DECLARATION OF CUSTODIAN OF RECORDS

Name of applicant: x JULIEN OLIVIER
(Applicant)

_____ 117543-1
WCAB No. **Control No.**

I declare as follows:

I am employed by and am the duly authorized custodian records and am authorized to certify records for:

x Exer Urgent Care
(Name of facility)

_____ **I certify that the accompanying records are true and complete copies of records maintained in the regular course and scope of business of my employer and were prepared by authorized personnel at or near the time of the acts, conditions or events which they intend to convey. No documents, records or other materials have been withheld except as noted below.**

OR, IN THE ALTERNATIVE

_____ **I HEREBY DECLARE, under penalty of perjury, that I have NO RECORDS on the patient, employee, or subject in request.**

Please explain if you have no records:

Records were produced in the following manner:

_____ Records were made available to **Platinum Copy Services** for copying.

_____ Records were delivered to **Platinum Copy Services**.

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

Executed on x 10/22/2024, x No Signature Provided
Print Name

x No Signature Provided
Signature of Custodian

File no: 117543-1

Medical Records Excerpt

Patient Name	Julien Oliver
WCAB #	ADJ14026805, 15211612
Social Security No.	566-75-4657
Date of Birth	06/27/1967
Employer	Country of Los Angeles
Date of Injury	11/07/1990-12/15/2020

Past Medical/Surgical History	N/A.	
Social History	Never smoker.	7
Occupation History	N/A.	
Current Medications	Medrol 4 mg. Triamcinolone Acetonide 0.1 %. Fluocinonide 0.05 %. Prednisone 10 mg.	8

PAGE NO.	DATE OF SERVICE	PROVIDER	EXCERPT
21-23	06/08/2018	Cory S. Spurlock, MD Exer Urgent Care	Office Visit Note Chief Complaint: Patient complaint of poison oak on left wrist and on right arm. Skin condition located over the volar surface of left wrist. History of Present Illness: Patient presenting problem started 2-3 days ago. History includes rash to left arm after hiking, possible poison oak. The symptoms started suddenly. Symptoms started 2-3 days ago. The symptoms are constant. The character of symptoms is poorly characterized by patient. Overall patient rates the severity of these symptoms as mild. Exacerbated by touching nothing seems to relieve symptoms. Has tried apple cider vinegar, alcohol, baking soda. Severity of the problem as mild. There is pain associated with the problem. The problem is improving. The onset of the problem was gradual. Left wrist poison oak exposure. This is a new problem for the patient. Onset of symptoms was about 4 days ago. Vitals: BP: 133/79 mm Hg. Wt: 185 lbs. Physical Examination: General: Patient is overweight BMI: 25.8. Skin and Soft Tissue Exam: Maculopapular rash to left FA, erythema. Excoriation. Diagnosis / Plan: Skin problem located over the volar surface of left wrist. Dermatitis contact. Medrol 4 mg.

PAGE NO.	DATE OF SERVICE	PROVIDER	EXCERPT
			Triamcinolone Acetonide 0.1 %. Return back to your regular physician as needed. Assumed care of patient.
24-26	06/15/2018	Cory S. Spurlock, MD Exer Urgent Care	Office Visit Note Chief Complaint: Patient complaint of rash on forearms. History of Present Illness: Patient prior visit were reviewed. Presenting problem of started 3-4 days ago. Pruritic rash to forearms. Patient was seen previously for poison oak minimal improvements now worse since returning from Cabo san Lucas. Patient notes the gradual onset of these symptoms. Symptoms started 4-5 days ago. Symptoms are worsening. The symptoms are constant. Reports burning. Severity of the problem is mild. The onset of the problem was sudden. Onset of symptoms was about 7 days ago. Follow up poison oak. This is a new problem for the patient. Review of System: Skin: Rash. Pruritus. Physical Examination: General: Patient is overweight BMI: 25.1. Skin and Soft Tissue Exam: There is an erythematous papular rash to bilateral forearms. Diagnosis / Plan: Rash. Pruritus. Fluocinonide 0.05 % topical cream. Prednisone 10 mg. Orders: Dexamethasone Sodium phosphate 10 mg. Return back to your regular physician as needed. Assumed care of patient. Condition: Stable. Disposition: The patient is being discharged with an abnormal pulse. The patient discharged from department.
8-11	03/01/2019	Devlyn Corrigan, DO Exer Urgent Care	Office Visit Note Chief Complaint: Patient complaint of left foot pain. The pain level is 5/10. History of Present Illness: Patient's prior visits were reviewed. Patient presents for an evaluation of left foot pain, The onset of the presenting problem began 5-6 weeks ago. Patient presents today with complaints of mild to moderate pain localized to the

PAGE NO.	DATE OF SERVICE	PROVIDER	EXCERPT
			ball of the left foot. Patient states he runs a lot to maintain his cardio. A patient report having a past medical history of plantar fasciitis that flares up once in a while hurts to bear weight. Onset of symptoms was about 40 days ago. This is a new problem for the patient The onset of the problem was gradual. The problem is worsening. There is pain associated with the problem, severity of the problem as moderate. Complains of local foot pain. Unable to bear weight due to pain. Patient is comfortable, foot exam: patient is here today for left foot pain that started 5-6 weeks ago. Review of System: Musculoskeletal: Pain in the left foot. Physical Examination: General: Patient is overweight BMI: 25.8. Musculoskeletal Exam: Callus is noted over the plantar aspect of the ball of the left foot. X-ray of Left Foot Minimum of 3 Views: Impression: Questionable fracture of the proximal phalanx great toe. Diagnosis / Plan: Left foot pain. Left foot injury. Naprosyn 500 mg. X-ray of left foot minimum of 3 views. Disposition: Patient is being discharged with an abnormal pulse. Condition they are stable for discharge. Patient discharged from department. Follow up with Brendan Riley.
2-4	02/15/2020	Cory S. Spurlock, MD Exer Urgent Care	Office Visit Note Chief Complaint: Patient complaint of sore throat, left ear aches. History of Present Illness: The patient's prior evaluations were reviewed. Patient presenting for evaluation of URI symptoms. Presenting problem started 3 days ago, complains of a sore throat complains of a left sided earache. Left earache, sore throat. Onset of symptoms was about 3 days ago. This is a new problem for the patient The onset of the problem was gradual. The problem is stable, complains of feeling sick without particular focus or specific complaints. Severity of the problem as mild.

PAGE NO.	DATE OF SERVICE	PROVIDER	EXCERPT
			Review of System: ENT: Sore throat. Pain in left ears. Physical Examination: General: Patient is overweight BMI: 25.3. ENT Exam: Erythema is noted in the oropharynx. There is evidence of erythema and effusion with cerumen in the left TM. Diagnosis / Plan: Sore throat. Earache. Acute maxillary sinusitis. Augmentin 875 mg-125 mg. Medrol 4 mg. Disposition: Patient discharged from department. The patient has been dispositioned.
18-20	05/02/2020	Michelle Bensoussan, PA-C / Robin Klein, DO Exer Urgent Care	Office Visit Note Chief Complaint: Patient complaint of rash on face and left ear pain. Earache. Rash. History of Present Illness: Patient's prior visits were reviewed. Patient presents with left ear pain. The onset of the presenting problem began 6 weeks ago. He also has a mild rash to his left forehead for the past 1.5 weeks. Patient was seen for same left ear pain on 2/15 and was prescribed Augmentin but symptoms have no resolved. Patient notes the gradual onset of these symptoms. Review of System: ENT: Pain in left ears. Physical Examination: General: Patient is overweight BMI: 25.1. Diagnosis / Plan: Earache. Rash. Patient will go to Stevenson ranch clinic for proper physical exam accepted by Dr. Spurlock. Patient was referred from virtual care with ear pain. On exam he has bilateral cerumen impaction. Ears were irrigated successfully with alleviation of his symptoms. He is stable for die with follow up and returns precautions. Return back to your regular physician as needed. Medication list reviewed. Disposition: Patient transferred to other. Condition at discharge is stable. The patient has been dispositioned.
30-32	12/26/2020	Crystal Gillespie, PA-C Exer Urgent Care	Office Visit Note

PAGE NO.	DATE OF SERVICE	PROVIDER	EXCERPT
			Chief Complaint: Patient presents with clinical visit. Patient with URI symptoms. History of Present Illness: Patient consented to routine clinic encounter. Patient's prior visits were reviewed. Patient presenting for an evaluation of COVID-19 screening and testing. Presenting problem started 2 days ago, coronavirus screening questions. In contact with individual diagnosed with COVID-19 patient's family member tested positive for COVID-19, patient expresses concern for possible exposure 2 days ago. Has an intermittent cough, Complains of nasal congestion and fullness. Good PO fluid intake. Unable to determine onset of present illness at this time. Review of System: ENT: Nasal drainage. Pulmonary: Cough. Physical Examination: General: Patient is overweight BMI: 25.8. Diagnosis / Plan: Exposure to COVID-19. Medication list reviewed. Return back to your regular physician as needed. Follow up and ER precautions as discussed. Orders: SARS antigen FIA. Disposition: Patient discharged from department. Condition at discharge stable. The patient has been dispositioned
33-36	12/29/2020	Kerry McCabe, DO Exer Urgent Care	Office Visit Note Chief Complaint: Patient presents with clinic visit and URI symptoms. History of Present Illness: Patient consented to routine clinic encounter. The patient’s prior evaluations were reviewed. Patient presenting for an evaluation of COVID-19 screening and testing, Presenting problem started 2-3 days ago, coronavirus screening questions. In contact with individual diagnosed with COVID-19. Patient's family members x 3 tested positive for COVID-19, Has an intermittent cough, complains of dry non-productive cough, and complains of nasal congestion and fullness. Complains of ageusia, just generally feels achy with malaise. Unable to determine onset of present Illness at this time.

PAGE NO.	DATE OF SERVICE	PROVIDER	EXCERPT
			Review of System: General: Sense of general malaise and feels generally sick. ENT: Ageusia. Nasal drainage. Pulmonary: Cough. Physical Examination: General: Patient is overweight BMI: 25.5. Laboratory Report: SARS Antigen FIA: Positive. Diagnosis / Plan: Exposure to COVID-19. URI. Cough. Medication list reviewed. SARS Antigen FIA. Assumed care of patient. LOS manually stopped. Disposition: Patient discharged from department. The patient has been dispositioned. Addendum Note: Discussed positive COVID-19 antigen result with patient. Recommended 10 days of self-isolation and following CDC guidelines. Recommended patient inform close contacts patient had within 2 days of symptom presentation to quarantine/get tested as well. Patient to discuss positive COVID-19 antigen test.
12-17	04/05/2022	Jonathan Karroll, MD Exer Urgent Care	Office Visit Note Chief Complaint: Patient complaints of pain in stomach. Stomach-ache. Local pain over the anterior abdominal wall. Pain is 8/10. History of Present Illness: Patient's prior visits were reviewed. Patient presents with stomach pain. Developed problem PTA. Patient presents with abdominal pain that began last night x 1 day ago and pain is located in the epigastric region and is non-radiating; pain at first was intermittent and now is more constant. Patient has spastic colon with loose stools. Patient has had no change in bowel habits since the onset of abdominal pain. Patient was at a tanning salon x 1 day ago and some chemicals splashed into his mouth and thinks that is causing his abdominal pain, Patient had oatmeal and toast for breakfast today, a turkey sandwich and cup of tea for lunch. Past medical history of spastic colon. Patient is under a lot of stress as his daughter will be getting married in the next couple of days and is concerned about symptoms while having to travel soon. Onset of symptoms was about 1 day ago; This is a new

PAGE NO.	DATE OF SERVICE	PROVIDER	EXCERPT
			problem for the patient. The onset of the problem was sudden. The problem is worsening. There is pain associated with the problem. Severity of the problem as moderate. Patient complains of abdominal pain X 1 day. Patient states mild diarrhoea. Review of System: GI: Abdominal pain. Physical Examination: General: Patient is overweight BMI: 25.1. Patient is mildly anxious. Laboratory Report: Comprehensive Metabolic Panel: Sodium: 146 (H). Glucose: 128 (H). Urinalysis: Specific Gravity: >=1.030 (H). Diagnosis / Plan: Epigastric abdominal pain. Pepcid 20 mg. Ondansetron 4 mg. Final diagnosis is low risk but a number of moderately complex issues were considered as discussed. Assumed care of patient. Patient presents with complaints of abdominal pain. Exam is benign, including normal abdominal exam, vitals are stable, and labs were unremarkable. Follow up and given strict return ED precautions including abdominal pain, fever, n/v, syncope or other worrisome symptoms. Lab orders. Disposition: Patient is stable for discharge. The patient is being discharged with an abnormal pulse.
27-29	09/26/2023	Zacary Schwarzkopf, MD Exer Urgent Care	Office Visit Note Chief Complaint: Patient complaints of ear plugged up. History of Present Illness: Patient with presenting problem started 44 days ago. Decreased hearing in the left ear. Can't hear as well out of the left ear. Left ear clogged, happens every year. Onset of symptoms was about 4 days ago. This is a new problem for the patient the onset of the problem was gradual. The problem is stable. Describes the problem as left ear plugged up. Severity of the problem is mild. Physical Examination: General: Patient is overweight BMI: 25.8. ENT: Impacted cerumen is noted in the left external auditory canal. Procedure: Cerumen was removed with extensive irrigation of ear with lukewarm water to avoid

PAGE NO.	DATE OF SERVICE	PROVIDER	EXCERPT
			aculovestibular reflex. Post removal the canal was clear with no significant residual inflammation. Successfully removed all foreign material. Diagnosis / Plan: Moderate elevation of systolic pressure this visit. Decreased hearing. Impacted cerumen. Assumed care of patient. Patient is present with decreased hearing out of his left ear for the past 4 days. Reports he occasionally gets cerumen build up and often needs ear clogging. His left ear canalis included by cerumen which was cleared via irrigation. Patient tolerated procedure well. Recommending at home peroxide solution and ear irrigation as needed to prevent future cerumen impactions. Recommend he monitor BP at home and follow-up with PMD or return to revaluation if it is persistently elevated above 120/80. LOS manually stopped. Final diagnosis is low risk but a number of moderately complex issues were considered as discussed. Disposition: Patient discharged from department. Condition at discharge is stable. The patient has been dispositioned.
5-7	02/27/2024	Jonathan Bechtel, PA Exer Urgent Care	Office Visit Note Chief Complaint: Patient complaint of injured left wrist, Injury. Soft tissue injury to volar surface of left wrist. History of Present Illness: Patient's prior visits were reviewed. The onset of the presenting problem began 4 weeks ago. Lifting heavy objects while moving. Severity of the problem as mild. There is pain associated with the problem, The problem is stable. The onset of the problem was gradual. Onset began 3-4 weeks ago, This is a new problem for the patient complaint on/off sharp pain in left wrist x 3·4 weeks, patient states that he was moving heavy furniture and that is when the pain started , Onset: 3-4 weeks days ago. Physical Examination: General: Patient is overweight BMI: 26.4. Musculoskeletal: Patient has mild to moderate joint pain with movement of the dorsum of the left wrist. The overall exam surrounding the dorsum or the left wrist is consistent with a mild to moderate sprain/strain.

PAGE NO.	DATE OF SERVICE	PROVIDER	EXCERPT
			Diagnosis / Plan: Soft tissue injury volar surface of left wrist. LOS manually stopped. Continue use the wrist brace. For orthopaedic referral patient will need to follow up with his PCP. Supportive care discussed alternate ice with heat applications as directed. Consistent with tendinitis of the left wrist. Based on mechanism of injury there is low suspicion for fracture, so x-rays were not done at this time. Medication list reviewed. Disposition: The patient is being discharged with an abnormal pulse. Condition they are stable for discharge. Patient discharged from department. The patient has been dispositioned.

exer URGENT CARE
Exer - Stevenson Ranch
25548 The Old Road, #U1
Stevenson Ranch, CA 91381
Phone: 661-556-9020
Fax: 661-556-9021

Name: **Olivier, Julien**	DOB: 6/27/1967	Sex: M
Acct #: 2eaa6d715c25bf	MR #: 1a482d417d72940	AGE: 52
Visit Date: 02/15/2020 10:09	Bed #:	
Dispositioning Provider: Cory S Spurlock MD		
Patient's PMD: none		

Addendum Note

02/15/2020 10:10 Discussed timely access of health information with patient. (SA)

Chief Complaint

1) P/C: " sore throat, L ear ache"
2) Earache

Visit Type

Office Visit, Established Patient

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Continue - no change - Confirmed Review #1

Vitals

Blood Pressure:	Pulse:	Temperature:	Respiration:
**BP: 117/7 (02/15 10:27)	P: 82 (02/15 10:27)	Temp: 97.9 Oral (02/15 10:27)	Resp: 16/min (02/15 10:27)

Height: Hgt: 71 inch **BSA:** BSA: 2.0

Weight: Wgt: 182 lb **BMI:** BMI: 25.3

Pulse Oximetry:
Pulse OX: 98% on Room air at 02/15 10:27

Nursing History

10:11 Combined form signed by patient.
Financial Consent signed by patient. (SA)
10:26 left earache, sore throat.
Onset of symptoms was about 3 days ago.
This is a new problem for the patient.
The onset of the problem was gradual.
The problem is stable.
Complains of feeling sick without particular focus or specific complaints.
Describes severity of the problem as mild.
History provided by patient. (DV)

RN Update Notes and Disposition

RN Continuation Notes:

10:09 Patient preferred communication methods have been completed. (SA)
10:26 Review #1: medications confirmed from Daisy Virgen 10:28 (DV)

Nursing Disposition:

10:26 Clinician needs to review BMI.
10:34 Disposition: Discharge.
A disposition has been completed for Julien Olivier. by Daisy Virgen (chart contributor).
Patient was discharged from department to home.
Patient left alone.
Discussed signs and symptoms of worsening to return to ER.
Understands aftercare instructions.
Verbalizes back importance of aftercare instructions. (DV)
20:48 Patient removed from Tracker Board by Laura Jean Traber FD. (LJT)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Exam started at 10:37 02/15/2020. Have reviewed staff history and I concur. Able to get a good history. Outside records ordered for review: Have reviewed and agree with staff notes. The patients prior evaluations were reviewed . History comes from patient. Patient is a 52 year old male presenting for evaluation of URI symptoms. Presenting problem started 3 days ago. Complains of a sore throat. Complains of a left sided earache. No history of fever. No cough. No nasal congestion. No sinus symptoms. Denies headache. No other medical complaints at this time. Combined form signed by patient. Financial Consent signed by patient. left earache, sore throat. Onset of symptoms was about 3 days ago. This is a new problem for the patient. The onset of the problem was gradual. The problem is stable. Complains of feeling sick without particular focus or specific complaints. Describes severity of the problem as mild. History provided by patient.

Summary

Scribe Signature and Attestation By signing my name below, I, Brandon Alvarado, attest that this documentation has been prepared under the direction and in the presence of Cory Spurlock, MD. Brandon Alvarado, Scribe. 2/15/2020 10:30 AM Provider Attestation I, Cory Spurlock, personally performed the services described in this documentation. All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and agree that the record reflects my personal performance and is accurate and complete. Cory Spurlock, MD. 2/15/2020 10:30 AM

Physical Exam

General Presentation: Patient is overweight BMI = 25.3 (NIH criteria overweight = BMI between 25 and 30) Vital signs reviewed. Patient is alert. The patient appears to be comfortable.

Neurological Exam: Patient is alert. Oriented to person, place, and time.

Eye Exam: Normal sclera.

ENT Exam: Erythema is noted in the oropharynx. The uvula is midline there is no evidence of soft tissue swelling. Normal external ear exam without evidence of acute inflammation. Normal external canal. There is evidence of erythema and effusion with cerumen in the L TM. No evidence of venous jugular distension. The neck is supple, with no evidence of meningismus. No cervical adenopathy is noted.

Pulmonary Exam: Currently in no acute respiratory distress. Normal, non labored respirations. The breath sounds are normal, with good equal air movement.

Cardiac Exam: Regular rate and rhythm. No murmur. No rub. No gallop.

Skin and Soft Tissue Exam: Skin color is normal. No rash. Skin is warm. Dry to touch.

Musculoskeletal Exam: Full range of motion in all extremities.

Neuro - Psychiatric Exam: Mood and affect normal.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Past Medical History: Immunizations are up to date. No significant past medical history. Immunizations are up to date. No significant past medical history. Has no prior surgeries. No prior hospitalizations.

Family History: Family history is not known. No significant family history.

Social History: Patient never smoked. Patient is married. Patient lives with family. Patient is married. Patient lives with family. Patient is employedyes Social drinker. No drug use.

Review of Systems:

GENERAL ROS: Negative general review of systems.
EYES ROS: Negative opthalmic ROS.
ENT ROS: Has a sore throat. Denies nasal drainage. Has pain in left ear(s). Denies sinus pain. Denies sinus congestion. Denies facial pain.
CARDIAC ROS: Both cardiac and respiratory ROS are negative.
PULMONARY ROS: Both cardiac and respiratory ROS are negative.
GI ROS: Negative GI ROS.
GU ROS: Negative GU ROS.
MUSCULOSKELETAL ROS: Negative musculoskeletal and extremity ROS.
SKIN ROS: Negative dermatologic ROS.
NEURO ROS: Negative neurologic ROS.
COMPLETED ROS: All other systems are negative.

Diagnosis and Plan

Primary Diagnosis:

Sore throat - J02.9
Earache - H92.02
Acute Maxillary sinusitis - J01.00

Rx:

02/15/2020 - Augmentin 875 mg-125 mg tablet One by mouth two times a day Refills: 0 Dispense: (20 Tablet)
Copy DO NOT DISPENSE sent electronically to: CVS/pharmacy #9858 Phone: 661-254-3766
02/15/2020 - Medrol (Pak) 4 mg tablets in a dose pack As directed by mouth Take as directed Refills: 0 Dispense: (1 Pack(s)) Copy DO NOT DISPENSE sent electronically to: CVS/pharmacy #9858 Phone: 661-254-3766

Disposition and Notes: Medication list reviewed. Patient discharged from department. The patient Julien Olivier has been dispositioned. The disposition provider is Cory S Spurlock MD (electronic signature). -- -

Chart signed by: Cory S Spurlock MD (CSS)(electronic signature 02/15/2020 10:42:35)

Contributors:
Soraya Alvarez (SA)
Daisy Virgen (DV)
Brandon Alvarado Scribe (BA)
Cory S Spurlock MD (CSS)
Laura Jean Traber FD (LJT)

exer URGENT CARE
Exer - Stevenson Ranch
25548 The Old Road, #U1
Stevenson Ranch, CA 91381
Phone: 661-556-9020
Fax: 661-556-9021

Name: **Olivier, Julien**	DOB: 6/27/1967	Sex: M
Acct #: 4ac641bf33d1b9	MR #: 1a482d417d72940	AGE: 56
Visit Date: 02/27/2024 15:36	Bed #:	
Dispositioning Provider: Jonathan Bechtel PA		
Patient's PMD: none		

Addendum Note

02/27/2024 15:39 Patient communication preferences completed.
Discussed timely access of health information with patient. (KB)

Chief Complaint

1) P/C: "Injured LT wrist"
2) Injury
3) Soft tissue injury to volar surface of left wrist.

Visit Type

Office Visit, Established Patient

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Continue - no change - Confirmed Review #1

Vitals

Blood Pressure:	Pulse:	Temperature:	Respiration:
BP: 138/80 (02/27 15:57)	*P: 52 (02/27 15:57)	Temp: 97.0 Tympanic (02/27 15:57)	Resp: 16/min (02/27 15:57)

Height: Hgt: 71 inch **BSA:** BSA: 2.1

Weight: Wgt: 190 lb (02/27 15:56) **BMI:** BMI: 26.4

Pulse Oximetry:
Pulse OX: 99% on Room air at 02/27 15:57

Nursing History

15:36 Patient's prior visits were reviewed. (KB)
15:56 History provided by patient.
Describes severity of the problem as mild.
There is pain associated with the problem.
The problem is stable.
The onset of the problem was gradual.
Onset began 3-4 weeks ago.
This is a new problem for the patient.
pt c/o on/off sharp pain in Lt wrist x 3-4 weeks, pt states that he was moving heavy furnature and that is when the pain started .
Onset: 3-4 weeks days ago. (EG)

RN Update Notes and Disposition

RN Continuation Notes:

15:39 Patient preferred communication methods have been completed. (KB)
15:56 Review #1: medications confirmed from Esmeralda Gonzalez MA-XRT 15:58 (EG)

Nursing Disposition:

15:56 Clinician needs to review BMI.
16:13 Disposition: Discharge.
Patient given copy of clinical summary.
Patient was discharged from department to home.
Patient left alone.
Discussed signs and symptoms of worsening to return to ER.
Understands aftercare instructions.
Verbalizes back importance of aftercare instructions.
A disposition has been completed for Julien Olivier. by Esmeralda Gonzalez MA-XRT (chart contributor). (EG)
20:52 Patient removed from Tracker Board by Tiarra Hay MA. (TH)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Patient's prior visits were reviewed. Exam started at 16:00 02/27/2024. Patient's prior visits were reviewed. No history to suggest any head injury. The onset of the presenting problem began 4 weeks ago. Have reviewed staff history and I concur. Have reviewed and agree with staff notes. History comes from patient. Able to get a good history. Mechanism of injury: LIFTING HEAVY OBJECTS WHILE MOVING. No other injuries. History provided by patient. Describes severity of the problem as mild. There is pain associated with the problem. The problem is stable. The onset of the problem was gradual. Onset began 3-4 weeks ago. This is a new problem for the patient. pt c/o on/off sharp pain in Lt wrist x 3-4 weeks, pt states that he was moving heavy furnature and that is when the pain started . Onset: 3-4 weeks days ago.

Physical Exam

General Presentation: Patient is overweight BMI = 26.4 (NIH criteria overweight = BMI between 25 and 30) Vital signs reviewed. Patient is alert. The patient does not appear in distress.

Neurological Exam: Oriented to person, place, and time. No motor deficit.

Pulmonary Exam: Currently in no acute respiratory distress. Normal, non labored respirations.

Cardiac Exam: Peripheral pulses are strong and equal.

Skin and Soft Tissue Exam: The skin over the dorsum of the left wrist is intact with no lacerations or significant abrasions.

Musculoskeletal Exam: The patient has mild to moderate joint pain with movement of the dorsum of the left wrist. The anatomic snuff box is not tender palpation over the dorsum of the left wrist. The ulnar styloid is not tender palpation over the dorsum of the left wrist. No evidence of soft tissue swelling over the dorsum of the left wrist. No palpable effusion over the dorsum of the left wrist. The overall exam surrounding the dorsum of the left wrist is consistent with a mild to moderate sprain/strain. The rest of the wrist exam is normal. The radial pulse is OK and the distal color is good. The neurologic exam distal to the site of injury is intact.

Neuro - Psychiatric Exam: Mood and affect normal.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Past Medical History: No significant past medical history. Immunizations are up to date.

Family History: No significant family history.

Social History: Patient never smoked. Social drinker. Patient is married.

Orders, Results, Procedures and Course in Department

Update Note:

16:10 LOS manually stopped - visit completed

Based on these findings and differential Continue use the wrist brace. For orthopedic referral patient will need to follow-up with his PCP. Supportive care discussed, alternate ice with heat applications as directed. History and exam findings most consistent with tendinitis of the left wrist. Based on mechanism of injury there is low suspicion for fracture, so x-rays were not done at this time.

Patient verbalizes understanding of discharge instructions.

Diagnosis and Plan

Primary Diagnosis:

Soft tissue injury volar surface of left wrist - S69.82XA

Disposition and Notes: The patient is being discharged with an abnormal pulse. After review of the problem and in the context of their medical condition they are stable for discharge. Condition at discharge - stable. Patient discharged from department. Medication list reviewed. No Attending/Supervising Physician required. The patient Julien Olivier has been dispositioned. The disposition provider is Jonathan Bechtel PA (electronic signature). -- - The patient Julien Olivier has been dispositioned. The disposition provider is Jonathan Bechtel PA (electronic signature). -- -

Chart signed by: Jonathan Bechtel PA (JB)

Contributors: Katheryn Blancas MA (KB)
Esmeralda Gonzalez MA-XRT (EG)
Jonathan Bechtel PA (JB)
Tiarra Hay MA (TH)

exer URGENT CARE
Exer - Stevenson Ranch
25548 The Old Road, #U1
Stevenson Ranch, CA 91381
Phone: 661-556-9020
Fax: 661-556-9021

Name: **Olivier, Julien**	DOB: 6/27/1967	Sex: M
Acct #: 32fcd105954c34	MR #: 1a482d417d72940	AGE: 51
Visit Date: 03/01/2019 18:33	Bed #:	
Dispositioning Provider: Devlyn Corrigan DO		
Patient's PMD: none		

Addendum Note

03/01/2019 18:34 Discussed timely access of health information with patient. (TL)

Chief Complaint

1) P/C: "L foot pain"
2) Foot problem

Visit Type

Office Visit, Established Patient

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Continue - no change - Confirmed Physician confirmed

Medrol (Pak) 4 mg tablets in a dose pack As directed tablets,dose pack by mouth Take as directed
- Notes: - Continue - no change - Confirmed Physician confirmed

triamcinolone acetonide 0.1 % topical cream apply a thin film cream topically to affected area two to three times daily
- Notes: - Continue - no change - Confirmed Physician confirmed

fluocinonide 0.05 % topical cream apply a thin film cream topically to affected area two - four times a day until clear
- Notes: - Continue - no change - Confirmed Physician confirmed

prednisone 10 mg tablet Take tablet by mouth 3 tabs BID X 3 days, 2 tabs BID X 3 days, one tab BID X 3 days, 1 tab once a day X 3 days
- Notes: - Continue - no change - Confirmed Physician confirmed

Vitals

Blood Pressure:	Pulse:	Temperature:	Respiration:
BP: 133/78 (03/01 18:44)	*P: 53 (03/01 18:44)	Temp: 98.0 Oral (03/01 18:44)	Resp: 18/min (03/01 18:44)

Pain:
Pain 5/10 at 03/01 18:44

Height: Hgt: 71 inch **BSA:**BSA: 2.1

Weight: Wgt: 185 lb **BMI:**BMI: 25.8

Pulse Oximetry:
Pulse OX: 97% on Room air at 03/01 18:44

Nursing History

18:35 Combined form signed by patient.
18:36 Financial Consent signed by patient. (TL)

18:46 left foot pain .
Onset of symptoms was about 40 days ago.
This is a new problem for the patient.
The onset of the problem was gradual.
The problem is worsening.
There is pain associated with the problem.
Describes severity of the problem as moderate.
History provided by patient.
18:47 No recent injury.
Complains of local foot pain.
Denies pruritus.
No history of plantar warts.
Denies rash.
No erythema.
No drainage.
No history of gout.
No prior history of similar problems.
No fever.
Unable to bear weight due to pain.
Patient is comfortable.
Foot exam: patient is here today for left foot pain that started 5-6 weeks ago. .

RN Update Notes and Disposition

RN Continuation Notes:

18:34 Patient preferred communication methods have been completed. (TL)

Nursing Disposition:

18:44 Clinician needs to review BMI.
19:02 Disposition: Discharge.
A disposition has been completed for Julien Olivier. by Tammy Bibian MA/XRY (chart contributor).
Patient was discharged from department to home.
Patient left alone.
Discussed signs and symptoms of worsening to return to ER.
Understands aftercare instructions.
Verbalizes back importance of aftercare instructions. (TB)
10:53 Patient removed from Tracker Board by Laura Jean Traber FD. (LJT)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Exam started at 18:44 03/01/2019. Patient's prior visits were reviewed. Able to get a good history. Outside records ordered for review: Have reviewed and agree with staff notes. The patients prior evaluations were reviewed Have reviewed staff history and I concur. History comes from patient. Patient is a 51 year old male who presents for an evaluation of left foot pain. The onset of the presenting problem began 5-6 weeks ago. Patient presents today with complaints of mild to moderate pain localized to the ball of the left foot. Denies any recent trauma or injury to the affected area. Pt states he 'runs' a lot to maintain his cardio. Pt reports having a PMHx of plantar fasciitis that flares up 'once in a while'. Hurts to bear weight. No recent head injury or LOC. No erythema, warmth or swelling noted. No history of fever, significant muscle pain or recent weight loss. Not associated with numbness. Not associated with tingling. Not associated with weakness. No diaphoresis noted. Shortness of breath has not been an associated symptom. No chest pain or heart palpitations. No nausea, vomiting or diarrhea. No other medical concerns at this time. Combined form signed by patient. Financial Consent signed by patient. left foot pain . Onset of symptoms was about 40 days ago. This is a new problem for the patient. The onset of the problem was gradual. The problem is worsening. There is pain associated with the problem. Describes severity of the problem as moderate. History provided by patient. No recent injury. Complains of local foot pain. Denies pruritus. No history of plantar warts. Denies rash. No erythema. No drainage. No history of gout. No prior history of similar problems. No fever. Unable to bear weight due to pain.

Patient is comfortable. Foot exam: patient is here today for left foot pain that started 5-6 weeks ago. . null

Summary

Scribe Signature and Attestation By signing my name below, I, Brandon Alvarado, attest that this documentation has been prepared under the direction and in the presence of Devlyn Corrigan, DO. Brandon Alvarado, Scribe. 3/1/2019 6:45 PM Provider Attestation I, Devlyn Corrigan, personally performed the services described in this documentation. All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and agree that the record reflects my personal performance and is accurate and complete. Devlyn Corrigan; DO. 3/1/2019 6:45 PM

Physical Exam

General Presentation: Patient is overweight BMI = 25.8 (NIH criteria overweight = BMI between 25 and 30) Vital signs reviewed. Patient is alert. The patient appears to be comfortable.

Neurological Exam: Patient is alert. Oriented to person, place, and time. No motor deficit. No sensory deficit.

Eye Exam: Normal sclera.

ENT Exam: Normal voice. Normocephalic. No evidence of venous jugular distension. The neck is supple, with no evidence of meningismus.

Pulmonary Exam: Currently in no acute respiratory distress. Normal, non labored respirations. The breath sounds are normal, with good equal air movement.

Cardiac Exam: Regular rate and rhythm. No murmur. No rub. No gallop.

Skin and Soft Tissue Exam: Skin color is normal. No rash. Skin is warm. Dry to touch.

Musculoskeletal Exam: Callus is noted over the plantar aspect of the ball of the left foot; area is non-tender. No obvious deformity. No wamrth, swelling or erythema noted. NV intact distally. Full range of motion in all extremities. No extremity edema. No calf tenderness.

Neuro - Psychiatric Exam: Mood and affect normal.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Past Medical History: Immunizations are up to date. No significant past medical history. Immunizations are up to date. No significant past medical history. Has no prior surgeries. No prior hospitalizations.

Family History: Family history is not known. No significant family history.

Social History: Patient never smoked. Patient is married. Patient lives with family. Patient is married. Patient lives with family. Patient is employedyes Social drinker. No drug use.

Review of Systems:

GENERAL ROS: Negative general review of systems.
EYES ROS: Negative opthalmic ROS.
ENT ROS: Negative ENT ROS.
CARDIAC ROS: Both cardiac and respiratory ROS are negative.
PULMONARY ROS: Both cardiac and respiratory ROS are negative.
GI ROS: Negative GI ROS.
GU ROS: Negative GU ROS.
MUSCULOSKELETAL ROS: Has pain in the left foot. Denies back pain. Denies neck pain. No joint pain. No stiffness.
SKIN ROS: Negative dermatologic ROS.
NEURO ROS: Negative neurologic ROS.
COMPLETED ROS: All other systems are negative.

Orders, Results, Procedures and Course in Department

Orders	Cancel	MD	Ordered	Started	Finished	Notes and Updates

1) X-Ray of left Foot minimum of 3 views (Indication: Painful foot.)		DC	DC 03/01/2019 18:49	TB 03/01/2019 19:01	TB 03/01/2019 19:01	03/01/2019 19:11 X-ray of left Foot minimum of 3 views - Films were reviewed pending final reading. (DC) 03/01/2019 19:11 They show an area of questionable fracture. (DC) 03/01/2019 19:12 Questionable fracture of the proximal phalanx great toe. (DC)

Tests and Results:
X-ray of left Foot minimum of 3 views - Films were reviewed pending final reading.
They show an area of questionable fracture.
Questionable fracture of the proximal phalanx great toe.

Update Note:
19:09 Noted that the patient medication list has a potential conflict with Naprosyn but the benefits outweigh the potential risk.

Diagnosis and Plan

Primary Diagnosis:
Foot pain (left) - M79.609
Foot Injury - left (first metatarsal stress fracture) - S90.922A

Rx:
03/01/2019 - Naprosyn 500 mg tablet One by mouth every 12 hours as needed for pain or fever Refills: 0 Dispense: (15 Tablet) Copy DO NOT DISPENSE sent electronically to: CVS/pharmacy #9858 Phone: 661-254-3766

Custom DC Instructions: Return back to your regular physician as needed none

Referral Providers:
Providence, Primary Care Phone: 888-432-5464
We are referring you for -- Routine re-evaluation Please follow up with: Primary Care Providence: 888-432-5464 You should be seen
If your condition worsens or you develop new symptoms contact us during business hours or if your condition is much worse or we are not open go to the hospital emergency department for evaluation. Riley, Brendan Phone: 3104438999
We are referring you for -- Routine re-evaluation Please follow up with: Brendan Riley: 100 Medical Plaza, Suite 460 Los Angeles CA 90095 3104438999 3102084847 (PODIATRY) For this appointment you should be seen

Disposition and Notes: Medication list reviewed. Return back to your regular physician as needed none The patient is being discharged with an abnormal pulse. After review of the problem and in the context of their medical condition they are stable for discharge. Patient discharged from department. The patient Julien Olivier has been dispositioned. The disposition provider is Devlyn Corrigan DO (electronic signature). --

Chart signed by: Devlyn Corrigan DO (DC)(electronic signature 03/01/2019 19:12:51)

Contributors:
Tayler Laughlin Assistant Center Manager (TL)
Devlyn Corrigan DO (DC)
Tammy Bibian MA/XRY (TB)
Brandon Alvarado Scribe (BA)
Laura Jean Traber FD (LJT)
Beth Wilson Stato Admin (BW)

exer URGENT CARE
Exer - Stevenson Ranch
25548 The Old Road, #U1
Stevenson Ranch, CA 91381
Phone: 661-556-9020
Fax: 661-556-9021

Name: **Olivier, Julien**	DOB: 6/27/1967	Sex: M
Acct #: 46f70673f9b6df	MR #: 1a482d417d72940	AGE: 54
Visit Date: 04/05/2022 15:04	Bed #:	
Dispositioning Provider: Jonathan Karroll MD		
Patient's PMD: none		

Addendum Note

04/05/2022 16:10 Will discuss lab results with the patient. (JK)
04/05/2022 15:04 Discussed timely access of health information with patient. (DC)

Chief Complaint

1) P/C: "pain in stomach"
2) Stomachache
3) Local pain over the anterior abdominal wall - no acute injury.

Visit Type

Office Visit, Established Patient

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Confirmed Review #1

Vitals

Blood Pressure:	Pulse:	Temperature:	Respiration:
*BP: 172/90 (04/05 15:23)	*P: 51 (04/05 15:23)	Temp: 97.9 T. scan (04/05 15:23)	Resp: 18/min (04/05 15:23)
*BP: 171/85 (04/05 16:12)	*P: 50 (04/05 16:12)		Resp: 16/min (04/05 16:12)

Pain:
Pain 8/10 at 04/05 15:23
Pain 8/10 at 04/05 15:23

Height: Hgt: 71 inch**BSA:**BSA: 2.0

Weight: Wgt: 180 lb (Est.)**BMI:**BMI: 25.1

Pulse Oximetry:
Pulse OX: 99% on Room air at 04/05 15:23
Pulse OX: 97% on Room air at 04/05 16:12

Nursing History

15:06 Combined form signed by patient.
15:07 Financial Consent signed by patient. (DC)
15:10 Patient's prior visits were reviewed.
Onset of symptoms was about 1 days ago.
This is a new problem for the patient.
The onset of the problem was sudden.
The problem is worsening.

There is pain associated with the problem.
Describes severity of the problem as moderate.
History provided by patient.
Patient complains of abdominal pain X 1 day. Patient states mild diarrhea, no fever, and no vomiting. (DO)

RN Update Notes and Disposition

RN Continuation Notes:

15:04 Patient preferred communication methods have been completed. (DC)
15:10 Review #1: medications confirmed from Dennien Orellana MA 15:10 (DO)

Nursing Disposition:

15:10 Clinician needs to review BMI.
16:20 Disposition: Discharge.
A disposition has been completed for Julien Olivier. by Dennien Orellana MA (chart contributor).
Patient was discharged from department to home.
Patient left alone. (DO)
09:00 Patient removed from Tracker Board by Riley Van Hoek. (RV)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Patient's prior visits were reviewed. Exam started at 15:20 04/05/2022. Able to get a good history. Have reviewed staff history and I concur. Outside records ordered for review: The patients prior evaluations were reviewed and is non-contributory. Have reviewed and agree with staff notes. History comes from patient. 54 y/o male presents with stomach pain. Developed problem PTA. Patient presents with abd pain that began last night (x1 day ago) and pain is located in the epigastric region and is non-radiating. Pain at first was intermittent and now is more constant. No fever, chills, nvd. Patient has spastic colon with loose stools. Patient has had no change in bowel habits since the onset of abd pain. Patient reports no flank pain, chest pain, or trouble breathing. Patient was at a tanning salon x1 day ago and some chemicals splashed into his mouth and thinks that is causing his abd pain. Patient had oatmeal and toast for breakfast today, a turkey sandwich and cup of tea for lunch. Patient has had no loss of appetite. PMHx of spastic colon. No Medication. NKDA. Patient is under a lot of stress as his daughter will be getting married in Maui in the next couple of days and is concerned about sx while having to travel soon. No other medical complaints. Combined form signed by patient. Financial Consent signed by patient. Onset of symptoms was about 1 days ago. This is a new problem for the patient. The onset of the problem was sudden. The problem is worsening. There is pain associated with the problem. Describes severity of the problem as moderate. History provided by patient. Patient complains of abdominal pain X 1 day. Patient states mild diarrhea, no fever, and no vomiting.

Summary

Scribe Signature and Attestation By signing my name below, I, Paul Gerges, attest that this documentation has been prepared under the direction and in the presence of Jonathan Karroll, MD. Paul Gerges, Scribe. 4/5/2022 3:30 PM Provider Attestation I, Jonathan Karroll, personally performed the services described in this documentation. All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and agree that the record reflects my personal performance and is accurate and complete. Jonathan Karroll, MD. 4/5/2022 3:30 PM

Physical Exam

General Presentation: Patient is overweight BMI = 25.1 (NIH criteria overweight = BMI between 25 and 30) Alert and Oriented x4. Patient is pleasant and cooperative. Patient is mildly anxious.

Neurological Exam: Cranial nerves II through XII are intact. No motor deficit.

Eye Exam: PERRL. EOMs are intact. Sclera noninteric

ENT Exam: TMs normal color bilaterally with good landmarks. Nares are patent without mucosal injection. Posterior pharynx is clear. Uvula is midline. Negative for exudate. Mucosa is moist. Trachea is midine. Negative for thyromegaly. Carotids are full and equal bilaterally. Neck is supple without meningismus. Negative for cervical and supraclavicular

adenopathy.

Pulmonary Exam: Patient has symmetrical chest expansion present with good air movement. Lungs are clear to auscultation. Negative for use of accessory muscles. .

Cardiac Exam: Patient has S1 and S2 are normal without murmurs, gallops, or rubs..

Abdominal Exam: Patient has Bowel sounds present. Abd is not distended. Abd is soft and nontender. Negative for guarding, rebound, hepatosplenomegaly, flank pain, and CVAT. Murphy's sign is negative. No TTP over McBurney's point..

Skin and Soft Tissue Exam: Normal skin texture and turgor without petechial or purpuric lesions.

Musculoskeletal Exam: Negative for swelling and tenderness. NV status intact for all four extremities.

Neuro - Psychiatric Exam: Mood and affect normal.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Past Medical History: No immunization history record.

Family History: No significant family history.

Social History: Patient is married. Patient never smoked.

Review of Systems:

GENERAL ROS: Negative general review of systems.
EYES ROS: Negative opthalmic ROS.
ENT ROS: Negative ENT ROS.
CARDIAC ROS: Both cardiac and respiratory ROS are negative.
PULMONARY ROS: Both cardiac and respiratory ROS are negative.
GI ROS: Has abdominal pain. Denies any nausea. Denies any episodes of vomiting. Denies having any diarrhea.
GU ROS: Negative GU ROS.
MUSCULOSKELETAL ROS: Negative musculoskeletal and extremity ROS.
SKIN ROS: Negative dermatologic ROS.
NEURO ROS: Negative neurologic ROS.
COMPLETED ROS: All other systems are negative.

Orders, Results, Procedures and Course in Department

Orders	Cancel	MD	Ordered	Started	Finished	Notes and Updates
1) Complete Blood Count/Auto Differential * (Comment: Done in lab)		JK	JK 04/05/2022 15:41	DO 04/05/2022 16:08		
2) Comprehensive Metabolic Panel (Comment: Done in lab)		JK	JK 04/05/2022 15:41	DO 04/05/2022 16:08	DO 04/05/2022 16:08	
3) Urinalysis (Comment: Done in lab)		JK	JK 04/05/2022 15:41	DO 04/05/2022 16:08	DO 04/05/2022 16:08	
4) Mylanta 15 mL (Using 500 mg-500 mg/5 mL aliquots or equiv.) PO Single dose now		JK	JK 04/05/2022 15:43	LA 04/05/2022 15:44	LA 04/05/2022 15:44	

External Feed Test Results:

LAB SOURCE
Patient name: Olivier, Julien
Results from: Exer with Providence Address: 25548 The Old Road #U1 Stevenson Ranch CA 91381
Medical Director:

Name: Olivier, Julien	Acct #: 46f70673f9b6df	Visit Date: 04/05/2022 15:04

Ordered by: Karroll,Jon
Date of Report:
Specimen ID: 46f70673f9b6df
Date Ordered: 04/05/2022 15:41:12
Date Received: 04/05/2022 15:41:12

Complete Blood Count/Auto Differential *

-- WBC	8.9 K/uL	(NL = 4.2-10.5)		F
-- RBC	4.78 M/uL	(NL = 4.60-6.20)		F
-- HGB	15.6 g/dL	(NL = 14.0-18.0)		F
-- HCT	46.3 %	(NL = 42.0-52.0)		F
-- MCV	97.0 fL	(NL = 81.0-101.0)		F
-- MCH	32.6 pg	(NL = 27.0-34.0)		F
-- MCHC	33.7 g/dL	(NL = 32.0-36.0)		F
-- Platelet	240.0 K/uL	(NL = 150.0-400.0)		F
-- %Gran	69.3 %	(NL = 37.0-92.0)		F
-- #Gran	6.3 K/uL	(NL = 2.0-7.8)		F
-- %Lymph	25.6 %	(NL = 10.0-58.5)		F
-- #Lymph	2.2 K/uL	(NL = 0.6-4.1)		F
-- %Mono	5.1 %	(NL = 0.1-24.0)		F
-- #Mono	0.4 K/uL	(NL = 0.1-1.8)		F

Comprehensive Metabolic Panel

-- Sodium	146 mmol/L	(NL = 128-145)	*H*	F
-- Potassium	4.2 mmol/L	(NL = 3.6-5.1)		F
-- Chloride	106 mmol/L	(NL = 98-108)		F
-- CO2	28 mmol/L	(NL = 18-33)		F
-- BUN	17 mg/dL	(NL = 7-22)		F
-- Creatinine	1.2 mg/dL	(NL = 0.6-1.2)		F
-- Calcium	9.9 mg/dL	(NL = 8.0-10.3)		F
-- Glucose	128 mg/dl	(NL = 73-118)	*H*	F
-- Alk Phos	71 U/L	(NL = 42-141)		F
-- ALT	22 U/L	(NL = 10-47)		F
-- AST	36 U/L	(NL = 11-38)		F
-- Total Bilirubin	0.8 mg/dL	(NL = 0.2-1.6)		F
-- Total Protein	7.4 g/dL	(NL = 6.4-8.1)		F
-- Albumin	4.2 g/dL	(NL = 3.3-5.5)		F

Urinalysis

--	COLOR	Yellow	(NL = Yellow)		F
--	CLARITY	Clear	(NL = Clear)		F
--	Glucose	Negative	(NL = Negative)		F
--	Bilirubin	Negative	(NL = Negative)		F
--	Ketone	Trace	(NL = Negative)		F
--	Sp. Gravity	>=1.030	(NL = 1.001-1.035)	*H*	F
--	Blood	Negative RBC/uL	(NL = Negative)		F
--	pH	5.5	(NL = 5.0-9.0)		F
--	Protein	Negative	(NL = Negative)		F
--	Urobilinogen	0.2 E.U./dL	(NL = 1.0)		F
--	Nitrites	Negative	(NL = Negative)		F
--	Leukocytes	Negative	(NL = Negative)		F

Update Note:
15:30 Assumed care of patient.
16:10 Evaluation and treatments: Labs: Complete Blood Count/Auto Differential * Comprehensive Metabolic Panel Urinalysis Medications this visit: Mylanta 15 mL (Using 500 mg-500 mg/5 mL aliquots or equiv.) PO Single dose now Based on these findings and differential Pt presents with complaints of abdominal pain. Exam is benign, including normal abdominal exam, vitals are stable. Labs were unremarkable. Pt has no evidence of acute, worrisome intra-abdominal or pelvic pathology at this time, such as appendicitis, volvulus, bowel obstruction, testicular torsion, or vascular etiology that would require emergent imaging or ED transfer. No evidence for DKA, pyelonephritis, UTI, pancreatitis, cholecystitis. Pt is stable for discharge with f/u, and given strict return / ED precautions, including abdominal pain, fever, n/v, syncope or other worrisome symptoms.

Diagnosis and Plan

Primary Diagnosis:
Abdominal Pain (Epigastric) - R10.84

Rx:
04/05/2022 - Pepcid 20 mg tablet One by mouth Take 1 tablet bid Refills: 0 Dispense: (30 Tablet) Copy DO NOT DISPENSE sent electronically to: CVS/pharmacy #9858 Phone: 661-254-3766
04/05/2022 - ondansetron 4 mg disintegrating tablet One by mouth every 6 hours as needed for nausea Refills: 0 Dispense: (12 ZZ) Copy DO NOT DISPENSE sent electronically to: CVS/pharmacy #9858 Phone: 661-254-3766

Custom DC Instructions: Recheck at Exer tomorrow if no improvement.

Disposition and Notes: I have reviewed the BP findings and the patient is stable for discharge The patient is being discharged with an abnormal pulse. After review of the problem and in the context of their medical condition they are stable for discharge. Final dx is low risk but a number of moderately complex issues were considered as discussed The patient Julien Olivier has been dispositioned. The disposition provider is Jonathan Karroll MD (electronic signature). -- -

Chart signed by: Jonathan Karroll MD (JK)(electronic signature 04/05/2022 16:10:39)

Contributors: Destiny Calderon Front Desk (DC)
Dennien Orellana MA (DO)
Paul Gerges Scribe (PG)
Jonathan Karroll MD (JK)

External Data (ED)
Riley Van Hoek (RV)

exer URGENT CARE
Exer VirtualCare
390 N. Pacific Coast Hwy Suite 3000
El Segundo, CA 90245
Phone: 424-277-9615

Name: **Olivier, Julien**	DOB: 6/27/1967	Sex: M
Acct #: fcbc47dba9e4bd	MR #: 1a482d417d72940	AGE: 52
Visit Date: 05/02/2020 18:21	Bed #:	
Dispositioning Provider: Michelle Bensoussan PA-C in association with: Robin Klein DO		
Patient's PMD: none		

Addendum Note

05/02/2020 18:21 Discussed timely access of health information with patient. (RH)

Chief Complaint

1) P/C: "Rash on face and Lt ear pain"
2) Earache
3) Rash

Visit Type

Office Visit, Established Patient

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Confirmed Review #1

Medrol (Pak) 4 mg tablets in a dose pack As directed tablets,dose pack by mouth Take as directed
- Notes: - Confirmed Review #1

Augmentin 875 mg-125 mg tablet One tablet by mouth two times a day
- Notes: - Confirmed Review #1

Vitals

Height: Hgt: 71 inch**BSA:**BSA: 2.0
Weight: Wgt: 180 lb**BMI:**BMI: 25.1

RN Update Notes and Disposition

RN Continuation Notes:

18:42 Review #1: medications confirmed from Michelle Bensoussan PA-C 18:42 (MB)

Nursing Disposition:

18:46 LOS manually stopped - visit completed (MB)
19:22 Patient removed from Tracker Board by Brian Chao ADMIN. (BC)
20:10 A disposition has been completed for Julien Olivier. by Dayna Underwood BSN,RN (chart contributor). (DU)
10:23 Patient removed from Tracker Board by Melissa Garcia FD. (MG)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Exam started at 18:28 05/02/2020. Patient's prior visits were reviewed. Patient's prior visits were reviewed. Patient presents with left ear pain. The onset of the presenting problem began 6 weeks ago. He also has a mild rash to his left

forehead for the past 1.5 weeks. Not itchy or painful. Denies using any new products, medications, or foods. Denies swimming recently. Outside records ordered for review: Have reviewed and agree with staff notes. History comes from patient. The patients prior evaluations were reviewed Patient was seen for same left ear pain on 2/15 and was prescribed Augmentin but symptoms have no resolved. Have reviewed staff history and I concur. Patient notes the gradual onset of these symptoms. No associated nausea. Diarrhea has not been an associated symptom. No history of associated fever. Shortness of breath has not been an associated symptom. Patient's prior visits were reviewed.

Physical Exam

General Presentation: The patient is a well developed well nourished middle aged adult male in no acute distress. He does not appear acutely ill or toxic. Vital signs reviewed. The patient appears to be comfortable. Patient is overweight BMI = 25.1 (NIH criteria overweight = BMI between 25 and 30)

Neurological Exam: Patient is alert. Oriented to person, place, and time.

Eye Exam: Extra ocular movement normal. Normal sclera.

ENT Exam: No tragus tenderness. Grossly normal hearing to spoken voice and finger rub. The neck is supple, with no evidence of meningismus.

Pulmonary Exam: Currently in no acute respiratory distress. Normal, non labored respirations.

Skin and Soft Tissue Exam: Skin color is normal.

Neuro - Psychiatric Exam: Mood and affect normal.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Past Medical History: No significant past medical history.

Family History: No significant family history.

Social History: Patient lives with family.

Review of Systems:

GENERAL ROS: No history of fever, weight gain, unexplained weight loss, fatigue, or sleep disturbance.
EYES ROS: Denies double vision, blurred vision, redness or eye pain.
ENT ROS: Denies sore throat. Denies nasal drainage. Has pain in left ear(s). Denies sinus pain. Denies sinus congestion. Denies facial pain.
CARDIAC ROS: Denies cough, sputum, shortness of breath, chest pain, palpitations, or syncope.
PULMONARY ROS: Denies cough, sputum, shortness of breath, chest pain, palpitations, or syncope.
GI ROS: Denies abdominal pain, nausea and vomiting, diarrhea, black or bloody stools or flank pain.
GU ROS: Denies dysuria, frequency, hematuria, diffuculty with urination or problems with incontinence
MUSCULOSKELETAL ROS: Denies neck and back pain. No arthritis or stiffness
SKIN ROS: Has a rash. Denies pruritus. Denies any swelling.
NEURO ROS: Denies headaches, blackouts,loss of strength or sensation,difficulty walking,difficulty with speech, diplopia, seizures, or confusion.
PSYCHIATRIC ROS: Denies any feelings of anxiety, depression, paranoia or suicidal thoughts.
ENDOCRINE ROS: No history of heat cold intolerance, polyphagia or excessive thirst.
HEME - LYMPHATIC ROS: No easy bruisability or unexplained bleeding.
ALLERGY - IMMUNOLOGY ROS: No history of significant seasonal allergies, unexplained or recurrent infections.

Orders, Results, Procedures and Course in Department

Update Note:

18:46 Based on these findings and differential EXAM LIMITED AS THIS IS A VIRTUAL VISIT. PATIENT WILL GO TO STEVENSON RANCH CLINIC FOR PROPER PHYSICAL EXAM. ACCEPTED BY DR. SPURLOCK.

Diagnosis and Plan

Primary Diagnosis:

Name: Olivier, Julien	Acct #: fcbc47dba9e4bd	Visit Date: 05/02/2020 18:21

Earache - H92.02
Rash - R21

Custom DC Instructions: Return back to your regular physician as needed none

Disposition and Notes: R Medication list reviewed. I (Michelle Bensoussan PA-C) certify this patient requires transfer. Patient transferred to Other. Anticipated benefit of transfer: Services available at facility. Transferred via Private Car. Discussed transfer with Dr. Spurlock who accepted transfer. Referring physician to receiving physician contact confirmed. Implied consent, no authorized representative available. Patient is unable to sign - Virtual Care.. Condition at discharge - stable. I have reviewed the chart of Julien Olivier and it is ready for final disposition - Michelle Bensoussan PA-C. Return back to your regular physician as needed none The patient Julien Olivier has been dispositioned. The disposition provider is Brian Wilbur MD (electronic signature). -- -
Pt was referred from virtual care with ear pain. On exam, he has bilateral cerumen impaction. Ears were irrigated successfully with aleviation of his symptoms. He is stable for d/c with f/u and return precautions.

Chart signed by: Michelle Bensoussan PA-C (MB) Cosigned: Robin Klein DO (05/02/2020 18:46:18) (electronic signature)

Contributors:
Ryan Hill Medical Assistant (RH)
Michelle Bensoussan PA-C (MB)
Brian Wilbur MD (BW)
Brian Chao ADMIN (BC)
Cory S Spurlock MD (CSS)
Dayna Underwood BSN,RN (DU)
Melissa Garcia Center Lead (MG)

exer URGENT CARE
Exer - Stevenson Ranch
25548 The Old Road, #U1
Stevenson Ranch, CA 91381
Phone: 661-556-9020
Fax: 661-556-9021

Name: **Olivier, Julien**	DOB: 6/27/1967	Sex: M
Acct #: 4e7426b8e5bfcf	MR #: 1a482d417d72940	AGE: 50
Visit Date: 06/08/2018 09:02	Bed #:	
Disposition Provider: Cory S Spurlock MD		
Patient's PMD: none		

Addendum Note

06/08/2018 09:02 Discussed timely access of health information with patient. (TL)

Chief Complaint

1) P/C: "poison oak on L wrist and on R arm"
2) Skin condition located over the volar surface of left wrist.

Visit Type

Office Visit, New Patient

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Confirmed Review #1

Vitals

Blood Pressure:	Pulse:	Temperature:	Respiration:
BP: 133/79 (06/08 09:10)	P: 63 (06/08 09:10)	Temp: 97.3 Oral (06/08 09:10)	Resp: 14/min (06/08 09:10)

Height: Ht: 71 inch **BSA:** BSA: 2.1
Weight: Wgt: 185 lb **BMI:** BMI: 25.8

Pulse Oximetry:
Pulse OX: 98% at 06/08 09:10

Nursing History

09:04 Combined form signed by patient.
Financial Consent signed by guardian or representative. (TL)
09:08 History provided by patient.
Describes severity of the problem as mild.
There is pain associated with the problem.
The problem is improving.
The onset of the problem was gradual.
L wrist poison oak exposure. .
This is a new problem for the patient.
Onset of symptoms was about 4 days ago. (RH)

RN Update Notes and Disposition

RN Continuation Notes:

09:02 Patient preferred communication methods have been completed. (TL)
09:08 Review #1: medications confirmed from Ryan Hamilton MA/Xray 09:10 (RH)

Nursing Disposition:
09:08 Clinician needs to review BMI.
09:12 LOS manually stopped - visit completed
09:20 A disposition has been completed for Julien Olivier. by Ryan Hamilton MA/Xray (chart contributor).
Disposition. Discharge.
Patient left alone.
Discussed signs and symptoms of worsening to return to ER.
Understands aftercare instructions.
Verbalizes back importance of aftercare instructions. (RH)
15:05 Patient removed from Tracker Board by Natasha Erasmus Front Desk. (NE)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Exam started at 09:14 06/08/2018. Presenting problem started 2-3 days ago. Have reviewed staff history and I concur. Have reviewed and agree with staff notes. History comes from patient. Able to get a good history. History includes: Rash to left forearm, after hiking, possible poison oak The symptoms started suddenly. Symptoms started 2-3 days ago. The symptoms are constant. The character of symptoms are poorly characterized by patient. Overall patient rates the severity of these symptoms as mild. Exacerbated by touching Nothing seems to relieve symptoms. No prior episodes reported. Has tried: Apple cider vingear, alcohol, baking soda. No other symptoms. No history of associated fever. No laceration. No foreign body. Combined form signed by patient. Financial Consent signed by guardian or representative. History provided by patient. Describes severity of the problem as mild. There is pain associated with the problem. The problem is improving. The onset of the problem was gradual. L wrist poison oak exposure. . This is a new problem for the patient. Onset of symptoms was about 4 days ago.

Physical Exam

General Presentation: Patient is overweight BMI = 25.8 (NIH criteria overweight = BMI between 25 and 30) Vital signs reviewed. Patient is alert. The patient appears to be comfortable.

Neurological Exam: Patient is alert. Oriented to person, place, and time.

Eye Exam: Pupils are reactive to light. Extra ocular movement normal.

ENT Exam: Pharynx normal. The uvula is midline there is no evidence of soft tissue swelling Grossly normal hearing to spoken voice and finger rub. The neck is supple, with no evidence of meningismus.

Pulmonary Exam: Currently in no acute respiratory distress. Normal, non labored respirations.

Cardiac Exam: Regular rate and rhythm. Peripheral pulses are strong and equal.

Skin and Soft Tissue Exam: maculopapular rash to left FA, erythema, excoriation

Neuro - Psychiatric Exam: Mood and affect normal.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Past Medical History: Immunizations are up to date. No significant past medical history.

Family History: Family history is not known.

Social History: Patient never smoked. Patient is married. Patient lives with family.

Review of Systems:
GENERAL ROS: Denies any fever. No unusual weight gain. Denies any weight loss.
EYES ROS: Has Diplopia.
ENT ROS: Denies sore throat. Denies nasal drainage.
PULMONARY ROS: Denies a cough. No wheezing.

GI ROS: Denies abdominal pain. Denies any nausea. Denies any episodes of vomiting.
GU ROS: Denies dysuria.
MUSCULOSKELETAL ROS: Denies back pain. No joint pain.
SKIN ROS: Has a rash.
NEURO ROS: Denies headaches.
COMPLETED ROS: All other systems are negative.

Orders, Results, Procedures and Course in Department

Update Note:
09:06 Assumed care of patient.

Diagnosis and Plan

Primary Diagnosis:
Skin problem located over the volar surface of left wrist - R21
Dermatitis - Contact - L25.9

Rx:
06/08/2018 - Medrol (Pak) 4 mg tablets in a dose pack As directed by mouth Take as directed Refills: 0 Dispense: (1 Pack(s)) This was an E-script sent to: CVS/pharmacy #9858 Phone: 661-254-3766
06/08/2018 - triamcinolone acetonide 0.1 % topical cream apply a thin film topically to affected area two to three times daily Refills: 0 Dispense: (15 Gram(s)) This was an E-script sent to: CVS/pharmacy #9858 Phone: 661-254-3766

Custom DC Instructions: Return back to your regular physician as needed none

Disposition and Notes: The patient Julien Olivier has been disposition. The disposition provider is Cory S Spurlock MD (electronic signature). -- Return back to your regular physician as needed none

Chart signed by: Cory S Spurlock MD (CSS)(electronic signature 06/08/2018 09:29:01)

Contributors:
Tayler Laughlin Assistant Center Manager (TL)
Cory S Spurlock MD (CSS)
Ryan Hamilton MA/Xray (RH)
Saheb Dhillon Scribe (SD)
Natasha Erasmus Front Desk (NE)
Beth Wilson Stato Admin (BW)

exer URGENT CARE
Exer - Stevenson Ranch
25548 The Old Road, #U1
Stevenson Ranch, CA 91381
Phone: 661-556-9020
Fax: 661-556-9021

Name: **Olivier, Julian**	DOB: 6/27/1967	Sex: M
Acct #: 7e9b3bc0c326df	MR #: 1a482d417d72940	AGE: 50
Visit Date: 06/15/2018 18:14	Bed #:	
Dispositioning Provider: Gary S Spurlock MD		
Patient's PMD: none		

Addendum Note

06/15/2018 18:15 Discussed timely access of health information with patient. (RT)

Chief Complaint

1) P/C: "rash on forearms"
2) Rash

Visit Type

Office Visit, Established Patient

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Confirmed Review #1

triamcinolone acetonide 0.1 % topical cream apply a thin film cream topically to affected area two to three times daily
- Notes: (Also available in 0.025% and 0.5%) - Confirmed Review #1

Medrol (Pak) 4 mg tablets in a dose pack As directed tablets,dose pack by mouth Take as directed
Notes: Confirmed Review #1

Vitals

Blood Pressure:	Pulse:	Temperature:	Respiration:
*BP: 153 (06/15 18:26)	*P: 51 (06/15 18:26)	Temp: 97.2 Oral (06/15 18:26)	Resp: 20/min (06/15 18:26)

Height: Hgt: 71 inch **BSA:** BSA: 2.0

Weight: Wgt: 180 lb **BMI:** BMI: 25.1

Pulse Oximetry:
Pulse OX: 98% on Room air at 06/15 18:26

Nursing History

18:15 Combined form signed by patient.
18:16 Financial Consent signed by patient. (RT)
18:26 History provided by patient.
Describes severity of the problem as mild.
Did not answer question about quality of symptoms .
The onset of the problem was sudden.
Onset of symptoms was about 7 days ago.
F/U POISON OAK.
This is a new problem for the patient. (BB)

RN Update Notes and Disposition

RN Continuation Notes:

18:14 Patient preferred communication methods have been completed. (RT)
18:26 Review #1: medications confirmed from Brian Barnes LVN 18:26
18:49 IM Dexamethasone Sodium Phosphate given to patient in the Left arm
Lot: 018356
Patient acknowledged instructions regarding 15 min observation prior to leaving.
Observe for 15 minutes prior to discharge (BB)

Nursing Disposition:

18:26 Clinician needs to review BMI.
18:53 Disposition: Discharge.
A disposition has been completed for Julien Olivier. by Brian Barnes LVN (chart contributor). (BB)
21:02 Patient removed from Triage Board by Ruby Tafoya ED. (RT)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Exam started at 18:39 06/15/2018. Patient's prior visits were reviewed. Presenting problem started 3-4 days ago. Have reviewed staff history and I concur. Have reviewed and agree with staff notes. History comes from patient. Able to get a good history. History includes: Pruritic rash to forearms. Pt was seen previously for poison oak, minimal improvement, now worse since returning from Cabo San Lucas Patient notes the gradual onset of these symptoms. Symptoms started 4-5 days ago. Symptoms are worsening. The symptoms are constant. Reportedly burning. At the moment patient is not complaining of symptoms. Exacerbated by touch, time Nothing seems to relieve symptoms. No other symptoms. No history of associated fever. Combined form signed by patient. Financial Consent signed by patient. History provided by patient. Describes severity of the problem as mild. Did not answer question about quality of symptoms. The onset of the problem was sudden. Onset of symptoms was about 7 days ago. F/U POISON OAK. This is a new problem for the patient.

Physical Exam

General Presentation: Patient is overweight BMI = 25.1 (NIH criteria overweight = BMI between 25 and 30) Vital signs reviewed. Patient is alert. The patient appears to be comfortable.

Eye Exam: Pupils are reactive to light. Extra ocular movement normal.

ENT Exam: Pharynx normal. The uvula is midline there is no evidence of soft tissue swelling Grossly normal hearing to spoken voice and finger rub. The neck is supple, with no evidence of meningismus.

Pulmonary Exam: Currently in no acute respiratory distress. Normal, non labored respirations. The breath sounds are normal, with good equal air movement. The chest wall is not tender to palpation.

Cardiac Exam: Regular rate and rhythm. No murmur.

Skin and Soft Tissue Exam: Skin is warm. There is a erythematous papular rash to bilateral forearms, no evidence of secondary infection.

Musculoskeletal Exam: No extremity tenderness.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Past Medical History: Immunizations are up to date. No significant past medical history.

Family History: Family history is not known.

Social History: Patient never smoked. Patient is married. Patient lives with family.

Review of Systems:

GENERAL ROS: Denies any fever. No unusual weight gain. Denies any weight loss.

EYES ROS: Denies blurred vision. Denies diplopia.
ENT ROS: Denies sore throat. Denies nasal drainage. Denies sinus pain. Denies sinus congestion.
PULMONARY ROS: Denies a cough. No wheezing. Denies any shortness of breath.
GI ROS: Denies abdominal pain. Denies any nausea.
GU ROS: Denies dysuria. Denies hematuria. Denies urinary frequency. No complaints of nocturia.
MUSCULOSKELETAL ROS: Denies back pain. Denies neck pain. No joint pain.
SKIN ROS: Has a rash. Has pruritus. Denies any swelling.
NEURO ROS: Denies headaches. Denies blackouts. Denies difficulty walking.
PSYCHIATRIC ROS: Denies anxiety. Denies depression.
HEME - LYMPHATIC ROS: No unexplained bruising.
COMPLETED ROS: All other systems are negative.

Orders, Results, Procedures and Course in Department

Orders	Cancel	MD	Ordered	Started	Finished	Notes and Updates
1) Dexamethasone Sodium Phosphate 10 mg (Using 10 mg/mL aliquots or equiv.) IM Single dose now (Comment: Based on 0.6 mg/kg single dose - max dose 10 mg)		CSS	CSS 06/15/2018 18:39	BB 06/15/2018 18:49	BB 06/15/2018 18:49	IM Dexamethasone Sodium Phosphate given to patient in the Left arm (BB) Lot: 018356 (BB) Patient acknowledged instructions regarding 15 min observation prior to leaving. (BB) Observe for 15 minutes prior to discharge (BB)

Update Note:
18:21 Assumed care of patient.

Diagnosis and Plan

Primary Diagnosis:
Rash - R21
Pruritus - L29.9

Rx:
06/15/2018 - fluocinonide 0.05 % topical cream apply a thin film topically to affected area two - four times a day until clear Refills: 0 Dispense: (30 Gram(s)) Copy DO NOT DISPENSE sent electronically to: CVS/pharmacy #9858 Phone: 661-254-3766
06/15/2018 - prednisone 10 mg tablet Take by mouth 3 tabs BID X 3 days, 2 tabs BID X 3 days, one tab BID X 3 days, 1 tab once a day X 3 days Refills: 0 Dispense: (40 Tablet) Copy DO NOT DISPENSE sent electronically to: CVS/pharmacy #9858 Phone: 661-254-3766

Custom DC Instructions: Return back to your regular physician as needed none

Disposition and Notes: I have reviewed the BP findings and the patient is stable for discharge. The patient is being discharged with an abnormal pulse. After review of the problem and in the context of their medical condition they are stable for discharge. Patient discharged from department. The patient Julien Olivier has been dispositioned. The disposition provider is Cory S Spurlock MD (electronic signature). -- Return back to your regular physician as needed none

Chart signed by: Cory S Spurlock MD (CSS)(electronic signature 06/15/2018 19:45:41)

Contributors: Ruby Tafoya FD (RT)
Cory S Spurlock MD (CSS)
Brian Barnes LVN (BB)
Beth Wilson State Admin (BW)

exer URGENT CARE
Exer - Stevenson Ranch
25548 The Old Road, #U1
Stevenson Ranch, CA 91381
Phone: 661-556-9020
Fax: 661-556-9021

Name: **Olivier, Julien**	DOB: 6/27/1967	Sex: M
Acct #: 17af799ca8686f	MR #: 1a482d417d72940	AGE: 56
Visit Date: 09/26/2023 12:28	Bed #:	
Dispositioning Provider: Zacary Schwarzkopf MD		
Patient's PMD: none		

Addendum Note

09/26/2023 12:30 Discussed timely access of health information with patient.
Patient communication preferences completed. (MM)

Chief Complaint

1) P/C: "ear plugged up"

Visit Type

Office Visit, Established Patient

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Continue - no change - Confirmed Physician confirmed

Pepcid 20 mg tablet One tablet by mouth Take 1 tablet bid
- Notes: - Continue - no change - Confirmed Physician confirmed

ondansetron 4 mg disintegrating tablet One tablet,disintegrating by mouth every 6 hours as needed for nausea
- Notes: - Continue - no change - Confirmed Physician confirmed

Vitals

Blood Pressure: *BP: 161/83 (09/26 13:30)
BP: 133/86 (09/26 13:56)

Pulse: P: 61 (09/26 13:30)

Temperature: Temp: 98.4 Tympanic (09/26 13:30)

Respiration: Resp: 18/min (09/26 13:30)

Height: Hgt: 71 inch **BSA:** BSA: 2.1

Weight: Wgt: 185 lb (09/26 13:29) **BMI:** BMI: 25.8

Pulse Oximetry:
Pulse OX: 98% on Room air at 09/26 13:30

Nursing History

12:30 Combined form signed by patient.
Financial Consent signed by patient. (MM)
13:29 L ear clogged, happens every year.
Onset of symptoms was about 4 days ago.
This is a new problem for the patient.
The onset of the problem was gradual.
The problem is stable.
Describes the problem as L ear plugged up .
Describes severity of the problem as mild.
History provided by patient. (BV)

Name: Olivier, Julien	Acct #: 17af799ca8686f	Visit Date: 09/26/2023 12:28

RN Update Notes and Disposition

RN Continuation Notes:

12:30 Patient preferred communication methods have been completed. (MM)

Nursing Disposition:

13:29 Clinician needs to review BMI.
13:58 Disposition: Discharge.
Patient given copy of clinical summary.
Patient was discharged from department to home.
Patient left alone.
Discussed signs and symptoms of worsening to return to ER.
Understands aftercare instructions.
Verbalizes back importance of aftercare instructions.
A disposition has been completed for Julien Olivier by Hugo Vela MA-XRT (chart contributor).
20:52 Patient removed from Tracker Board by Hugo Vela MA-XRT. (HV)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Exam started at 13:45 09/26/2023. Presenting problem started 44 days ago. Have reviewed staff history and I concur. Have reviewed and agree with staff notes. History comes from patient. Able to get a good history. Notes decreased hearing in the left ear. Can't hear as well ouf of the left ear. No ear pain. Combined form signed by patient. Financial Consent signed by patient. L ear clogged, happens every year. Onset of symptoms was about 4 days ago. This is a new problem for the patient. The onset of the problem was gradual. The problem is stable. Describes the problem as L ear plugged up . Describes severity of the problem as mild. History provided by patient.

Physical Exam

General Presentation: Patient is overweight BMI = 25.8 (NIH criteria overweight = BMI between 25 and 30) Vital signs reviewed. Patient is alert. The patient appears to be comfortable.

Neurological Exam: Patient is alert. Oriented to person, place, and time.

Eye Exam: Pupils are reactive to light. Extra ocular movement normal.

ENT Exam: Pharynx normal. Grossly normal hearing to spoken voice and finger rub. Impacted cerumen is noted in the left external auditory canal..

Pulmonary Exam: Currently in no acute respiratory distress. Normal, non labored respirations.

Cardiac Exam: Peripheral pulses are strong and equal.

Skin and Soft Tissue Exam: Skin color is normal. No rash.

Musculoskeletal Exam: No extremity tenderness. Full range of motion in all extremities.

Neuro - Psychiatric Exam: Mood and affect normal.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Past Medical History: No immunization history record.

Family History: No significant family history.

Social History: Patient is married. Patient never smoked.

Review of Systems:
COMPLETED ROS: All other systems are negative.

Orders, Results, Procedures and Course in Department

Name: Olivier, Julien	Acct #: 17af799ca8686f	Visit Date: 09/26/2023 12:28

Orders	Cancel	MD	Ordered	Started	Finished	Notes and Updates
1) Irrigate left ear with lukewarm water till clear.		ZS	ZS 09/26/2023 13:41	HV 09/26/2023 13:53	HV 09/26/2023 13:53	

Procedures: Cerumen was removed with extensive irrigation of ear with lukewarm water to avoid oculovestibular reflex. Post removal the canal was clear with no significant residual inflammation. Successfully removed all foreign material.

Update Note:
13:16 Assumed care of patient.
13:46 Based on these findings and differential

56-year-old male is present with decreased hearing out of his left ear for the past 4 days. Reports he occasionally gets cerumen buildup and often needs ear cleanings. He is denying any pain in his ear. Otherwise feels at baseline, offering no other complaints. He is in no acute distress, well-appearing, BP elevated 161/83, remainder of vital signs are reassuring. His left ear canal is occluded by cerumen which was cleared via irrigation. Patient tolerated procedure well. On repeat examination there are no signs of otitis media or otitis externa, TM and ear canal are normal-appearing. Remainder of physical exam is unremarkable. Recommending at home peroxide solution and ear irrigation as needed to prevent future cerumen impactions. Recommend he monitor BP at home and follow-up with PMD or return for reevaluation if it is persistently elevated above 120/80. Return/emergency department precautions discussed, all questions answered

13:49 LOS manually stopped - visit completed

Diagnosis and Plan

Primary Diagnosis:
Moderate elevation of systolic pressure this visit - R03.0
Decreased hearing - H91.92
Impacted cerumen - H61.23

Custom DC Instructions: Return back to your regular physician as needed none

Disposition and Notes: Patient discharged from department. Condition at discharge - stable. Medication list reviewed. Final dx is low risk but a number of moderately complex issues were considered as discussed I have reviewed the BP findings and the patient is stable for discharge The patient Julien Olivier has been dispositioned. The disposition provider is Zacary Schwarzkopf MD (electronic signature). -- - Return back to your regular physician as needed none

Chart signed by: Zacary Schwarzkopf MD (ZS)(electronic signature 09/26/2023 13:55:51)

Contributors: Melissa Mitchell MA (MM)
Zacary Schwarzkopf MD (ZS)
Hugo Vela MA (HV)

exer URGENT CARE
Exer - Stevenson Ranch
25548 The Old Road, #U1
Stevenson Ranch, CA 91381
Phone: 661-556-9020
Fax: 661-556-9021

Name: **Olivier, Julien**	DOB: 6/27/1967	Sex: M
Acct #: 202012261231321	MR #: 1a482d417d72940	AGE: 53
Visit Date: 12/26/2020 09:31	Bed #:	
Dispositioning Provider: Crystal Gillespie PA-C in association with: Crystal Gillespie PA-C		
Patient's PMD: none		

Addendum Note

12/26/2020 21:13 No need to contact patient - labs all OK (CG)
12/26/2020 10:12 Patient communication preferences completed.
12/26/2020 10:11 Discussed timely access of health information with patient. (LJT)

Chief Complaint

1) 661-714-7629 - Clinic Visit
2) URI symptoms

Visit Type

Office visit, Established
Office Visit, Established Patient

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Continue - no change - Confirmed Physician confirmed

Augmentin 875 mg-125 mg tablet One tablet by mouth two times a day
- Notes: - Continue - no change - Confirmed Physician confirmed

Medrol (Pak) 4 mg tablets in a dose pack As directed tablets,dose pack by mouth Take as directed
- Notes: - Continue - no change - Confirmed Physician confirmed

Vitals

Pulse:	Temperature:	Respiration:
P: 68 (12/26 10:53)	Temp: 97 T. scan (12/26 10:53)	Resp: 16/min (12/26 10:53)

Height: Hgt: 71 inch **BSA:** BSA: 2.1

Weight: Wgt: 185 lb **BMI:** BMI: 25.8

Pulse Oximetry:

Pulse OX: 98% on Room air at 12/26 10:53

Nursing History

10:54 Unable to determine Onset of Present Illness at this time: .
Unable to document who gave me the history: . (DV)

RN Update Notes and Disposition

Nursing Disposition:

10:53 LOS manually stopped - visit completed (CG)

Clinician needs to review BMI.
10:54 Disposition: Discharge.
A disposition has been completed for Julien Olivier. by Daisy Virgen (chart contributor). (DV)
21:25 Patient removed from Tracker Board by Hannah Weltmann Front Desk Associate. (HW)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Patient electronically consented to routine clinic encounter. Exam started at 09:32 12/26/2020. Outside records ordered for review: Have reviewed and agree with staff notes. History comes from patient. The patients prior evaluations were reviewed . Have reviewed staff history and I concur. Able to get a good history. Patient's prior visits were reviewed. Patient is a 53 year old male presenting for an evaluation of COVID 19 screening and testing. Presenting problem started 2 days ago. Coronavirus screening questions. In contact with individual diagnosed with Covid 19 Patient's family member tested positive for COVID-19. Patient expresses concern for possible exposure 2 days ago. Has an intermittent cough. Complains of nasal congestion and fullness. No history of fever. No OTC meds. No history of sore throat. No chest pain Not short of breath. No sputum production. No sinus symptoms. No earache or drainage from ears. No eye symptoms. Denies headache. Good PO fluid intake. No vomiting. No diarrhea. No other symptoms. The rest of the review systems are negative. Unable to determine Onset of Present Illness at this time: . Unable to document who gave me the history: .

Summary

Scribe Signature and Attestation By signing my name below, I, Sophia Yang, attest that this documentation has been prepared under the direction and in the presence of Crystal Gillespie, PA-C, Sophia Yang, Scribe. 12/26/2020 10:56 AM I, Crystal Gillespie, PA-C, personally performed the services described in this documentation. All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and agree that the record reflects my personal performance and is accurate and complete. Crystal Gillespie, PA-C 12/26/2020 10:56 AM

Physical Exam

General Presentation: Vital signs reviewed. Patient is alert. The patient appears to be comfortable. Patient is overweight BMI = 25.8 (NIH criteria overweight = BMI between 25 and 30)

Neurological Exam: Patient is alert. Oriented to person, place, and time.

Eye Exam: Normal sclera.

ENT Exam: Normal voice. Normocephalic. The neck is supple, with no evidence of meningismus.

Pulmonary Exam: Currently in no acute respiratory distress. Normal, non labored respirations.

Skin and Soft Tissue Exam: Skin color is normal.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Review of Systems:

GENERAL ROS: Negative general review of systems.
EYES ROS: Negative opthalmic ROS.
ENT ROS: Denies sore throat. Has nasal drainage. Denies ear pain. Denies sinus pain. Denies sinus congestion. Denies facial pain.
CARDIAC ROS: No chest pain. Denies palpitations. Denies syncope.
PULMONARY ROS: Has a cough. No wheezing. Denies any shortness of breath.
GI ROS: Negative GI ROS.
GU ROS: Negative GU ROS.
NEURO ROS: Negative neurologic ROS.
COMPLETED ROS: All other systems are negative.

Orders, Results, Procedures and Course in Department

Name: Olivier, Julien	Acct #: 202012261231321	Visit Date: 12/26/2020 09:31

Orders	Cancel	MD	Ordered	Started	Finished	Notes and Updates
1) SARS Antigen FIA (Comment: Done in lab)		CG	DV 12/26/2020 10:48	DV 12/26/2020 10:53	DV 12/26/2020 10:53	

External Feed Test Results:

LAB SOURCE
Patient name: Olivier, Julien
Results from: Exer - More than Urgent Care Address: 25548 The Old Rd. #U1 Stevenson Ranch CA 91381
Medical Director: Lab Director: Leif Lunsford M.D.
Ordered by: Gillepsie,Crystal
Date of Report: 12/26/2020 18:52:00
Specimen ID: 202012261231321
Date Ordered: 12/26/2020 10:48:00

SARS Antigen FIA -

-- SARS Antigen FIA Negative F 7
Positive results for SARS Antigen. - Positive results indicate the presence of viral antigens, but clinical correlation with patient history and other diagnostic information is necessary to determine infection status.
Negative results for SARS Antigen. - Negative results should be treated as presumptive and confirmed with a molecular assay, if necessary for patient management. Negative results do not rule out COVID-19 and should not be used as the sole basis for treatment or patient management decisions.
This test is manufactured by Quidel for Sofia 2 SARS Antigen FIA. The Sofia SARS Antigen FIA is only for use under the Food and Drug Administration's Emergency Use Authorization.

Update Note:

18:40 Evaluation and treatments: Labs: SARS Antigen FIA Based on these findings and differential Pt appears well, non toxic, speaking in complete sentences comfortably. DDX: r/o covid VS stable, not hypoxic. PE unremarkable. Pt stable for discharge home with f/u and ER precautions as discussed.

Diagnosis and Plan

Primary Diagnosis:

Exposure to Covid 19 - Z20.822

Custom DC Instructions: Return back to your regular physician as needed none

Disposition and Notes: Medication list reviewed. Patient discharged from department. Condition at discharge - stable. No Attending/Supervising Physician required. The patient Julien Olivier has been dispositioned. The disposition provider is Crystal Gillespie PA-C (electronic signature). -- - The patient Julien Olivier has been dispositioned. The disposition provider is Crystal Gillespie PA-C (electronic signature). -- - Return back to your regular physician as needed none

Chart signed by: Crystal Gillespie PA-C (CG) Cosigned: Crystal Gillespie PA-C (12/26/2020 10:48:41) (electronic signature)

Contributors:
Zion Ramirez Scribe (ZR)
Crystal Gillespie PA-C (CG)
Laura Jean Traber FD (LJT)
Daisy Virgen (DV)
Sophia Yang SCRIBE (SY)
Hannah Weltmann Front Desk Associate (HW)

exer URGENT CARE
Exer - Stevenson Ranch
25548 The Old Road, #U1
Stevenson Ranch, CA 91381
Phone: 661-556-9020
Fax: 661-556-9021

Name: **Olivier, Julien**	DOB: 6/27/1967	Sex: M
Acct #: 202012291217762	MR #: 1a482d417d72940	AGE: 53
Visit Date: 12/29/2020 09:17	Bed #:	
Dispositioning Provider: Kerry McCabe DO		
Patient's PMD: none		

Addendum Note

12/29/2020 17:31 Discussed positive Covid 19 antigen result with patient. Patient denies any new or worsening symptoms. Recommended 10 days of self-isolation and following CDC guidelines. Recommended patient inform close contacts patient had within 2 days of symptom presentation to quarantine/get tested as well. Patient verbalized understanding. All questions answered. (DC)
12/29/2020 11:06 Call patient to discuss POSITIVE COVID 19 ANTIGEN TEST. (KM)

Chief Complaint

1) 661-714-7629 - Clinic Visit
2) URI symptoms

Visit Type

Office visit, Established

Allergies

No known drug allergies

Medications

Takes no meds - no OTC or prescription drugs currently
- Notes: - Continue - no change - Confirmed Review #1

Vitals

Pulse:
P: 75 (12/29 09:42)

Temperature:
Temp: 97.3 T. scan (12/29 09:42)

Height: Hgt: 71 inch **BSA:**BSA: 2.0

Weight: Wgt: 183 lb (Est.) **BMI:**BMI: 25.5

Pulse Oximetry:
Pulse OX: 97% on Room air at 12/29 09:42

Nursing History

09:41 History provided by patient.
10:14 Unable to determine Onset of Present Illness at this time: . (BG)

RN Update Notes and Disposition

RN Continuation Notes:

09:41 Review #1: medications confirmed from Brian Gonzalez MA_XRY 09:42 (BG)

Nursing Disposition:

09:41 Clinician needs to review BMI.
10:14 Disposition: Discharge.

A disposition has been completed for Julien Olivier. by Brian Gonzalez MA_XRY (chart contributor). (BG)
20:56 Patient removed from Tracker Board by Hannah Weltmann Front Desk Associate. (HW)

--- CLINICAL PROVIDER NOTE ---

History of Present Illness

Patient electronically consented to routine clinic encounter. Exam started at 09:18 12/29/2020. Able to get a good history. Have reviewed staff history and I concur. Have reviewed and agree with staff notes. Outside records ordered for review: History comes from patient. The patients prior evaluations were reviewed . Patient is a 53 year old male presenting for an evaluation of COVID 19 screening and testing. Presenting problem started 2-3 days ago. Coronavirus screening questions. In contact with individual diagnosed with Covid 19 . Patient's family members (x3) tested positive for COVID 19. Has an intermittent cough. Complains of dry nonproductive cough. Complains of nasal congestion and fullness. Complains of ageusia. Just generally feels achy with malaise No history of fever. No history of sore throat. No chest pain Not short of breath. No anosmia. No NVD. No other complaints at this time. Patient not seen using telemedicine History provided by patient. Unable to determine Onset of Present Illness at this time: .

Summary

Scribe Signature and Attestation By signing my name below, I, Zion Ramirez, attest that this documentation has been prepared under the direction and in the presence of Kerry McCabe, DO. Zion Ramirez, Scribe. 12/29/2020 9:52 AM Provider Attestation I, Kerry McCabe, DO, personally performed the services described in this documentation. All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and agree that the record reflects my personal performance and is accurate and complete. Kerry McCabe, DO. 12/29/2020 9:52 AM

Physical Exam

General Presentation: Vital signs reviewed. Patient is alert. The patient appears to be comfortable. Patient is overweight BMI = 25.5 (NIH criteria overweight = BMI between 25 and 30)

Neurological Exam: Patient is alert. Oriented to person, place, and time.

Eye Exam: Normal sclera.

ENT Exam: Normal voice. Normocephalic. The neck is supple, with no evidence of meningismus.

Pulmonary Exam: Currently in no acute respiratory distress. Normal, non labored respirations.

Skin and Soft Tissue Exam: Skin color is normal. Not diaphoretic.

Past Medical Hx, Family Hx, Social Hx, and Review of Systems

Past Medical History: No immunization history record.

Family History: No significant family history.

Social History: Patient is married. Unknown if patient has ever smoked.

Review of Systems:

GENERAL ROS: Has a sense of general malaise and feels generally sick. Denies any fever.
ENT ROS: Has ageusia. Denies sore throat. Has nasal drainage.
CARDIAC ROS: No chest pain. Denies palpitations. Denies syncope.
PULMONARY ROS: Has a cough. No wheezing. Denies any shortness of breath.
GI ROS: Negative GI ROS.
NEURO ROS: Negative neurologic ROS.
COMPLETED ROS: All other systems are negative.

Orders, Results, Procedures and Course in Department

Orders	Cancel	MD	Ordered	Started	Finished	Notes and Updates

1) SARS Antigen FIA (Comment: Done in lab)			BG 12/29/2020 09:49	BG 12/29/2020 10:13	BG 12/29/2020 10:13	

External Feed Test Results:

LAB SOURCE
Patient name: Olivier, Julien
Results from: Exer - More than Urgent Care Address: 25548 The Old Rd. #U1 Stevenson Ranch CA 91381
Medical Director: Lab Director: Leif Lunsford M.D.
Ordered by: McCabe,Kerry
Date of Report: 12/29/2020 11:05:00
Specimen ID: 202012291217762
Date Ordered: 12/29/2020 09:49:00

SARS Antigen FIA -

-- SARS Antigen FIA Positive *+* F 7
Positive results for SARS Antigen. - Positive results indicate the presence of viral antigens, but clinical correlation with patient history and other diagnostic information is necessary to determine infection status.
Negative results for SARS Antigen. - Negative results should be treated as presumptive and confirmed with a molecular assay, if necessary for patient management. Negative results do not rule out COVID-19 and should not be used as the sole basis for treatment or patient management decisions.
This test is manufactured by Quidel for Sofia 2 SARS Antigen FIA. The Sofia SARS Antigen FIA is only for use under the Food and Drug Administration's Emergency Use Authorization.

Update Note:

09:37 Assumed care of patient.
Assumed care of patient.
09:55 LOS manually stopped - visit completed

Diagnosis and Plan

Primary Diagnosis:

Exposure to Covid 19
URI
Cough
- Z20.822
null - Z20.822
null - R05
null - J06.9

Custom DC Instructions: You may review information regarding today's visit, by using our Patient Portal. To set up your own personal Patient Portal please visit our web site at . The portal requires either Edge, Firefox, Chrome or Safari. Follow the links and instructions. To set up a new portal you must provide us with a valid and unique e-mail address, which we use to confirm activation of your portal page. From the portal you may view, download or transmit your clinical summary or transistion of care record within 1 business day of your visit. You may also review your laboratory data as it has been reviewed by our providers.

Disposition and Notes: Medication list reviewed. Patient discharged from department. The patient Julien Olivier has been dispositioned. The disposition provider is Kerry McCabe DO (electronic signature). -- -

Chart signed by: Kerry McCabe DO (KM)(electronic signature 12/29/2020 10:53:51)

Contributors: Zion Ramirez Scribe (ZR)
Crystal Gillespie PA-C (CG)
Kerry McCabe DO (KM)

Brian Gonzalez MA_XRY (BG)
Diana Cantero PA-C (DC)
Hannah Weltmann Front Desk Associate (HW)

DECLARATION OF CUSTODIAN OF RECORDS

Name of applicant: x JULIEN OLIVIER
(Applicant)

WCAB No.

117543-1
Control No.

I declare as follows:

I am employed by and am the duly authorized custodian records and am authorized to certify records for:

x EXER URGENT CARE
(Name of facility)

X I certify that the accompanying records are true and complete copies of records maintained in the regular course and scope of business of my employer and were prepared by authorized personnel at or near the time of the acts, conditions or events which they intend to convey. No documents, records or other materials have been withheld except as noted below.

OR, IN THE ALTERNATIVE

_____ I HEREBY DECLARE, under penalty of perjury, that I have NO RECORDS on the patient, employee, or subject in request.

Please explain if you have no records:

Records were produced in the following manner:

_____ Records were made available to Platinum Copy Services for copying.

X Records were delivered to Platinum Copy Services.

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

Executed on x 10/22/2024, x ERICKSON RIVERA
Print Name

x Erickson Rivera
Signature of Custodian

Control # 117543-1

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF INDUSTRIAL ACCIDENTS
WORKER'S COMPENSATION APPEALS BOARD

Case No. ADJ14026805; 15211612

(IF APPLICATION HAS BEEN FILED CASE NUMBER MUST BE INDICATED REGARDLESS OF DATE INJURY)

Julien Olivier

Claimant/Applicant

vs.

County of Los Angeles / Sedgwick CMS

SUBPOENA DUCES TECUM

(When records are mailed, identify then by using above case number or attaching a copy of a subpoena)

(NO APPEARENCE IS NECESSARY WHEN RECORDS ARE PRODUCED BY DEPOSITION DATE.)

People of the State of California Send Greetings to:

We COMMAND YOU to appear before: PLATINUM COPY

Exer Urgent Care
25548 The Old Rd Unit 1
Stevenson Ranch, California, 91381

at P.O. Box 353 Van Nuys, CA 91408 PH (818) 985-8885 FX (818) 985-8822

on the 22 day of October 2024 at 9:00 o'clock A.M. to testify in the above-entitled matter and to bring with you and produce the following described documents, papers, books, records:

Any and All MEDICAL RECORDS from 01/01/1990 to present including, notes, reports; including but not limited to: inpatient, outpatient, physical therapy, pharmacy records, dental records, emergency room, clinic, or paramedic care, to include X-Ray reports, industrial and private records pertaining to the patient from the first date of treatment to present .

APPLICANT:	DOB:	SS#:	DOI:	CLAIM#:
Julien Olivier	06/27/1967	566-75-4657	11/07/1990-12/15/2020	121-02891-A

(Do not produce X-rays unless specifically mentioned above.)

For failure to attend as required, you may be deemed guilty of contempt and liability to pay to the parties aggrieved all losses and damages sustained thereby and forfeit one hundred dollars in addition thereto.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is Served herewith

Date October 02 2024

WORKERS COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA

Secretary, Assistant Secretary, Workers Compensation Judge

Date September 22, 2024

You are directed to make the original records available for inspection and copying at the address of the Deposition Officer given above or, with the consent of the Deposition Officer, at your place of business during normal business hours in accordance with California Evidence Code Section 1560(e). Do not release the requested records to the deposition officer prior to the date and time stated above.

SEE RESERVE SIDE
[SUBPOENA INVALID WITHOUT DECLARATION]

This subpoena does not apply to any member of the Highway Patrol, Sheriffs Office or city Police Department unless accompanied by notice from the Board that deposit of the witness fee has been made in accordance with Government code 6809 7.2, at seq.

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evidence Code 1561) to the person and place stated above within ten (10) days of the date of service of this subpoena.

DIA WCAB 32 (Side 1)(Rev. 06/94)

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. ADJ14026805; 15211612

STATE OF CALIFORNIA, County of Los Angeles

The undersigned states:
that he/she is (one of) the attorney (s) of records/representative (s) for the applicant/defendant in the action captioned On the reverse hereof That Exer Urgent Care has in his/her possession or under his/her control the documents described on the reverse hereof. That the said documents are material to the issues involved in the case for the following reasons:
Where subpoena duces tecum is for pretrial discovery no affidavit of good cause is required under LC 5710, CCP 2020(d)(l), 1987.5, 2025; To provide an accurate medical history of the applicant to the treating doctor or QME(L.C. §10626), to establish apportionment (if any), to prove an injury and notice thereof, to prove the right to compensation,

Declaration for Injuries on or After January 1,1990 and Before January 1,1994

☐ That an Employee's Claim for Worker's Compensation Benefits (DWC Form1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependent (s) of the decedent, and that a true copy of the form filed is attached hereto. *(Check box if applicable and part of declaration below. See instructions on front of subpoena)*

Executed on October 02 2024, at Van Nuys, California.

Straussner Sherman — Ordered by

14555 Sylvan St, Van Nuys, California, 91411 — Address

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of Los Angeles

I, the undersigned, state that I served the foregoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Exer Urgent Care	October 02 2024	25548 The Old Rd Unit 1 Stevenson Ranch, California, 91381

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

Executed on October 02 2024, at Van Nuys, California.

Signature

DWC WCAB 32 (Side 2)(Rev. 09/94)

DECLARATION OF CUSTODIAN OF RECORDS

Name of applicant: x_____
(Applicant)

_____ _____
WCAB No. Control No.

I declare as follows:

I am employed by and am the duly authorized custodian records and am authorized to certify records for:

x _____
(Name of facility)

_____ I certify that the accompanying records are true and complete copies of records maintained in the regular course and scope of business of my employer and were prepared by authorized personnel at or near the time of the acts, conditions or events which they intend to convey. No documents, records or other materials have been withheld except as noted below.

_____

_____

_____

OR, IN THE ALTERNATIVE

_____ I HEREBY DECLARE, under penalty of perjury, that I have NO RECORDS on the patient, employee, or subject in request.

Please explain if you have no records:

_____

_____

_____

Records were produced in the following manner:

_____ Records were made available to **Platinum Copy Services** for copying.

_____ Records were delivered to **Platinum Copy Services**.

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

Executed on x _____, x_____
Print Name

x_____
Signature of Custodian

~~PROOF OF SERVICE~~

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed by PLATINUM COPY in the aforesaid country, I am over the Age of eighteen years and not a party to the within entitled action, my business address is P.O. Box 353. Van Nuys, CA 91408

On 10/02/2024, I served the within Subpoena Duces Tecum **Control # 117543-1** on the interested parties in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid to be placed in the US POSTAL SERVICE mailbox located in Glendale CA, following ordinary business practices at my businesses. I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. It is deposited with the US Postal Service on the same day in the ordinary course of business.

I declare under penalty of perjury that the foregoing is true and correct, Executed on 10/02/2024, at Glendale, California.

/s/
Joe Karapetian

Parties:
Attention Custodian of Records:

Exer Urgent Care
25548 The Old Rd Unit 1, Stevenson Ranch, California, 91381

Sedgwick CMS
P.O Box 11028, Orange, California 92856

Straussner Sherman
14555 Sylvan St, Van Nuys, California 91411

, , Alaska

8088

Platinum Copy Services
P.O. Box 353
Van Nuys, CA 91408
818-985-8885

BANK OF AMERICA
6551 Van Nuys Blvd.
Van Nuys, CA 91401
11-35/1210

10/04/2024

PAY TO THE ORDER OF Exer Urgent Care $ **15.00

Fifteen and 00/100** DOLLARS

Exer Urgent Care
2381 Rosecrans Ave #115
El Segundo, CA 90245

MEMO Julien Olivier

⑈008088⑈ ⑆121000358⑆ 000220442420⑈

exer URGENT CARE

PATIENT REGISTRATION FORM

***All Patients** - This information is required for you to get your lab results on the patient portal*

Patient Legal First Name: JUAN Legal Last Name: OLIVER

Date of Birth: Month 06 Day 17 Year 1967

Email Address: OLIVERS4D JCLOUD.COM CELL Phone: 661 714-7629

Parent/Guardian Name (if patient less than 18 yrs. old): _____

Were you referred by a physician for this visit?

☑ No ☐ Yes - Name _____

***Existing Patients** - Please check box if there has been NO change to the information below and proceed to next section ☐*
New Patients (Required)

Address: _____

City: _____ Apt #: ____ State: _____ Zip Code: _____

HOME Phone: (_____) _____ - _____ WORK Phone: (_____) _____ - _____

Last four digits of SS#: XXX - XX - _____ Sex at Birth (for medical treatment): F M Gender Identity (optional): F M X

Preferred Pharmacy: CVS MCB & W (CHANGE SOURCE) Pharmacy Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Primary Care Doctor: _____ Phone: _____

Government Required Information (All)			
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed		
Ethnicity:	☐ Hispanic/Latino	☐ Non-Hispanic/Latino	
Race:	☐ American Indian/Alaskan Native	☐ Asian	☐ Black/African American
	☐ Native Hawaiian/Pacific Islander	☐ White	☐ Other

Reason for your visit today: INJURED L/ WRIST

Did you injure yourself at work? ☐ Yes ☐ No

If you are here for COVID testing, do you have any symptoms? ☐ Yes ☐ No

☐ Check here to have your COVID-19 test/visit submitted to your insurance. *(Your insurance may or may not cover these services. You agree to bear full financial responsibility for all the services not covered by your insurance plan. Please contact your insurance plan for further guidance.)*

I understand that I am financially responsible for all labs that are sent out and will be billed directly by those labs.

I agree to allow Exer Urgent Care's research team to quickly explain how I can earn a stipend for participating in an anonymous research study and I am not obligated to participate. ☐ Yes ☐ No

Date: 09.27.24 X _____

Patient (or Representative) Signature

To view our office policies and consents, please go to: www.exerurgentcare.com/officepolicies/
To view our Notice of Privacy Practices, please go to: www.exerurgentcare.com/privacy-policy-and-practices/ Rev. 4/24/23

exer URGENT CARE

PATIENT REGISTRATION

***Required** (This information provides you access to the patient portal)*

Patient Name: JOSE OLIVIER Date of Birth 6/27/67

Parent/Guardian Name (if patient less than 18 yrs old): _____

Email Address: OLIVIERS42 ICLOUD.COM Cell Phone: (661) - 714-7629

☐ ***Please check this box if there has been no change to information below and proceed to next section***

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

SS# _____ - _____ - _____ Sex: M F

Preferred Pharmacy: _____ Pharmacy Phone: (____) _____ - _____

Optional

Emergency Contact: _____ Phone: _____

Relationship: _____

Primary Care Doctor: _____ Phone: _____

☐ Do not fax/email records to my doctor

Government Required					
	Marital Status:	☐ Single	☑ Married	☐ Divorced	☐ Partnered	☐ Widowed
	Ethnicity:	☐ Hispanic/Latino	☐ Non-Hispanic/Latino		
	Race:	☐ American Indian/Alaskan Native	☐ Asian	☐ Black/African American	
		☐ Native Hawaiian/Pacific Islander	☑ White	☐ Other	

Do you have any of the following symptoms of COVID-19? ☐ Yes ☑ No

Fever, Chills, Body Aches, Cough, Congestion, Sore Throat, Shortness of Breath, Nausea, Diarrhea, Vomiting, Loss of Smell or Taste.

Have you or anyone in your household tested positive for COVID-19 in the last 14 days? ☐ Yes ☑ No

Reason for your visit today: PAIN IN STOMACH

Did you injure yourself at work? ☐ Yes ☑ No

If you are here for COVID-19 testing or screening, please check all that apply:

Routine Testing – may not require provider evaluation

No symptoms or exposure *(travel, school, daycare, employer, camp, etc.)*

☐ PCR

☐ Antigen

Diagnostic Testing – requires evaluation by provider

☐ Pre-op COVID-19 testing

☐ COVID-19 exposure or symptoms

☐ Check here to have your COVID-19 test/visit submitted to your insurance. *(Your insurance may or may not cover these services. You agree to bear full financial responsibility for all the services not covered by your insurance plan. Please contact your insurance plan for further guidance.)*

Date: 04-05-22 X _____

Patient or Representative Signature

To view our office policies and consents please go to: www.exerurgentcare.com/officepolicies/

To view our Notice of Privacy Practices please go to: www.exerurgentcare.com/privacy-policy-and-practices/

Rev. 11/14/2021

Exer
MORE THAN URGENT CARE

New Patient Registration

Gender (M) F Date of Birth 06/27/67 SS# 566 75 4657

Name: JULIAN OLIVIER

Address: 25791 IRMA DR.

City: VALENCIA State: CA Zip Code: 91355

Home Phone: ( ) -

Work Phone: (323) 526 - 5635

Cell Phone: (661) 714 - 7629

Email Address: OLIVIER254@ICLOUD.COM

Marital Status: ☐ Single ☑ Married ☐ Divorced ☐ Partnered ☐ Widowed

Primary Care Doctor: NONE ☐ Do not fax my chart to my doctor

How did you hear about us?

Physician Referral:	☐ Primary Care Doctor	☐ Physician:		
Referred By:	☐ Insurance Company	☐ Family	☐ Friend	☐ School Leadership
Heard About/ Saw It:	☐ Radio	☐ Banner at School	☐ Billboard	☒ Walk In
Read About It:	☐ Newspaper	☐ Email about Exer	☐ Social Media	☐ Searched online
Attended Exer:	☐ Sport & School Event	☐ Open House	☐ Other:	

Emergency Contact: MICHELLE OLIVIER

Relationship: WIFE Phone: (661) 713 - 5931

Signature of Patient or Guardian: [signature] Date: 06 08 18

exer URGENT CARE

PATIENT REGISTRATION FORM

***All Patients** - This information is required for you to get your lab results on the patient portal*

Patient Legal First Name: JULIE Legal Last Name: OLIVER

Date of Birth: Month 06 Day 22 Year 67

Email Address: OLIVER540 ICLOUD.COM CELL Phone: 661 714 7629

Parent/Guardian Name (if patient less than 18 yrs. old): N/A

Were you referred by a physician for this visit?

☐ No ☐ Yes - Name _____

***Existing Patients** - Please check box if there has been NO change to the information below and proceed to next section ☐*
New Patients (Required)

Address: _____

City: _____ Apt #: ____ State: _____ Zip Code: _____

HOME Phone: (____) _____ - _____ WORK Phone: (____) _____ - _____

Last four digits of SS#: XXX - XX - ____ Sex at Birth (for medical treatment): F M Gender Identity (optional): F M X

Preferred Pharmacy: CVS (GRANADA SQUARE) Pharmacy Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Primary Care Doctor: _____ Phone: _____

Government Required Information (All)

Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Partnered ☐ Widowed
Ethnicity:	☐ Hispanic/Latino		☐ Non-Hispanic/Latino	
Race:	☐ American Indian/Alaskan Native		☐ Asian	☐ Black/African American
	☐ Native Hawaiian/Pacific Islander		☐ White	☐ Other

Reason for your visit today: EAR PLUGGED UP

Did you injure yourself at work? ☐ Yes ☐ No

If you are here for COVID testing, do you have any symptoms? ☐ Yes ☐ No

☐ Check here to have your COVID-19 test/visit submitted to your insurance. *(Your insurance may or may not cover these services. You agree to bear full financial responsibility for all the services not covered by your insurance plan. Please contact your insurance plan for further guidance.)*

I understand that I am financially responsible for all labs that are sent out and will be billed directly by those labs.

I agree to allow Exer Urgent Care's research team to quickly explain how I can earn a stipend for participating in an anonymous research study and I am not obligated to participate. ☐ Yes ☐ No

Date 09/26/23 X _____
Patient (or Representative) Signature

To view our office policies and consents, please go to: www.exerurgentcare.com/officepolicies/
To view our Notice of Privacy Practices, please go to: www.exerurgentcare.com/privacy-policy-and-practices/ Rev. 4/24/23