> – Pt in to establish care. He is with WPW and status post ablation of pathway in 2014. He first became aware of this in 2011 while in Okinawa, Japan when he felt fluttering in his heart when he was carrying a friend. Pt stated the day after he had stroke like symptoms and hemiparesis. He was taken to the hospital and underwent testing and then was airlifted to a US hospital wounded warriors for several weeks but did not want to get an ablation. Pt got out of the military and was awaiting cryoablation in the VA but did not receive it. In 2014, he had another syncopal episode and was taken to the hospital where he</p>

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			<p>underwent an ablation. He continued to have skipped heart beats almost immediately after the ablation but was afraid of returning to the VA due to his prior experiences. Pt states it's difficult for him to exercise due to palpitations but no rapid heart rates and he has episodes of near syncope nearly twice a week.</p> <p>Current RX – Clonidine 0.1mg, Aspirin 81mg, and Ibuprofen 400mg</p> <p>DX – WPW syndrome and palpitations with syncope and near syncope</p>
9/11/2018	VA Medical Center	Philippe Montgrain, M.D. (pulmonary & critical care medicine)	<p><u>SLEEP STUDY CONSULT</u> – Pt referred for study due to sleep issues. He takes Trazodone prior to sleep and will wake up choking and gasping for air.</p> <p>DX – no significant obstructive sleep apnea</p>
10/2/2018	VA Medical Center	Richard Schulz, PMHNP-BC	<p><u>PROGRESS NOTES</u> – Pt would like letter for landlord for service dog for his PTSD. He also wants to have his bilateral knee pain, bilateral ankle and bilateral foot pain looked at. He's had knee pain for the past years and this has caused an increase in his ankle and foot pain over the past 2 weeks. His right foot was swollen and he had to elevate it or a night. Pt would like PT and pain medicine. He rides motorcycles without any problems. Possible foot pain and swelling is exacerbated by operation of motorcycle.</p>

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			<p>ROS noted he <b>denied depression, anxiety, memory loss, SI/HI, and AH/VH.</b></p> <p>Current RX – acetaminophen 325mg, <b>Clonidine 0.1mg (for PTSD), Duloxetine 20mg</b>, Meloxicam 15mg, Menthol/M-Salicylate 10-15% topical cream, Aspirin 81mg, and Ibuprofen 400mg</p> <p>DX – bilateral knee pain; ankle pain; foot ankle pain; and CLBP</p>
11/15/2018	VA Medical Center	James Ruddy, M.D.	<p><u>PROGRESS NOTES</u> – Pt in for oral wounds. He had his teeth braces removed last month and fitted with retainer that is too tight and caused discomfort and lesions. He went to orthodontist yesterday and had retainer fit adjusted. He would like RX for oragel to reduce discomfort.</p> <p>ROS noted he <b>denied depression, anxiety, memory loss, SI/HI, and AH/VH.</b></p> <p>Current RX – Acetaminophen 325mg, <b>Clonidine 0.1mg (for PTSD), Duloxetine 20mg</b>, Meloxicam 15mg, Menthol/M-Salicylate 10-15% topical cream, Benzocaine 20% dental gel, Aspirin 81mg, and Ibuprofen 400mg</p> <p>DX – poor fitting retainer</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
11/30/2018	VA Medical Center	Cassidy Halle, RN	<p><u>ER VISIT</u> – Pt in for STD check because he doesn't trust his last sexual partner. He denied any signs or symptoms, just wants to be safe. He wants check for gonorrhea/chlamydia. He recently divorced and has been sexually active, unprotected sex with women. He would like to get serious with a woman and wants to make sure he doesn't have anything.</p> <p>Current RX – Acetaminophen 325mg, Benzocaine 20% dental gel, Clonidine 0.1mg (taken for PTSD symptoms), Meloxicam 15mg, Duloxetine 20mg, Methol/M-Salicylate 10-15% topical cream, Aspirin 81mg, and Ibuprofen 400mg</p> <p>IMP – STD check</p>
1/9/2019	VA Medical Center	James J. Ruddy, FNP	<p><u>PROGRESS NOTES</u> – Pt c/o headaches for past 4 days behind his eyes and can move from left right eye, throbbing all day. Tylenol PM helps but does not relieve all pain. He has increased pain and pressure with moving his head in the down position with quick head movements. Pt had cold symptoms for past 2 weeks prior to headache. He had minor blurry vision yesterday for a short period which resolved.</p> <p><b>Pt is not taking Duloxetine as prescribed, lost med during move of apartments, is willing to resume and increase to 60mg as recommended by psych. Pt has history of anxiety disorder.</b></p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>ROS denied depression, anxiety, memory loss, SI/HI, and AH/VH.</p> <p>Current RX – Acetaminophen 325mg, Benzocaine 20% dental gel, <b>Clonidine 0.1mg (taken for PTSD symptoms)</b>, Meloxicam 15mg, Menthol m-/Salicylate 10-15% topical cream, Albuterol 90mcg, Diphenhydramine 25mg, <b>Duloxetine 30mg</b>, Fluticasone prop 50mcg, Guifenesin 400mg, Loratadine 10mg, Sodium Chloride 0.65% nasal spray, Aspirin 81mg, and Ibuprofen 400mg</p> <p>DX – Sinus headache with congestion; Anxiety (PTSD) and somatic pains; and mild intermittent asthma</p>
1/25/2019	VA Medical Center	David Krummen (electrophysiology)	<u>HOLTER MONITOR STUDY</u> – Predominant underlying rhythm was Sinus Rhythm. Isolated SVEs were rare and Isolated VEs were rare.
1/25/2019	VA Medical Center	Jisha Joshua, M.D. (pulmonary)	<u>SLEEP CLINIC NOTE</u> – Pt with past medical history of anxiety, PTSD referred for insomnia. He was last seen on 8/24/18. Pt underwent an HST which did not show elevated AHI but did show respiratory efforts and possible arousals. He states he did not sleep during the study. Pt continues to have insomnia, mainly early awakenings. He has been going to bed at 10pm (before it was 8 pm) and able to fall asleep but wakes up around 3-4. Pt is woken up from nightmares from PTSD as well as

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>form his history of cardiac arrest from WPW. He gets palpitations and is going for a Holter later today. Pt is on clonidine and trazodone for sleep from his psychiatrist. Pt also started on duloxetine by PCP and asked to increase dose by his psychiatrist but he's not been taking it. Pt feels fatigued and sleepy throughout the day but doesn't take any daytime naps.</p> <p>Current RX – Clonidine 0.1mg (for PTSD), aspirin 81mg, and Ibuprofen 400mg</p> <p>IMP – OSA screen – ESS = 6 and stop bag score of 4. Pt has poor sleep hygiene but also described some apnea and snoring. Given that and history of palpitations and choking, recommend formal sleep study to see if he is a candidate for CPAP or apnearx.</p> <p>Discussed cognitive behavioral therapy for insomnia but he is not interested as he has tried it for PTSD before and did not feel any better.</p>
2/15/2019	VA Medical Center	Raymond Gysler, FNP-C	<p><u>PROGRESS NOTES</u> – Pt c/o lesion on the side of his penis for one week that is slow growing and painful. He denied high risk sexual behavior stating monogamous with girlfriend for past 3 years.</p> <p>Current RX – Acetaminophen 325mg, Albuterol 90mcg,</p>

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			Benzocaine 20% dental gel, Clonidine 0.1mg (taken for PTSD symptoms), Fluticasone prop 50mcg, Loratadine 10mg, Meloxicam 15mg, Menthol m-/Salicylate 10-15% topical cream, Sodium Chloride 0.65% nasal spray, Aspirin 81mg, and Ibuprofen 400mg  DX - folliculitis
3/21/2019	VA Medical Center	Luella Poniktera, LVN	<u>PROGRESS NOTES</u> – Pt c/o abdominal pain, nausea, vomiting, and intermittent rectal bleeding for past 2 weeks. The pain is located to the left of his abdomen with intermittent episodes of nausea and vomiting. He has a history of hemorrhoids and occasional bleeding noted on toilet paper. Pain is worse when lying down. He reports he has been on a juice fast the past 4 days.  Pt also has a history of sternal popping. He was injured while part of an IED exercise and having other soldiers fall on him while in the military. Pt also has a history of bilateral shoulder pain for past several years.  ROS denied depression, anxiety, memory loss, SI/HI, and AH/VH.  DX – abdominal pain (likely due to his juice fast); bilateral shoulder pain; sternal mobility; and low back pain
3/21/2019	VA Medical Center	Farshad Bahador,	X-RAY ABDOMEN – Normal

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4/1/2019	VA Medical Center	M.D. (radiology) Flexi Krainski, M.D. (cardiac electrophysiology)	<p><u>PROGRESS NOTES</u> – Pt with past medical history of WPW status post ablation. He underwent a Ziopatch on 1/25/19 but wore it only for 2 days as it fell off due to sweating at night. He had no significant symptoms during the time he wore it. On 1/22/19, he reported episodes of presyncope, feeling jittery and almost passing out when he was walking over to his neighbor's house. No associated stimulant or recreational THC use at that time.</p> <p>Current RX – Acetaminophen 325mg, Albuterol 90mcg, Benzocaine 20% dental gel, <b>Clonidine 0.1mg (taken for PTSD symptoms)</b>, Fluticasone prop 50mcg, Loratadine 10mg, Meloxicam 15mg, Menthol m-/Salicylate 10-15% topical cream, Sodium Chloride 0.65% nasal spray, Aspirin 81mg, and Ibuprofen 400mg</p> <p>DX – WPW syndrome and palpitations with syncope and near syncope</p>
5/28/2019	VA Medical Center	David Krummen (electrophysiology)	<u>HOLTER MONITOR STUDY</u> – Sinus tachycardia
6/14/2019	VA Medical Center	John Bas, M.D. (internal medicine)	<u>PROGRESS NOTES</u> – Pt c/o sinus infection for past 3 weeks waking up congested. Use of Sodium Chloride nasal spray did not help. He woke up in a cold sweat. Pt felt dizzy and nauseous for past 3 weeks with dizziness in the morning. Pt is not dehydrated, drinking plenty of water. Pt pulled a muscle

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			<p>in his neck or back and he can't look over his right shoulder since Saturday. Pt put a helmet on his head and pushed down l/t shooting pains, lost sensations in right hand quickly with pins and needles sensation to the hand is back to normal. He will see black and white stars when looking to the right. He's pulled this muscle before, similar symptoms when active on duty. He has tried treatment at home with lidocaine patches, heating pad, tens machine and massage and pain is not getting better. He is interested in chiro.</p> <p>DX – URI and neck pain (likely trapezial strain)</p> <p>RX – Flexeril 10mg and Naproxen 500mg</p>
6/20/2019	VA Medical Center	Cynthia Catrell, RN	<p><u>CALL NOTES</u> – Pt would like fertility testing due to lack of conception after he and his wife trying for one year to conceive. He reports testicular pain since 2012 and testicular mass that is same size as testicle and movable.</p>
6/26/2019	VA Medical Center	Cheryl Pierce, RN	<p><u>TRIAGE NOTES</u> – Pt called c/o chest pain radiating from the mid chest to the back for several months. He has been having palpitations. Pt has ongoing cardiac symptoms for the past 4 years. He has been feeling lightheaded and dizzy. He reports increase symptoms when lifting objects. Pt has WPW and had an ablation 4 year ago. He reports history of leaking heart valve. Pt called today because he became diaphoretic and felt like his heart was pounding and he became dizzy. Pt hung up call before he could be transferred.</p>

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7/7/2019	Sharp Grossmont	Joshua Doros, M.D. (emergency medicine)	<p><u>ER VISIT</u> – Pt c/o palpitations, vomiting, and chills. He felt off but then an hour ago was sitting down and felt sudden onset of pain in chest and vomited. He has history of WPW. He also c/o mild SOB. Pt admits to having one whiskey drink prior to arrival. He has a history of <b>anxiety, PTSD, WPW status post ablation 5 years ago with palpitations</b>. Pt feels he is very tachycardic.</p> <p>Pt's history includes current smoker, kidney infection, <b>PTSD, anxiety</b>, stroke, and WPW.</p> <p><b>DX – palpitations and anxiety/PTSD</b></p>
7/8/2019	VA Medical Center	John Bas, M.D. (internal medicine)	<p><u>PROGRESS NOTES</u> – Pt in for routine f/u. He was seen in ER at Sharp Grossmont on 7/6/19. He was at home when he noticed acute episode of diaphoresis and palpitations. No cardiac changes were noted and he was released home. Pt would like <b>repeat sleep study</b>. He has a history of abdominal pain with diarrhea and history of hemorrhoids which has since resolved. Pt also reports left testicular pain and deformity of left scrotum with standing.</p> <p>ROS noted <b>denied depression, anxiety, memory loss, SI/HI, and AH/VH</b>.</p> <p><b>DX – palpitations; abdominal pain/hemorrhoids; question of sleep apnea; and left testicular pain</b></p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
7/20/2019	VA Medical Center	David Bryman, M.D. (emergency medicine)	<p><u>ER VISIT</u> – Pt c/o fatigue for several weeks with severe ST 2 weeks ago with no treatment. He noticed swollen lumps at groin for a few weeks with no discharge. Pt is married and had HIV testing recently because they are getting ready to start a family.</p> <p>Current RX – Acetaminophen 325mg, Benzocaine 20% dental gel, Clonidine 0.1mg, Fluticasone prop 50mcg, Colon electrolyte lavage, Hydrocortisone 1/pramoxine 1%, Loratadine 10mg, Meloxicam 15mg, Menthol 10-15% topical cream, Sodium Chloride 0.65% nasal spray, Aspirin 81mg, and Ibuprofen 400mg</p> <p>IMP – small palp nodes at inguinal region</p>
7/20/2019	VA Medical Center	Farshad Bahador, M.D. (radiology)	<u>CT ABDOMEN &amp; PELVIS</u> – no acute abnormality
7/20/2019	VA Medical Center	Paul Stark, M.D. (radiology)	<u>X-RAY CHEST</u> - Normal
10/22/2019	VA Medical Center	Cynthia Catrell, RN	<u>CALL NOTES</u> – Pt would like consult for carpal tunnel testing stating he gets a tingling feeling with pins and needles in the right hand.
10/27/2019	VA Medical Center	Alexa Shaffer, RN	<u>PROGRESS NOTES</u> – Pt c/o red swollen rash on groin for past 3 days getting worse. He went to urgent care and was diagnosed with skin infection.
11/22/2019	VA Medical Center	Simona B. Walker, RN	<u>ER TRIAGE</u> – Pt c/o brownish/yellow fluid dripping from nose this morning. He presents with nose bleed and

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			lightheaded that started 3 hours ago.
11/25/2019	VA Medical Center	John Bas, M.D. (internal medicine)	<u>WORK STATUS</u> – Pt has been under care for URI and may return to work w/o restrictions
2/27/2020	VA Medical Center	Cynthia Catrell, RN	<u>CALL NOTES</u> – Pt went to urgent care and was diagnosed with pityriasis rosea.
5/28/2020	San Gorgonio Memorial Hospital	Richard Preci, D.O. (emergency medicine)	<u>ER VISIT</u> – Pt presented with c/o muscle cramps and syncopal episode of past 2 hours prior to arrival. He is a power line worker and was working outside when at 1600 he was on facetime with his wife and was not feeling well. Pt stated that he sat in his car and proceeded to vomit. Afterwards, he walked outside and had a syncopal episode. Pt woke up on the ground with his legs over the forklift. Shortly afterwards, his abdomen, legs, and arms began to cramp. Pt denied prior drugs and alcohol.  ROS is positive for chest pain, abdominal pain, and other aches and pains.  Pt has a history of smoking cigarettes.  DX – Rhabdo and AKI  Pt is improved upon d/c.
5/28/2020	San Gorgonio Memorial Hospital	Chul E. Chae, M.D. (radiology)	<u>X-RAY CHEST</u> – no acute abnormality of chest <u>CT HEAD</u> – no acute abnormality of head

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5/28/2020	San Gorgonio Memorial Hospital	Rahij Ghazal, M.D. (internal medicine)	<p><u>D/C SUMMARY</u> – Pt with history of Wolff-Parkinson-white status post ablation was working in the heat for several hours without adequate hydration and fainted twice. He felt much weaker since then with cramping in his legs and muscles, and he was confused. He was brought to the ER last night and appeared dehydrated. Pt was admitted and started on fluid. His kidney function came back to normal but his CPK has continued to trend up. Pt needs more IV fluids and monitor CPK. He is a VA patient and is being transferred to the VA hospital to continue care there.</p> <p>DX – acute rhabdomyolysis; acute renal failure; syncope; and history of Wolff-Parkinson-White</p>
6/1/2020	VA Medical Center	Ali Parand, M.D. (internal medicine)	<p><u>CALL NOTES</u> – Pt was d/c Saturday after being hospitalized for 2 days for rhabdomyolysis/aki due to heat exhaustion while working as a groundsman for Edison. He still has generalized muscle soreness. Pt would like to remain off work until he recovers. He is concerned of repeat heat exhaustion. He states the company he was working for overworked him.</p> <p>DX – status post heat exhaustion, rhabdo/aki</p> <p>Pt given off work letter through 7/1/20.</p>
6/26/2020	VA Medical Center	Ali Parand, M.D. (internal medicine)	<p><u>CALL NOTES</u> – Pt has persistent back pain symptoms and continued bilateral mid-back pain. His symptoms are not as</p>

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			<p>bad as when he was hospitalized for rhabd/aki 3-4 weeks ago but states his symptoms have not improved much. Pt states he developed intermittent pain in the left groin over the past 2-3 weeks and intermittent dysuria and suprapubic pain when initiating urinary stream. His urine has been gold in color. Pt's had frequent nausea and intermittent dry heaves. He is trying to drink plenty of liquids but this is limited by nausea and worsening back pain if he drinks too much at one time. Pt would like another work-excuse to allow him to remain off work until the end of July.</p> <p>Pt still has pain over the left forearm svt it is gradually improving.</p> <p>DX – persistent bilateral mid back pain, now with left groin and dysuria, r/o nephrolithiasis; and left forearm svt</p>
6/26/2020	VA Medical Center	Cynthia Catrell, RN	<p><u>CALL NOTES</u> – Pt reports he is improving but with ongoing pain and would like letter from PCP excusing him from work through 8/1/20. Pt reports still waking up with stabbing back pain and pressure along with bilateral lower back pain near his kidneys throughout the day. He still feels nauseous but mostly when stabbing pain occurs when lying down.</p>
9/18/2020	VA Medical Center	Alexa Shaffer	<p><u>CALL NOTES</u> – Pt stated he is going to start filing out state disability paperwork regarding his kidney issue that is ongoing. He has ongoing kidney pain. He would like doctor to write medical note for his current ongoing lawsuit against</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
9/22/2020	VA Medical Center	John Bas, M.D. (internal medicine)	his job.  <u>PROGRESS NOTES</u> – Pt seen by phone today for follow up. He continues to have kidney related pain, lethargy, and intolerance to heat.  Current RX – Diclofenac 1% topical gel; Aspirin 81mg; and Ibuprofen 400mg  DX – history of recent heat injury with subsequent rhabdomyolysis and kidney injury
12/16/2020	PQME Report	Stanley J. Majcher, M.D. (internal medicine)	<u>INITIAL INTERNAL MEDICINE PQME REPORT</u> – <i>This evaluation stated he is TTD. Causation is determined to be 100% industrial.</i>  Pt injured virtually total body associated with heat stroke/rhabdomyolysis, kidney failure, and other internal organ failure. He was hired by Abercrombie Pipeline Company in March 2020 as a groundsman working 80 hours per week, at times more. His duties involved heavy lifting, running power lines, digging ditches, and lifting heavy items.  Pt has a history of a congenital abnormality detected during his career in the US Marine Corps. His heart condition is Wolfe-Parkinson-White syndrome which is a congenital abnormality involving the conduction mechanism within the heart. The disease is associated with complications and

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>eventually required surgical intervention in the form of an ablation. The ablation had been completed several years prior to his date of hire (around 2015). Prior to his date of hire, he took Tambocor 150mg.</p> <p>On 5/28/20, he was working at Morongo Reservation in Redlands where temperatures were between 115 and 119 degrees. Pt started working around 5:30 am and was performing his usual duties. Around Noon, he noted severe pain in the urinary bladder, flanks, and entire abdomen. Pt tried to consume water but this did not relieve his symptoms. He then developed a series of complications including cramps in virtually all muscles in his body, confusion, dizziness, and recurrent episodes of syncope. Pt continued working despite his symptoms and around 5:30 pm his first episode of syncope occurred, fainting. The employer did not arrange for a paramedic to be called but instead took him to gas station and gave him water which did not relieve his symptoms. His total cramps progressed in severity and his symptoms were intense. Pt noted severe pain in his calves. A coworker tried massaging his calves without relief. Pt had another episode of fainting and a coworker transported him to San Joaquin Hospital where he was hospitalized for 1 ½ days before being transported to the VA hospital, Loma Linda University Medical Center. Pt was treated for rhabdomyolysis, kidney failure, and other complications</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>related to heat stroke.</p> <p>Pt is currently being treated by the VA at Loma Linda.</p> <p>Pt currently c/o intense pain involving virtual every part of his body, particularly the muscles of the abdomen and urinary bladder area. He had recurrent episodes of loose bowel movements, severe epigastric pain, is extremely sensitive to the sun where he develops nausea and vomiting, generalized headaches, and <b>his sleep pattern is interrupted with about 3 hours of sleep per night</b>. Pt also has severe flank pain and severe muscle pain and tenderness.</p> <p>Pt denied any prior workers' comp claims. He has no prior MVAs.</p> <p>Pt's medical history includes Wolfe-Parkinson-White syndrome for which he underwent a cardiac ablation.</p> <p>Pt has no known allergies.</p> <p>DX – (1) history of rhabdomyolysis (severe muscle injury); (2) history of kidney failure; and (3) history of multiple episodes of fainting and other generalized symptoms associated with industrial injury on 5/28/20.</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>Causation is industrial due to the heavy work in an atmosphere of high temperatures and inadequate fluid intake resulting in damage to his body muscles, kidneys, and other body parts associated with the underlying injuries caused by the muscles and kidney injuries.</p> <p>Pt is TTD.</p> <p>Recommend he continue to be followed by VA hospital or private nephrologist.</p> <p><u>At this time there are no applicable nonindustrial factors.</u></p>
2/9/2021	VA San Diego	Jon Bas, M.D. (internal medicine)	<p><u>REVIEW OF LAB RESULTS</u> – Normal except elevated CK.</p>
3/5/2021	VA Medical Center	John Bas, M.D. (internal medicine)	<p><u>PROGRESS NOTES</u> – Pt in for f/u by telephone today. He was working in May establishing electrical lines and working in the heat when he subsequently developed heat stroke, rhabdo, and acute kidney injury. Pt was seen in the ER and later transferred for ICU level care. He attempted to apply for a workers' comp claim but was denied due to lack of sufficient paperwork submitted at the time of his hospitalization.</p> <p>Pt's past medical history includes history of heat stroke; acute renal failure syndrome; nontraumatic rhabdomyolysis; pityriasis rosea; knee pain; <b>posttraumatic stress disorder</b>;</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>community acquired MRSA; tricuspid valve regurgitation; pain in testicle; Wolff-Parkinson-White pattern; and <b>anxiety reaction</b>.</p> <p>Current RX – Diclofenac topical gel 1%, <b>Gabapentin 100mg</b>, Naproxen 500mg, Aspirin 81mg, and Ibuprofen 400mg</p> <p>DX – history of heat stroke; acute renal failure syndrome; and nontraumatic rhabdomyolysis</p>
3/11/2021	VA Medical Center	Natalie Swiss, M.D. (nephrology)	<p><u>CONSULTATION</u> – Pt with history of acute kidney injury status post hydration and rhabdomyolysis. He is in for f/u. Pt has been previously seen by nephrology. He reports when he lays flat he has back pain and tightness with muscle twitches which he calls kidney pains. He also has more difficulty holding his urine. Pt thinks he is drinking the same amount.</p> <p>Pt is taking naproxen and <b>gabapentin</b> for his pain. He takes it when pain is unbearable mostly at night when he stops moving.</p> <p>DX – AKI secondary to rhabdo (no evidence of ongoing kidney disease); and lower back pain</p>
4/20/2021	<b>PQME Supp</b>	Stanley J. Majcher, M.D. (internal medicine)	<p><u>SUPPLEMENTAL PQME REPORT</u> – In response to attorney letter, Evaluator recommends evaluation by cardiologist for the Pt's history of chest palpitations which</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>would be very helpful to all concerned parties. It is noted he has a history of significant issues including confusion, dizziness, and fainting. Cardiovascular issues may be playing a role in some of his issues, therefore consultation with another cardiologist is strongly recommended.</p> <p><b>Evaluator is not a psychiatrist, therefore any issues for psychiatric injury should be evaluated by a psychiatrist.</b></p>
7/8/2021	PQME Re-Eval	Stanley J. Majcher, M.D. (internal medicine)	<p><u>INTERNAL MEDICINE PQME RE-EVALUATION – This evaluation stated no changes from prior report and recommends an orthopedist to determine WPI since per the AME Guides, that is required for muscle injuries. Upon receipt of the orthopedist reports, the Evaluator will issue a supplemental report.</u></p> <p>Currently, Pt c/o pain involving virtually every muscle in his body. He doesn't know the results of his consultation with a nephrologist who is ordinarily involved in management because heat stroke results in major damage to the muscles. Pt noted a 20 lb weight loss. He then states upon further refection that he doesn't believe he had been evaluated by a nephrologist. His subjective issues are unchanged from the prior report.</p> <p>DX – heat stroke/rhabdomyolysis</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			<p>Currently, Evaluator's opinions and conclusions remain the same, most notably the industrial injury caused by heat stroke involving the muscles and kidneys.</p> <p>Pt currently has diffuse muscle pain and his last laboratory report still reveals evidence of muscle injury as of 3/5/21.</p> <p>In view of the fact that he has muscle injuries, Evaluator does not have the expertise to determine WPI because the evaluation would require consideration of orthopedic issues. The underlying cause is rhabdomyolysis which refers to muscle injury but AMA guides require a type of evaluation that this Evaluator cannot due because this Evaluator is not an orthopedist. Recommend referral to an orthopedist to address the subjective and objective findings per the AME guides to determine WPI.</p> <p>At this time, records refer to a resolution of any kidney injury and Evaluator does not believe that a follow up evaluation by a nephrologist is necessary.</p> <p>The only issue that remains to be resolved is the extent of the WPI due to the Pt's persistent subjective and objective findings, notably continuous elevation of CPK level.</p> <p>Evaluator will review reports from the orthopedist and will</p>

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DATE(S)	MEDICAL PROVIDER	PHYSICIAN(S)	DESCRIPTION
			submit a supplemental report.

#### ADMINISTRATIVE RECORDS

DATE(S)	DESCRIPTION
6/23/2020	<u>APPLICATION FOR ADJUDICATION OF CLAIM</u> – DOI: 6/4/20. Employee injured during the scope and course of employment including excretory, <b>stress</b> , and unclass. Application is filed in disagreement regarding liability for TDI/PDI; reimbursement for medical expense; rehabilitation; medical treatment; supplemental job displacement/RTW; compensation at proper rate; and all per labor code.
7/28/2020	<u>APPLICATION FOR ADJUDICATION OF CLAIM</u> – DOI: 5/28/20. Employee injured kidney, bladder, intestines, <b>sleep loss, and psyche</b> working outside and suffering heat stroke and kidney failure. Application is filed in disagreement regarding liability for TDI/PDI; reimbursement for medical expense; rehabilitation; medical treatment; supplemental job displacement/RTW; compensation at proper rate; and all per labor code.
8/10/2020	<u>AMENDED APPLICATION FOR ADJUDICATION OF CLAIM</u> – DOI: 5/28/20. Amended to add <b>sleep loss</b> .
8/19/2020	<u>AMENDED APPLICATION FOR ADJUDICATION OF CLAIM</u> – DOI: 5/28/20. Amended to show correct employer.
9/23/2020	<u>AMENDED APPLICATION FOR ADJUDICATION OF CLAIM</u> – DOI: 5/28/20. Amended to include weight loss and chest palpitations.
8/24/2021	<u>AMENDED APPLICATION FOR ADJUDICATION OF CLAIM</u> – DOI: 5/28/20. Amended to include musculoskeletal system.



STATE OF CALIFORNIA  
Division of Workers' Compensation  
Disability Evaluation Unit

EMPLOYEE'S DISABILITY QUESTIONNAIRE

DEU Use Only

This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee

Brenden

First Name

MI

Moore

Last Name

360-11-1170

SSN (Numbers Only)

292 Finnors St. Hemet California

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

Hemet

City

State

Zip Code

Date of Birth

05/12/1990

MM/DD/YYYY

Date of Injury

05/28/2020

MM/DD/YYYY

Employer

Abercrombie Pipeline

Nature of Employers Business

Claim Number 1

Claim Number 2 \_\_\_\_\_

Claim Number 3 \_\_\_\_\_

Claim Number 4 \_\_\_\_\_

Claim Number 5 \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:**

How was your evaluating doctor selected? (check one)

From a list of doctors provided by the State of California, Division of Workers' Compensation.

Other (explain) \_\_\_\_\_

What is the name of the doctor who will be doing the evaluation?

Dr. Agarwal

When is your examination scheduled? 12/06/2021

What were your job duties at the time of your injury?

moving 1000lb rails, climbing up and down powerlines, moving  
Steel, driving forklifts.

What is the disability resulting from your injury?

heat stroke, kidney failure

How does this injury affect you in your work?

Have you ever had a disability as a result of another injury or illness? NO

If so, when? \_\_\_\_\_

Please describe the disability?

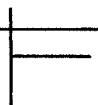
Date

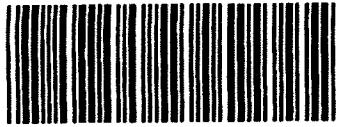
12/06/2021

MM/DD/YYYY

Signature

Brenden Moore





**State of California  
Division of Workers' Compensation  
Disability Evaluation Unit**

DEU Use Only

**REQUEST FOR SUMMARY RATING DETERMINATION  
of Qualified Medical Evaluator's Report**

**INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:**

1. Use this form if employee is unrepresented and has not filed an application for adjudication.
2. Complete this form and forward it along with a complete copy of all medical reports and medical records concerning this case to the physician scheduled to evaluate the existence and extent of permanent impairment or disability.
3. Send the EMPLOYEE'S DISABILITY QUESTIONNAIRE, DEU FORM 100 to the employee in time for the medical evaluation.
4. **This form must be served on the employee prior to the evaluation. Be sure to complete the proof of service.**

**INSTRUCTIONS TO THE PHYSICIAN:**

1. If the employee is unrepresented, review and comment upon the Employee's Disability Questionnaire, (DEU Form 100), in your report. (If the employee does not have a completed Form 100 at the time of the appointment, please provide the form to the employee.)
2. Submit your completed medical evaluation and, if the employee is unrepresented, the DEU Form 100, to the Disability Evaluation Unit district office listed below. **PLEASE USE THIS FORM AS A COVER SHEET FOR SUBMISSION TO THE DISABILITY EVALUATION UNIT.**
3. Serve a copy of your report and the Form 100 upon the claims administrator and the employee.

Date of first medical report indicating the existence of permanent impairment or disability: \_\_\_\_\_  
MM/DD/YYYY

Last date for which temporary disability indemnity was paid: \_\_\_\_\_  
MM/DD/YYYY

**Submit To: Disability Evaluation Unit**

Address/PO Box (Please leave blank spaces between numbers, names or words)

City \_\_\_\_\_ CA \_\_\_\_\_ Zip Code \_\_\_\_\_

Physician \_\_\_\_\_

Exam Date \_\_\_\_\_ MM/DD/YYYY

**Claims Administrator**

Company Name

Street Address1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Claim Number 1

Claim Number 2

Claim Number 3

Claim Number 4

Claim Number 5

Phone No. \_\_\_\_\_

Adjustor \_\_\_\_\_

Employer \_\_\_\_\_

Employee \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_

Last Name \_\_\_\_\_

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

[REDACTED] \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Injury \_\_\_\_\_  
MM/DD/YYYY

Date of Birth \_\_\_\_\_  
MM/DD/YYYY

SSN (Numbers Only) \_\_\_\_\_

Case No (if any) \_\_\_\_\_

OCCUPATION \_\_\_\_\_  
(Please attach job description or job analysis, if available)

**WEEKLY GROSS EARNINGS** \_\_\_\_\_

(Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is attached.)



**PROOF OF SERVICE BY MAIL**

On \_\_\_\_\_, I served a copy of this Request for Summary Rating Determination on

Name of Employee \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Brenden Moore  
Signature

***State of California***  
**DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT**

**DECLARATION REGARDING PROTECTION OF MENTAL HEALTH RECORD**

(Health and Safety Code § 123115(b) and § 36.5, Title 8, California Code of Regulations)

**NOTE: THE MENTAL HEALTH RECORD(S) ATTACHED TO THIS DECLARATION MUST NOT BE  
SEEN BY OR COPIED BY Branden Moore FOR THE REASONS**

(Print name of injured employee)  
**STATED BELOW:**

I, Sanjay Agarwal, M.D., declare as follows:  
(Print your name)

1. I am licensed in the state of California as a Psychiatry, license number A101145  
(Type of license)

2. The attached medical record pertains to:

Employee name: Branden Moore

Address: 292 Finnhorse St. Hemet, CA 92545 Phone: \_\_\_\_\_

W.C. Claim number: WC608-E60694-00

W. C. Claims administrator: Liberty Mutual Phone: 916-621-1060

3. In my professional medical judgment and pursuant to Health and Safety Code § 123115(b), the attached mental health record, or the portions of this record designated below and on the face of the record, if seen or copied by the employee named above, will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, (describe medical basis for conclusion):

**This psychiatric report is in indeed confidential. People often tend to misunderstand and/or distort information enclosed herein., and this may interfere with psychotherapy. For individuals who are suicidal or homicidal, the results of disclosure can be irreversible. For these reasons, this report should not be shown to the claimant.**

4. On December 06, 2021, I was asked by the above named employee, or I was required by law, to serve a copy of this medical record on the employee.

5. On that same date, I advised the employee that the record only could be inspected by, copied or provided to a licensed physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, on behalf of the employee, and that the employee must use that mechanism to obtain the record.

6. The employee has designated the following physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, for alternate service of the employee's copy of this record:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical license no. (CA, if known): \_\_\_\_\_

Date of employee designation of this physician or health care provider: \_\_\_\_\_

(MM/DD/YYYY)

7. For the above reasons, in response to the employee's request of \_\_\_\_\_ (date MM/DD/YYYY) for a copy of the record, I responded in the following manner: (*Check one below, as appropriate.*)

- I declined to allow the employee to personally inspect or receive a copy of the record.
- I declined to allow the employee to personally inspect, receive a copy or to be served personally with a copy of the record. However, at the employee's request, I did provide to, or serve a copy of the record on, the physician or health care provider designated by the employee as noted below:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Manner of Service: (mail, overnight mail, courier, fax) \_\_\_\_\_

8. From this time forward, I shall note in the medical file for this employee each time any licensed physician, within the definition of Labor Code 3209.3 or a health care provider as defined in Health and Safety Code § 123105, requests to inspect or copy this record on behalf of the employee.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date signed: 1/12/22

(Signature) 

Sanjay Agarwal, M.D.

(Print name)

Address: 410 Townsquare Lane, Huntington Beach, CA 92648 Phone: (855) 472-3894

File record of requests for copies of the attached record made subsequent to the declaration date above:

Date

Person

License type and License number

**State of California**  
**DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT**

**AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))**

Case Name: **Branden Moore** v **Abercrombie Pipeline**  
(employee name) (claims administrator name, or if none employer)  
Claim No.: **WC608-E60694-00** EAMS or WCAB Case No. (if any): **ADJ13339678**

I, **Charlie Helton**, declare:  
(Print Name)

1. I am over the age of 18 and not a party to this action.
2. My business address is: **410 Townsquare Lane, Huntington Beach, CA 92648**
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:
  - A depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
  - B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
  - C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
  - D placing the sealed envelope for pick up by a professional messenger service for service. (*Messenger must return to you a completed declaration of personal service.*)
  - E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service:  
(For each addressee,  
enter A – E as appropriate)

Date Served:

Addressee and Address Shown on Envelope:

<u>B</u>	<u>01/19/22</u>	Brett Sherry, Esq. Koszdin, Fields, Sherry & Katz 6151 Van Nuys Blvd. Van Nuys, CA 91401
<u>B</u>	<u>01/19/22</u>	Nicolett Ybarra, Esq. Law Offices of Muhar, Garber, Av & Duncan P. O. Box 7218 London, KY 40742
<u>B</u>	<u>01/19/22</u>	Ashlyn Laskey Liberty Mutual P. O. Box 779008 Rochlin, CA 95677
<u>B</u>	<u>01/19/22</u>	Branden Moore 292 Finnhorse St. Hemet, CA 92545

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 1/19/22

Charlie Helton

(signature of declarant)

Charlie Helton

(print name)