

CHUBB®

Western Claim Service Center
P.O. Box 42065
Phoenix, AZ 85080
O (213) 612-0880
F (800) 664-1765

July 22, 2020

Visionary Law Cerritos
8605 Santa Monica Blvd
West Hollywood, CA 90069-4109

Re: Employee: Audra Karim
Employer: Cal Ned, Inc.
Date of Injury: 2/06/2019
Policy Number: 000079523600 / 001101
Claim Number: 092019015968
Company: Vigilant Insurance Company

To whom it may concern:

In accordance with the Rules of Practice and Procedures of the Workers' Compensation Appeals Board, we submit the following:

(X) Medicals as follows: All Medicals received from May 14, 2020 to July 21, 2020 as listed below:

- PR-2 reports dated 6/2/20, 5/22/20, 5/8/20, 5/7/20, 4/30/20, 4/23/20, 4/16/20, 4/13/20, 4/9/20, 4/2/20, 3/5/20, 2/26/20, 2/10/20, 2/6/20
- Bell Community Medical Group reports dated 3/18/20, 3/5/20, 2/27/20

Sincerely,

Paul Pan

Paul Pan
Claims Examiner.xj

CC: Harrison Eichenberg & Murphy
P.O. Box: 640
Aguora Hills, CA 91376

**PROOF OF SERVICE
1013A (3) CCP**

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is P.O. Box 42065, Phoenix, Arizona 85080.

On July 22, 2020 I served the foregoing document described as medicals,

- PR-2 reports dated 6/2/20, 5/22/20, 5/8/20, 5/7/20, 4/30/20, 4/23/20, 4/16/20, 4/13/20, 4/9/20, 4/2/20, 3/5/20, 2/26/20, 2/10/20, 2/6/20
- Bell Community Medical Group reports dated 3/18/20, 3/5/20, 2/27/20

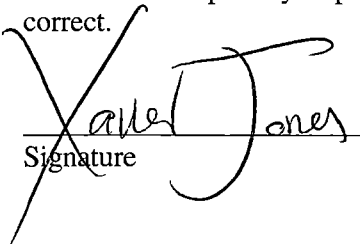
on the interested parties in this action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Los Angeles, California addressed as follows:

Visionary Law Cerritos
8605 Santa Monica Blvd
West Hollywood, CA 90069-4109

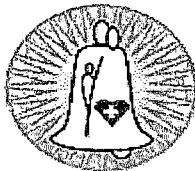
CC: Harrison Eichenberg & Murphy
P.O. Box: 640
Aguora Hills, CA 91376

Executed on July 22, 2020 in Los Angeles, California.

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


Signature

Xavier Jones
Typed or Printed Name



Bell Community Medical Group

4001 E Florence Avenue, Bell CA 90201 - 3403

Tel: 323 562-0595, Fax: 323 562-2047

Karim, Audra

Sex: Female, Date of Birth: 01-18-1972, Account No: SCL15443

Attending Provider: Michael Turk, D.C.

Encounter Date: 02-27-2020

Chief Complaint: Back Pain

Other Complaints: Lower extremity Problem/Injury

History of Present Illness

Back Pain

She has pain in the upper thoracic, mid thoracic, low thoracic and lumbosacral region. She describes this pain as an ache. She says it is severe. Const. She reports that the pain radiates to both legs.

Cumulative trauma, while lifting and carrying heavy baskets.

Lower extremity Problem/Injury

Patient presents with chief complain of pain and altered sensation in the lower extremity. There is pain in the right foot and left foot. Numb tingle, int. The symptoms are extremely severe.

Past Medical History

rheumatoid arthritis- possible dx. in past () .

Surgical History

No Known Surgical History

Social History

Work History: She is unemployed at present.

Family: She is single.

Current Medication

naproxen sodium 550 mg tablet 1 Twice A Day PRN, Prescribe 60 Tablet, Refills 2

orphenadrine citrate ER 100 mg tablet,extended release 1 Twice A Day PRN, Prescribe 60 Tablet, Refills 2

Nexium 20 mg capsule,delayed release 1 Capsule Twice A Day PRN, Prescribe 60 Capsule, Refills 2

back brace 1 Every Morning PRN, Prescribe 1 Each

Allergy

Coconut Flavor Allergy . Lactose Allergy . Pineapple Allergy . STRAWBERRY Allergy .

Physical Examination

General Appearance: female She looks her stated age.

Head/Scalp: Head is normocephalic and int. Head aches

Back: *The ROM for thoracic spine shows abnormal findings. Sp/te parasp ROM for lumbar spine reveals abnormal findings. +kemps, +valsalva* Tender over paraspinal area bilaterally to palpation. SLR is positive bilaterally.

Karim, Audra Female 01-18-1972

Assessment and Plan

ICD: Lumbar radiculopathy (M54.16)

Assessment: Rad

Plan: Chiro/pt 2x3

refer psych

request records

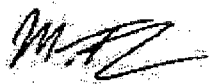
NCV LE

ICD: Thoracic myofascial strain (S29.019A)

Follow up After 3 Weeks

Attending Nurse:

Supervised by: Michael Turk, D.C.

A handwritten signature in black ink, appearing to read 'M. Turk', with a stylized flourish at the end.

Michael Turk, D.C.

This has been electronically signed on 02-27-2020



Bell Community Medical Group

4001 E Florence Avenue, Bell CA 90201 - 3403

Tel: 323 562-0595, Fax: 323 562-2047

Karim, Audra

Sex: Female, Date of Birth: 01-18-1972, Account No: SCL15443

Attending Provider: Michael Turk, D.C.

Encounter Date: 03-05-2020

Chief Complaint:

Other Complaints:

Past Medical History

rheumatoid arthritis- possible dx. in past () .

Surgical History

No Known Surgical History

Social History

Work History: She is unemployed at present.

Family: She is single.

Current Medication

naproxen sodium 550 mg tablet 1 Twice A Day PRN, Prescribe 60 Tablet, Refills 2

orphenadrine citrate ER 100 mg tablet, extended release 1 Twice A Day PRN, Prescribe 60 Tablet, Refills 2

Nexium 20 mg capsule, delayed release 1 Capsule Twice A Day PRN, Prescribe 60 Capsule, Refills 2

back brace 1 Every Morning PRN, Prescribe 1 Each

Allergy

Coconut Flavor Allergy . Lactose Allergy . Pineapple Allergy . STRAWBERRY Allergy .

Physical Examination

PTA Objective

Modalities: The following modalities are being used: vibrator/myofascial release and therapeutic exercise.

PTA- Objective Findings: Muscle spasm: right mid back, left mid back, right lower back and left lower back.

PTA Subjective

PTA- Subjective: Pain level - severe: right mid back, left mid back, right lower back and left lower back.

PTA-Assessment/Plan

PTA- Plan/Treatment: Spinal adjustment plan will be t-sp, l-sp and activator. Rehab exercise will be Active.

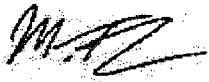
Patient has been referred to primary care. Psych - severe stress/anxiety

Karim, Audra Female 01-18-1972

Follow up After No Follow Up

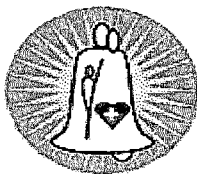
Attending Nurse: Zuniga Neftali

Supervised by: Michael Turk, D.C.

A handwritten signature in black ink, appearing to read 'M. Turk' with a stylized flourish at the end.

Michael Turk, D.C.

This has been electronically signed on 03-05-2020



Bell Community Medical Group

4001 E Florence Avenue, Bell CA 90201 - 3403

Tel: 323 562-0595, Fax: 323 562-2047

Karim, Audra

Sex: Female, Date of Birth: 01-18-1972, Account No: SCL15443

Attending Provider: Bruce Wasserman, OMD QME LAC

Encounter Date: 03-18-2020

Chief Complaint:

Other Complaints:

Past Medical History

rheumatoid arthritis- possible dx. in past () .

Surgical History

No Known Surgical History

Social History

Work History: She is unemployed at present.

Family: She is single.

Current Medication

naproxen sodium 550 mg tablet 1 Twice A Day PRN, Prescribe 60 Tablet, Refills 2

orphenadrine citrate ER 100 mg tablet,extended release 1 Twice A Day PRN, Prescribe 60 Tablet, Refills 2

Nexium 20 mg capsule,delayed release 1 Capsule Twice A Day PRN, Prescribe 60 Capsule, Refills 2

back brace 1 Every Morning PRN, Prescribe 1 Each

Allergy

Coconut Flavor Allergy . Lactose Allergy . Pineapple Allergy . STRAWBERRY Allergy .

Follow up After No Follow Up

Attending Nurse: Ramirez Marlene

Supervised by: Bruce Wasserman, OMD QME LAC

Bruce Wasserman, OMD QME LAC

This has been electronically signed on 03-18-2020

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury: 2/6/19
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact: PAUL PAN	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

***Status**

The patient rates the pain level as 6 and 7 on a scale of 1 to 10. ROM since last visit has remained unchanged. The patient is not working. The strength is unchanged since last visit. PT has been kept on hold. Encounter was performed remotely via synchronous communication with aid of HIPPA compliant doxy.Me portal. Patient verbally agreed to telemedicine session. Reports neck, low back which remains constant completed studies a year ago for neck and low back saw QME

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

General Appearance: female

Back: *The ROM for thoracic spine shows abnormal findings. ROM for lumbar spine reveals abnormal findings.* Tender over paraspinal area bilaterally to palpation. SLR is positive bilaterally.

Lower Extremity: *ROM for the right hip is abnormal. ROM for the left hip is abnormal.*

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Cont medications

cont PT and Acupuncture

all studies been delayed b/o quarantine

pending old records with MRIs of CS and LS

pending QME. Consult:Acupuncture to Kenneth Cherman,

The following medications were Dispensed.

The following medications were Prescribed.

Karim, Audra Female 01-18-1972

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ The patient will return to modified work on 05-12-2020, ____ with the following limitations or restrictions (Li

st all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolong sitting. She is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: ____ with no limitations or restrictions.

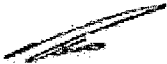
Patient's Next Appt.: 1 Week PRN 05-15-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 05-08-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 05-08-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro: Movsesian, PA Sara

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury: 2/6/19
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact: PAUL PAN	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc	Employer Phone:		

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

SUBJECTIVE COMPLAINTS

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Cont medications

cont PT and Acupuncture

all studies been delayed b/o quarantine

pending old records with MRIs of CS and LS

pending QME. Consult: Acupuncture to Kenneth Cherman,

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ The patient will return to modified work on 05-25-2020, ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolonged sitting. She is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: ____ with no limitations or restrictions.

Patient's Next Appt.: 1 Week PRN 05-29-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 05-22-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 05-22-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro: Orozco Michelle

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury:2/6/19
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact: PAUL PAN	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

***Status**

The patient rates the pain level as 6 and 7 on a scale of 1 to 10. ROM since last visit has remained unchanged. The patient is not working. The strength is unchanged since last visit. PT has been kept on hold.

Encounter was performed remotely via synchronous communication with aid of HIPPA compliant doxy.Me portal. Patient verbally agreed to telemedicine session.

Stopped coming b/o COVID-19

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

General Appearance: female

Back: *The ROM for thoracic spine shows abnormal findings. ROM for lumbar spine reveals abnormal findings.* Tender over paraspinal area bilaterally to palpation. SLR is positive bilaterally.

Lower Extremity: *ROM for the right hip is abnormal. ROM for the left hip is abnormal.*

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Cont medications, helping

Will restart PT/chiro/acu

Still need studies. Consult:Acupuncture to Kenneth Cherman,

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Karim, Audra Female 01-18-1972

Consults:

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ The patient will return to modified work on 06-03-2020, ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolonged sitting. She is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: ____ with no limitations or restrictions.

Patient's Next Appt.: 1 Month PRN 07-02-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 06-02-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 06-02-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

:			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation: Wardrobe dresser	SS#:	Phone:	Date of Injury:
CLAIMS ADMINISTRATOR:			
Name: Chubb Los Angeles.	Contact: PAUL PAN	Claim Number: 092019015968	
Address: Po Box 42065	City: Phoenix	State: AZ	Zip: 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

WC-Record review

Communication: Minutes Spent: 35 mins Documents Reviewed EDD form and medical records Reviewed the chart/consultants reports and filled out Statmnt of disab.

Vitals

Rads Reviewed

DIAGNOSIS

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

Karim, Audra Female 01-18-1972

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

Return to full duty on: ____ with no limitations or restrictions.

Patient's Next Appt.: PRN

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 05-07-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 05-07-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury:2/6/19
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact: PAUL PAN	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

***Status**

The patient rates the pain level as 8 and 9 on a scale of 1 to 10. ROM since last visit has remained unchanged. The patient is not working. The strength is unchanged since last visit. PT helped improve symptoms for the patient. Encounter was performed remotely via synchronous communication with aid of HIPPA compliant doxy.Me portal. Patient verbally agreed to telemedicine session. Patient is staying home

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

Back: The ROM for thoracic spine shows abnormal findings. ROM for lumbar spine reveals abnormal findings. Tenderness over paraspinal area bilaterally to palpation. SLR is positive bilaterally.
Lower Extremity: ROM for the right hip is abnormal. ROM for the left hip is abnormal.

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Continue medications, helping

Still need studies

Waiting to start acupuncture

Patient has cold symptoms, will need to go through quarantine. Consult: Acupuncture to Kenneth Cherman,

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Karim, Audra Female 01-18-1972

Consults:

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ The patient will return to modified work on 05-01-2020, ____ with the following limitations or restrictions (Li

st all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolonged sitting. She is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: ____ with no limitations or restrictions.

Patient's Next Appt.: 1 Week PRN 05-07-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 04-30-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 04-30-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury: 2/6/19
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact: PAUL PAN	Claim Number: 092019015968	
Address : Po Box 42065	City: Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

***Status**

The patient rates the pain level as 8 and 9 on a scale of 1 to 10. ROM since last visit has remained unchanged. The patient is not working. The strength is unchanged since last visit. PT helped improve symptoms for the patient.

Encounter was performed remotely via synchronous communication with aid of HIPPA compliant doxy.Me portal. Patient verbally agreed to telemedicine session.

Patient is staying home

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

Back: *The ROM for thoracic spine shows abnormal findings. ROM for lumbar spine reveals abnormal findings.* Tenderness over paraspinal area bilaterally to palpation. SLR is positive bilaterally.

Lower Extremity: *ROM for the right hip is abnormal. ROM for the left hip is abnormal.*

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Cont medications, helping

Still need studies

Waiting to start acupuncture

Patient has cold symptoms, will need to go through quarantine. Consult: Acupuncture to Kenneth Cherman,

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Karim, Audra Female 01-18-1972

Consults:

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ The patient will return to modified work on 04-24-2020, ____ with the following limitations or restrictions (Li

st all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolong sitting. She is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: ____ with no limitations or restrictions.

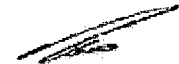
Patient's Next Appt.: 1 Week PRN 04-30-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 04-23-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 04-23-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury: 2/6/19
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact: PAUL PAN	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

***Status**

The patient rates the pain level as 8 and 9 on a scale of 1 to 10. ROM since last visit has remained unchanged. The patient is not working. The strength is unchanged since last visit. PT helped improve symptoms for the patient. Encounter was performed remotely via synchronous communication with aid of HIPPA compliant doxy.Me portal. Patient verbally agreed to telemedicine session. Patient is staying home

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

Back: *The ROM for thoracic spine shows abnormal findings. ROM for lumbar spine reveals abnormal findings.* Tenderness over paraspinal area bilaterally to palpation. SLR is positive bilaterally.
Lower Extremity: *ROM for the right hip is abnormal. ROM for the left hip is abnormal.*

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Continue medications, helping

Still need studies

Waiting to start acupuncture. Consult: Acupuncture to Kenneth Cherman,

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ The patient will return to modified work on 04-17-2020, ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolonged sitting. She is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: ____ with no limitations or restrictions.

Patient's Next Appt.: 1 Week PRN 04-23-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 04-16-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 04-16-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

:			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury:
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact: PAUL PAN	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

WC-Record review

Communication: Minutes Spent: 35 mins Documents Reviewed EDD form and medical records Reviewed the chart/consultants reports and filled out Statmnt of disab.

Vitals

Rads Reviewed

DIAGNOSIS

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

Karim, Audra Female 01-18-1972

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

Return to full duty on: ____ with no limitations or restrictions.

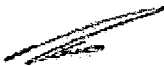
Patient's Next Appt.: PRN

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 04-13-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 04-13-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City : Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury: 2/6/19
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact:	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

***Status**

The patient rates the pain level as 8 and 9 on a scale of 1 to 10. ROM since last visit has remained unchanged. The patient is not working. The strength is unchanged since last visit. PT helped improve symptoms for the patient. Encounter was performed remotely via synchronous communication with aid of HIPPA compliant doxy.Me portal. Patient verbally agreed to telemedicine session.

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

Back: *The ROM for thoracic spine shows abnormal findings. ROM for lumbar spine reveals abnormal findings.* Tend er over paraspinal area bilaterally to palpation. SLR is positive bilaterally.
Lower Extremity: *ROM for the right hip is abnormal. ROM for the left hip is abnormal.*

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Cont medications, helping

Still need studies

Waiting to start acupuncture

Patient feels ill, advised to stay home for now. Consult: Acupuncture to Kenneth Cherman,

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ The patient will return to modified work on 04-10-2020, ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolonged sitting. She is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: ____ with no limitations or restrictions.

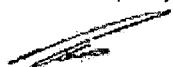
Patient's Next Appt.: 1 Week PRN 04-16-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 04-09-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 04-09-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury: 2/6/19
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact:	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

***Status**

The patient rates the pain level as 8 and 9 on a scale of 1 to 10. ROM since last visit has remained unchanged. The patient is not working. The strength is unchanged since last visit. PT has been kept on hold. Scheduled to start tomorrow Encounter was performed remotely via synchronous communication with aid of HIPPA compliant doxy.Me portal. Patient verbally agreed to telemedicine session.

On 2/27/20, patient was forced to go to Concentra and supposedly was released to full duty even if she was not ready. No exam performed.

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

Back: *The ROM for thoracic spine shows abnormal findings. ROM for lumbar spine reveals abnormal findings.* Tender over paraspinal area bilaterally to palpation. SLR is positive bilaterally.

Lower Extremity: *ROM for the right hip is abnormal. ROM for the left hip is abnormal.*

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Cont medications

Still need studies. Consult: Acupuncture to Kenneth Cherman,

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ The patient will return to modified work on 04-03-2020, ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolonged sitting. She

is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: ____ with no limitations or restrictions.

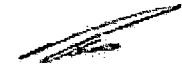
Patient's Next Appt.: 1 Week PRN 04-09-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 04-02-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 04-02-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

:			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury:
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact:	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc	Employer Phone:		

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

SUBJECTIVE COMPLAINTS

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

WC-Record review

Communication: Minutes Spent: 35 mins Documents Reviewed EDD form and medical records Reviewed the chart/consultants reports and filled out Statmnt of disab.

Vitals

Rads Reviewed

DIAGNOSIS

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

Karim, Audra Female 01-18-1972

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

Return to full duty on: ____ with no limitations or restrictions.

Patient's Next Appt.: PRN

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 03-05-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 03-05-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation: Wardrobe dresser	SS#:	Phone:	Date of Injury: 2/6/19
CLAIMS ADMINISTRATOR:			
Name: Chubb Los Angeles.	Contact:	Claim Number: 092019015968	
Address: Po Box 42065	City: Phoenix	State: AZ	Zip: 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

***Status**

The patient rates the pain level as 8 and 9 on a scale of 1 to 10. ROM since last visit has remained unchanged. The patient is not working. The strength is unchanged since last visit. PT has been kept on hold. Scheduled to start tomorrow

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

Back: The ROM for thoracic spine shows abnormal findings. ROM for lumbar spine reveals abnormal findings. Tender over paraspinal area bilaterally to palpation. SLR is positive bilaterally.

Lower Extremity: ROM for the right hip is abnormal. ROM for the left hip is abnormal.

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Cont medications

Consider acupuncture, refer to acupuncturist. The acupuncture will be performed in conjunction with physical therapy. CA MTUS/low back page 405: Acupuncture is recommended for use in the treatment of chronic moderate to severe low back pain as an adjunct to more efficacious treatments. Consult: Acupuncture to Kenneth Cherman,
The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults: Acupuncture

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ The patient will return to modified work on 02-27-2020, ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolonged sitting. She is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: ____ with no limitations or restrictions.

Patient's Next Appt.: 1 Week PRN 03-04-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 02-26-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 02-26-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

Reason for submitting report: Periodic Report			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury: 2/6/19
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact:	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

***Status**

The patient rates the pain level as 8 and 9 on a scale of 1 to 10. ROM since last visit has remained unchanged. The patient is not working. The strength is unchanged since last visit. PT has been kept on hold.

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

Back: *The ROM for thoracic spine shows abnormal findings. ROM for lumbar spine reveals abnormal findings.* Tender over paraspinal area bilaterally to palpation. SLR is positive bilaterally.

Lower Extremity: *ROM for the right hip is abnormal. ROM for the left hip is abnormal.*

Vitals

Rads Reviewed

DIAGNOSIS

Back disorder (M53.9), Thoracic and lumbosacral neuritis (M54.14), Bilateral hip bursitis (M70.71)

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

Cont medications

cont PT.

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

WORK STATUS

This patient has been instructed to:

Remain off-work until: __ __

Return to modified work on: __ The patient will return to modified work on 02-11-2020, __ with the following limitations or restrictions (Li

st all specific restrictions re: standing, sitting, bending, use of hands, etc.):

The patient will have the following work limitations: no prolonged standing, no prolonged walking and no prolong sitting. She is advised to restrict maximum weightlifting, pushing, pulling to 10 pounds. Maximum number of times of lifting, pushing, pulling recommended is 0-2 per hour.

Maximum bending and twisting recommended is: 0-2 times/hr.

Return to full duty on: _____ with no limitations or restrictions.

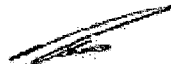
Patient's Next Appt.: 1 Week PRN 02-17-2020

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 02-10-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 02-10-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro: Movsesian, PA Sara

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Karim, Audra Female 01-18-1972

State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN PROGRESS REPORT (PR-2)

Please indicate why you are submitting a report. If patient is "Permanent and Stationary use DWC Form PR-3/IMC Form 81556.

:			
Last: Karim	First: Audra	M.I.:	Sex: female
Address: 510 S. Spring St., 705	City: Los Angeles	State: CA	Zip: 90013
	Date of Birth: 01-18-1972		
Occupation : Wardrobe dresser	SS#:	Phone :	Date of Injury:
CLAIMS ADMINISTRATOR:			
Name : Chubb Los Angeles.	Contact:	Claim Number: 092019015968	
Address : Po Box 42065	City : Phoenix	State : AZ	Zip : 85080
Phone:	FAX:	Email:	
Employer Name: Cal Ned Inc		Employer Phone:	

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

SUBJECTIVE COMPLAINTS

OBJECTIVE FINDINGS (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical examination

WC-Record review

Communication: Minutes Spent: 35 mins Documents Reviewed EDD form and medical records Reviewed the chart/consultants reports and filled out Statmnt of disab.

Vitals

Rads Reviewed

DIAGNOSIS

TREATMENT PLAN

(Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, services (e.g., physical therapy, manipulation, acupuncture).

Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Please consider this report a formal authorization request for the procedures/referrals described below.

The following medications were Dispensed.

The following medications were Prescribed.

The following studies/consultations are necessary and will be performed after 14 days from the date of this report, according to LC 4610 (g)(1):

Consults:

Karim, Audra Female 01-18-1972

WORK STATUS

This patient has been instructed to:

Remain off-work until: ____

Return to modified work on: ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

Return to full duty on: ____ with no limitations or restrictions.

Patient's Next Appt.: PRN

(Next report due no later than 30 to 45 days from date of report.)

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 02-06-2020

I declare under penalty of perjury that this is true and correct to the best of my knowledge and that I have not violated labor code # 139.3



Date: 02-06-2020

Signature

Executed at: Bell, CA 90201

Cal. Lic. # G78177

Name: Michael Bazel, MD

Address: 4001 E Florence Avenue, Bell CA 90201 - 3403

Specialty: Emergency Medicine

Next report due no later than

Phone: (323) 562-0595

Attending NP/PA/Chiro:

Supervised by: Michael Bazel, MD

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

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visionary Law Centers
8605 Santa Monica Blvd
West Hollywood, CA 90069-4109
On July 22, 2020 I served the following documents:

Re: Employee: Audra Karim
Employer: Cal Ned. Inc.



00101 0019885887

Mail Item Details

Item ID: 0000000101 0019885887

Received: 7/30/2020 12:54 AM BST

Delivered: 7/31/2020 5:11 PM BST

Arrived in Mailbox: 7/31/2020 5:11 PM BST

Carrier: USPS

Mail Class: First Class

Pages: 39

Dimensions: 11.83 x 9.23 x 0.20 in

Weight: 7.20 oz

Sender Text: