PQME DIAGNOSTIC TEST RX

Date Sent: 07/20/2021 1234 Co

PATIENT INFORMATION

Name: JOHN SMITH **DOB:** 11/05/1995 **Male:** ☒ **Female:** ☐

Date of Injury: 07/01/2018 **C.T.:**

Claim 1 #: 123456789 **Claim 2 #:**

WCAB 1 #: **WCAB 2 #:**

Address: 21550 VICTORY AVE

NORTHRIDGE CA 91324

Tel: (818) 777-7777 ☒ Land ☐ Cell ☐ Land ☒ Cell

Fax:

e-mail:

BILLING INFORMATION

Insurance Co. XYZ CO **Fax:**

Claims Examiner: JANE SMITH C.A. **Tel:** (818) 555-1245 **Ext:**

Insurance Address:. PO BOX 55555 PASADENA CA 60196

EXAM INFORMATION

Exam 1: XRAY: Left Forearm

Exam 2:

Exam 3:

Reason for Proceedure: Fx

SPECIAL INSTRUCTIONS:

STATE OF CALIFORNIA Division of Workers' Compensation Disability Evaluation Unit

DEU Use Only

EMPLOYEE'S DISABILITY QUESTIONNAIRE

07/29/2021

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

Employee

JOHN

First Name

MI

SMITH

Last Name

SSN (Numbers Only)

21550 VICTORY AVE

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

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

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

NORTHRIDGE

City

CA

State

93021-

Zip Code

Date of Birth 11/05/1995

MM/DD/YYYY

Date of Injury 1) 07/01/2018

MM/DD/YYYY

2)

MM/DD/YYYY

CONTINUOUS TRAUMA

Employer

Nature of Employers Business

Claim Number 1 123456789

Panel Number:

Claim Number 2 _____

Claim Number 3 _____

Claim Number 4 _____

Claim Number 5 _____

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:
How was your evaluating doctor selected? (check one)

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

☒ Other (explain) Selected by the insurers / attorneys representing the parties.

What is the name of the doctor who will be doing the evaluation? Robert L. Samson, MD

When is your examination scheduled? 07/29/2021

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

.

What is the disability resulting from your injury?

.

How does this injury affect you in your work?

Have you ever had a disability as a result of another injury or illness? _____

If so, when? _____

Please describe the disability?

Date 07/29/2021
MM/DD/YYYY

Signature _____

ROBERT L. SAMSON, M.D.
5375 FREMANTLE LANE
CALABASAS, CA 91302
Tel: (818) 888-1430 Fax: (818) 880-4799
e-mail: rlsors@charter.net

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

Re: JOHN SMITH
DOB: 11/05/1995

1. Authorization

I authorize _____✔_ (healthcare provider) to use and disclose the protected health information described below to _____Robert L. Samson, M.D._____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☑ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☑ I authorize the release of my complete health record with the exception of the following information:

☑ Mental health records

☑ Communicable diseases (including HIV and AIDS)

☑ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until 07/29/2022 (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

JOHN SMITH

Printed name of patient or personal representative and his or her relationship to patient

---

Date 07/29/2021

ROBERT L. SAMSON, M.D.
A MEDICAL CORPORATION
5375 FREMANTLE LANE
CALABASAS, CA 91302
TELEPHONE: (818) 888-1430
FAX: (818) 880-4799

Patient Intake Form

Welcome to the office of Robert L. Samson, M.D. Today you are here for an Orthopedic Evaluation.

This evaluation may have been scheduled by any one of the following: your attorney, and/or an insurance company or claims examiner for an insurance company.

The purpose of this evaluation is to obtain an objective opinion with regards to your current condition and to answer specific questions related to your condition, and your injury claim that were outlined by the requesting party/parties.

The evaluation is NOT meant to constitute a general medical evaluation and is NOT a substitute for your seeking any necessary care from your treating physician(s) or other health care provider.

The evaluation results are summarized in a written report which will be forwarded to the requesting party/parties.

Your help in completing the attached forms will give us information about you and your injury(ies), treatment and present health status.

The doctor will ask you about your injury(ies), treatment and present health. A physical evaluation will be performed. Any medical records received will be reviewed.

Additional information may be necessary to help in the evaluation, including x-rays and other laboratory studies.

Your evaluation is not intended or designed to cause you any harm, physical pain or discomfort. When you are being examined by the doctor you should not perform any movements beyond the limit which you feel able to physically tolerate, or which you feel could cause you ongoing physical harm or injury. However some tenderness or soreness can occur when you engage in movements which are performed during the orthopedic examination or when being examined in sensitive areas. Your description of any discomfort you experience may help the doctor better understand your condition. It is your responsibility to inform the doctor immediately if you begin to experience pain or discomfort which you believe to be excessive.

I certify that I have read this form, understand its contents, and been given my own copy.

Please sign your full name here

07/29/2021
Today's date

JOHN SMITH
Please print your name here

07/29/2021

PATIENT INFORMATION SHEET

NAME: JOHN SMITH (Last Name First, First Name & Full Middle) Birth Date: 11/05/1995 Age: 25

ADDRESS: 21550 VICTORY AVE City: NORTHRIDGE State: CA 93021- (with Zip Code)

Previous Address: City: State: (with Zip Code)

Home Phone: ( ) Marital Status: Married ☐ Single ☐ e-mail:

Claim #: Alt Phone: Widowed ☐ Divorced ☐ Sex: Male ☒ Female ☐

Soc.Sec.# Driver's License #

Patient's Employer: Position: Phone #

Employer's Address: City: State:

Spouse's Name: Soc.Sec. #

Spouse's Employer: Position: Phone #

Spouse's Employer's Address: City: State:

Family Physician: Referred by:

IN THE EVENT OF AN EMERGENCY - CONTACT: Name, address & phone of relative or friend (not spouse):

IF PATIENT IS A MINOR - PLEASE COMPLETE THE FOLLOWING INFORMATION

Father's Name: Soc.Sec #

Address: City: State:

Employer's Name: Address:

Home Phone: Bus. Phone: Driver's License:

Mother's Name: Soc.Sec. #

Address: City: State:

Employer's Name: Address:

Home Phone: Bus Phone: Driver's Licence:

MEDICAL INSURANCE INFORMATION - Required of all patients or payment is mandatory at first visit.

Blue Cross Medi-Care Group Private

Medi-Cal - Current POE required at time of service or payment will be required

Claims Examiner: (818) 555-1245 (Name of Insurance Company with Group Number and Subscriber's Name)

JANE SMITH C.A. XYZ CO PO BOX 55555 PASADENA

E-Mail: (Name of Insurance Company with Group Number and Subscriber's Name) CA 40512-

Fax:

Claim #: 123456789

Addit Claim #:

WCAB #:

Panel #:

Attorney 1 Attorney 2

Signature of Patient: (or Parent if patient is a minor) Date: 07/29/2021

Atty Tel 1: Atty Tel 2:

Atty Fax 1 Atty Fax 2:

Atty Email1: Atty Email 2:

S 1

ROBERT L. SAMSON, M.D.
5375 FREMANTLE LANE
CALABASAS, CA 91302
TELEPHONE: (818) 888-1430
FAX: (818) 880-4799

DIPLOMATE
AMERICAN BOARD OF ORTHOPAEDIC SURGERY

FELLOW
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

DATE 07/29/2021

EMPLOYER NAME _____

ADDRESS _____

NATURE OF BUSINESS_____

PATIENT NAME JOHN SMITH

SEX MALE [X] FEMALE [ ] DATE OF BIRTH 11/05/1995 AGE 25

RIGHT HANDED [X] LEFT HANDED [ ] AMBIDEXTROUS [ ]

ADDRESS_____

OCCUPATION_____DURATION OF EMPLOYMENT_____

WORK HOURS _____INJURED AT WHAT LOCATION_____-

DATE & HOUR OF INJURY OR ONSET OF SYMPTOMS 07/01/2018

DATE LAST WORKED_____DATE OF FIRST EXAM _____

DESCRIBE HOW THE ACCIDENT HAPPENED _____

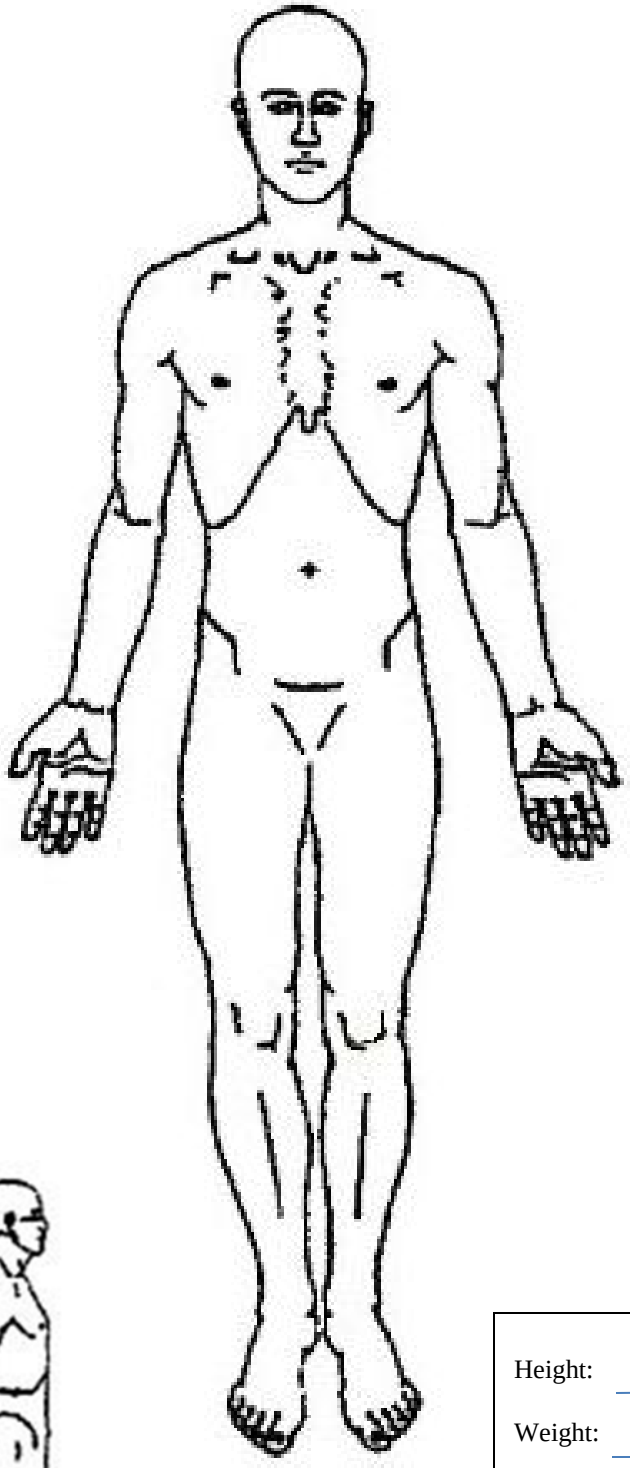
ROBERT L. SAMSON, M.D.
5375 FREMANTLE LANE
CALABASAS, CALIFORNIA 91302
TELEPHONE (818) 888-1430
FAX (818) 880-4799

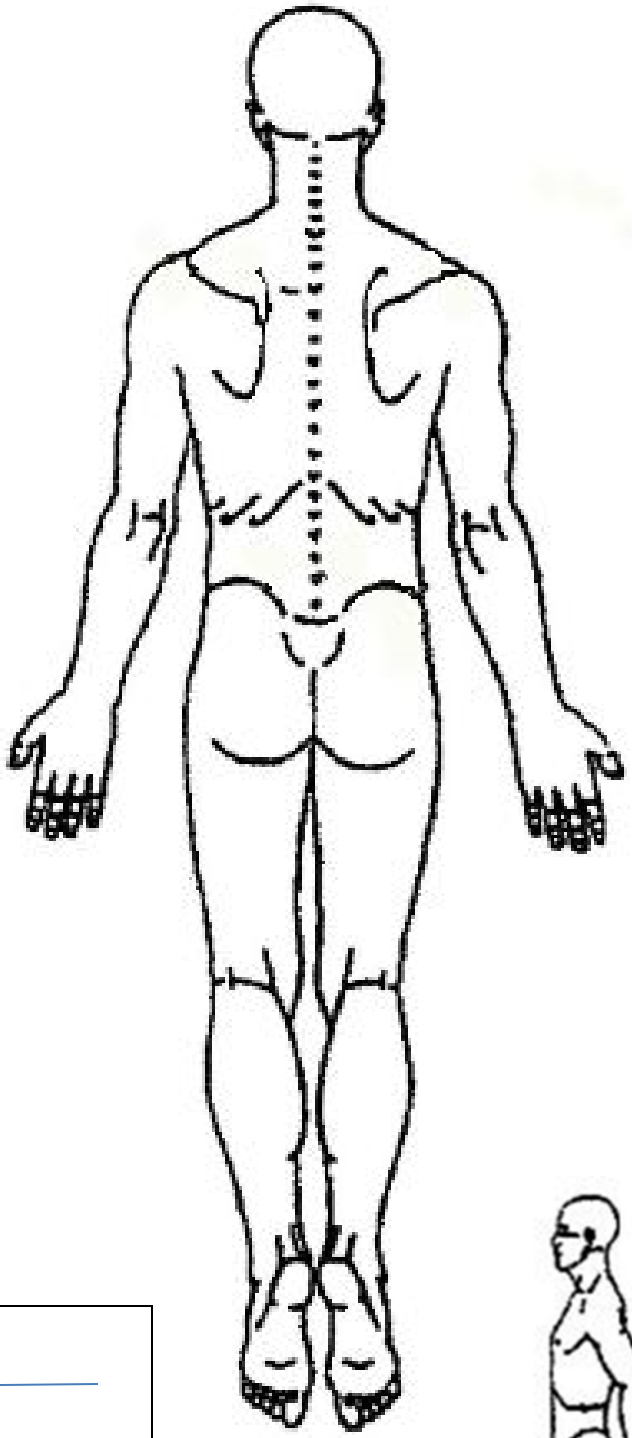
PATIENT NAME JOHN SMITH

DATE: 07/29/2021

ROBERT L. SAMSON, M.D.

Name: JOHN SMITH Date: 07/29/2021





Height: _____

Weight: _____

Symptom Key

A------Dull Ache
S-------Shooting Pain
B------Burning Pain
N------Pins & Needles
Sp-----Spasms
O------Other (Describe)

ROBERT L. SAMSON, M.D.
5375 FREMANTLE LANE
CALABASAS, CALIFORNIA 91302
TELEPHONE: (818) 888-1430

FAX: (818) 888-7430

PATIENT NAME: JOHN SMITH DATE: 07/29/2021

HAVE YOU HAD NEW INJURIES/PROBLEMS WITH SPINE, SHOULDERS, ARMS, HANDS, HIPS, KNEES, LEGS OR FEET/TOES SINCE LAST SEEN?
IF YES, DESCRIBE.

PRIOR WORK INJURIES:	BODY PART/S INJURED	TIME OFF WORK	LENGTH OF TREATMENT	RETURNED TO SAME JOB
YEAR				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
PRIOR NON WORK INJURIES:	**BODY PART/S INJURED**	**TIME OFF WORK**	**LENGTH OF TREATMENT**	**RETURNED TO SAME JOB**
YEAR				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

DO YOU HAVE A HISTORY OF: DIABETES, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, BLOOD DISEASES, INFECTIONS/TB ? YES ☐ NO ☐

PROBLEMS WITH YOUR HEART, LUNGS., INTESTINES, KIDNEYS, GLANDS, NERVES? YES ☐ NO ☐

WHAT OPERATIONS HAVE YOU HAD IN THE SINCE LAST SEEN?.

LIST YOUR CURRENT MEDICATIONS.

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TABLE 18-4 (PAGE 576)

Name: JOHN SMITH Date: 07/29/2021

I. Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain — Excruciating following any activity

Sum score of Section I: A–D = Total pain severity/4 = _____ Do Not Total

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Rarely — All of the time

Add total pain severity score (items A–D/4) to score for item E = _____ Do Not Total

Total pain severity score (range from 0 to 20) = _____ Do Not Total

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to shower or bathe without help

JOHN SMITH 07/29/2021

M. How much does your pain interfere with your ability to **write or type?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to **concentrate**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

Sum score of Section II:
A-P = Total score for activity limitation/16 =
Mean activity limitation = _____
Do Not Total

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week. (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse**?

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

Sum score of Section III:
A-E = Total pain impairment attributed to mood state/5 =
Mean score = _____
Do Not Total

Table 18 - 6 (page 584)

Worksheet for Calculating Total Pain Related Impairment Score

1. Sum scores section I. of Table 18-4, items A-D/4 + E _____
   Range 0 – 20

2. Sum scores section II. of Table 18-4, items (A-P/16) x 3 _____
   Range 0 - 30

3. Sum scores section III. of Table 18-4, items A-E/5 + E _____
   Range 0 – 10

4. Global pain behavior rating from Table 18-5 (page 580) _____
   Range -10 +10 *** see below**

Subtotal steps 1 through 4 (maximum = 70) _____

5. Physician adjustment based upon clinical judgement _____
   of individuals credibility
   Range – 10 to + 10

6. **Total pain-related impairment score** = total of steps _____
   1 through 5

*** Table 18 - 5 (page 580)** **Observable Pain Behaviors:**

1. Facial Grimacing
2. Holding or supporting affected body part or area
3. Limping or distorted gait
4. Frequent shifting of posture or position
5. Extremely slow movements
6. Sitting in rigid position
7. Moving in guarded or protective fashion
8. Moaning
9. Using a cane, cervical collar or other device
10. Stooping while walking
11. Other:

_____

Table 18 - 7 (page 584)

Determining Impairment Class on the basis of Total Pain-Related Impairment Score

Total Pain-Related Impairment Score	Impairment Class
0 - 06	**No significant impairment**
07 - 24	**Mild impairment**
25 - 42	**Moderate impairment**
43 - 60	**Moderate Severe impairment**
61 - 80	**Severe impairment**

ROBERT L. SAMSON, M.D.
5375 FREMANTLE LANEAD, # 982
CALABASAS, CALIFORNIA 91302
TELEPHONE (818) 888-1430
FAX (818) 880-4799

PATIENT NAME JOHN SMITH DATE 07/29/2021

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times.
Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

	Situation	**Chance of dozing**
1	Sitting and reading	
2	Watching TV	
3	Sitting, inactive in a public place (e.g. a theatre or a meeting)	
4	As a passenger in a car for an hour without a break	
5	Lying down to rest in the afternoon when circumstances permit	
6	Sitting and talking to someone	
7	Sitting quietly after a lunch without alcohol	
8	In a car, while stopped for a few minutes in the traffic	
	Total	

Score:
0-10 Normal range
10-12 Borderline
12-24 Abnormal

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PATIENT NAME: JOHN SMITH DATE: 07/29/2021

Iowa Fatigue Scale (IFS)

Please circle the number of the response that best indicates how you have felt in the past month.

	Not at all	A Little	Moderately	Quite a bit	Extremely
1. I feel worn out	1	2	3	4	5
2. I feel energetic	1	2	3	4	5
3. I feel slowed down in my thinking	1	2	3	4	5
4. I do quite a lot within a day	1	2	3	4	5
5. I have trouble concentrating	1	2	3	4	5
6. I feel drowsy	1	2	3	4	5
7. Physically I feel in good shape	1	2	3	4	5
8. I have low output	1	2	3	4	5
9. I have trouble with my memory	1	2	3	4	5
10. I feel rested	1	2	3	4	5
11. I can concentrate well.	1	2	3	4	5

Total

Scoring

Total = Q1 + (6-Q2) + Q3 + (6-Q4) + Q5 + Q6 + (6-Q7) + Q8 + Q9 + (6-Q10) + (6-Q11) [ ]

Fatigue Cut-offs for Total Score

Fatigue = 30 – 39
Severe fatigue = 40 - 55

Subscales

Cognitive = Q3 + Q5 + Q9 + (6-Q11) [ ]
Fatigue = Q1 + Q6 [ ]
Energy = (6-Q2) + (6-Q7) + (6-Q10) [ ]
Productivity = (6-Q4) + Q8 [ ]

Tab. 17-34 (548) Tot Hip Rep				Tab. 17-35 (549) Tot Knee Rep	
Diff cm	# of Points	Diff cm	# of Points	Diff cm	# of Points
a. Pain		**d. Deformity**		**a. Pain**	
None	44	Fix ADD		None	50
Slight	40	<10º	1	Mild, Occ	45
Moderate, Occ	30	≥10º	0	Stairs only	40
Moderate	20	Fix Int Rot		Walk & Stairs	30
Severe	10	<10º	1	Moderate	
b. Function		≥10º	0	Occas	20
Limp		Fix Ext Rot		Contin	10
None	11	<10º	1		
Slight	8	≥10º	0	Severe	0
Moderate	5	Fix Contract		**b. ROM**	
Severe	0	<15º	1	Add 1 pt ea 5º	25
Supp Device		≥15º	0	**c. Stability**	
None	11	Leg Len Disc		(max mov any posit)	
Cane, long wlks	7	<1.5 cm	1	AP	
Cane	5	≥1.5 cm	0	<5mm	10
1 Crutch	3	**e. ROM**		5-9mm	5
2 Canes	2	Flex		>9mm	0
2 Crutches	0	>90º	1	Medio-Lat	
Dist Walked		≤90º	0	5º	15
Unlim	11	ABD		6º-9º	10
6 Blks	8	>15º	1	10º-14º	5
3 Blks	5	≤15º	0	≥15º	0
Indoors	2	ADD			
In Bed/Chr	0	>15º	1	**SubTotal**	
c. Activities		≤15º	0	**Deduct d,e f**	
Stairs		Ext Rot		**d. Flex Contract**	
Normal	4	>30º	1	5º-9º	2
Use Rail	2	≤30º	0	10º-14º	5
Clm w dif	1	Int Rot		16º-20º	10
Cannot Clm	0	>15º	1	≥20º	20
Shoes/Socks		≤15º	0	**e. Ext Lag**	
Ease	4	**Table 17-33 (**page 5546547)	WP (LE) IMP	<10º	5
Diff cm	2	**THR**		10º-20º	10
Unable	0	Good Result: 85 - 100 pts	15 (37)	>20º	15
Sitting		Fair Result: 50 - 84 pts	20 (50)	**f. Alignmant**	
Any Chr, 1hr	4	Poor Result: < 50 pts	30 (75)	0º-4º	0
High Chr	2	**TKR**		5º-10º	3 pts/º
Unable	0	Good Result 85 - 100 pts	15 (37)	11º-15º	3 pts/º
Pub Transp		Fair Result: 50 - 84 pts	20 (50)	>15º	20
Able	1				
Unable	0	Poor Result: < 50 pts	30 (75)	**SubTotal deduct**	

Robert L. Samson, M.D.
5375 Fremantle Lane, Calabasas, CA 91302
Rev: 9.14 curr

EXAMINATION NOTES

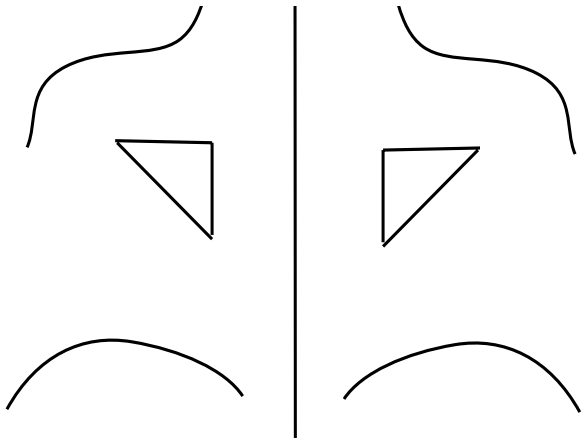
Patient Name: JOHN SMITH Exam Date: 07/29/2021

Grip Measurements (Pounds – Force)
R_____ /_____ / _____
L_____ /_____ / _____

	Comp	Dist
	_____	_____

UE Measurements	RIGHT	LEFT
Biceps	_____ cm.	_____ cm.
Forearms	_____ cm.	_____ cm.

LE Measurements	RIGHT	LEFT
Thighs	_____ cm.	_____ cm.
Knees	_____ cm.	_____ cm.
Calves	_____ cm.	_____ cm.



	Right	Left
Adson's	_____	_____
Tinel's	_____	_____
Phalen's	_____	_____
Finkelstein's	_____	_____

SLR	Right	Left
Seated	_____	_____
Supine		
SLR	_____	_____
Lesegue	_____	_____
Faber	_____	_____

Shoulders

ROM: F _____ / _____	>180º
Ab_____ / _____	>170º
E_____ / _____	>50º
ER_____ / _____	>60º
IR_____ / _____	>80º
Ad_____ / _____	>40º

	R	L
Neer:	_____	_____
Hawkins:	_____	_____
X-Over:	_____	_____

ELBOW	R	L
Flex:	_____	_____
Ext:	_____	_____
Pron:	_____	_____
Sup:	_____	_____
Flex/Pron	_____	_____
Supin/Ext	_____	_____

	R	L
Widest:	_____	_____
2nd:	_____	_____
3rd:	_____	_____
4th:	_____	_____
Narrow:	_____	_____

_____
_____
_____
_____

Gait:	Rt	Lt
Heel:		
Toe:		
Squat:		

2 Pt Discr:	Rt	Lt
	_____	_____

_____
_____
_____

Waddell's Signs of non-organic spinal pain
(3 out of 5 significant)

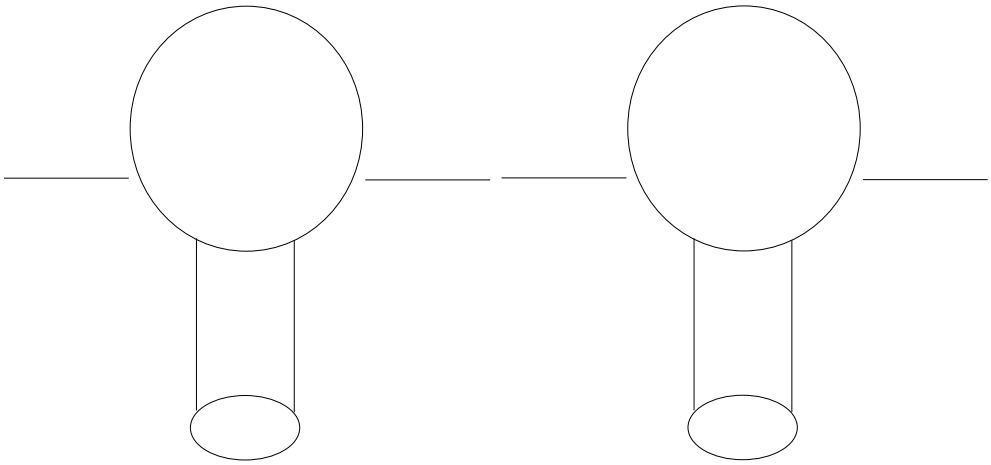
1. Light Pressure on Top of Head → LBP. Present [ ] Absent [ ]
2. Superficial Pinching of Lumbar Skin → LBP. Present [ ] Absent [ ]
3. Simulated Axial Rotation → LBP Present [ ] Absent [ ]
4. Non-Anatomic Sensory Abnormalities Present [ ] Absent [ ]
5. Inconsistent SLR (Sittng vs. Supine) Present [ ] Absent [ ]

JOHN SMITH

ROBERT L. SAMSON, M.D.

07/29/2021

Rev: 9.14 curr



	R	L	
Effusion:			
Synovitis:			
Flex			
Ext			
Laxity:			
Med			
Lat			
Ant			
Post			
PF Crep			
PF Grind			
Appr			
Slocum			
McMurr			
Apley			

Ankle:

Flex			**< 20º**
Ext			**< 10º**
Inv			**<20º**
Ever			**<10º**

Finger PIP:

Flex:			**>90º**
Ext:			**>10º**

Finger DIP:

Flex:			**>60º**
Ext:			**>10º**

Wrist:

Flex:			**< 50º**
Ext:			**< 50º**
Rad Dev:			**< 15º**
Uln Dev:			**< 25º**

Thumb CMC:

Abd:			**> 40º**
Add:			**≥ 8cm**
Opp:			**≥ 8cm**

Thumb MP:

Flex:			**> 50º**
Ext:			**> 0º**

Thumb IP:

Flex:			**>70º**
Ext:			**>0º**

Finger MP:

Flex:			**>90º**
Ext:			**>10º**

Hip:

Flex			**<100 º**
Ext			**>-09 º**
Int Rot			**<21 º**
Ext Rot			**<31 º**
Abd			**<26 º**
Add			**<16 º**
Abd Cont			**<-06 º**

Inclinometer Cervical ROM

Flexion:		**>50º**
Extension:		**>60º**

	R	L	
Tilt:			**>45º**
Rotation:			**>80º**

Inclinometer Thoracic ROM

Flexion:		**> 60º**
Rotation:		**> 30º**

Inclinometer Lumbar ROM

Flexion:		**>45º** **>60º**
Extension:		**>25º**

	R	L	
Tilt:			**>25º**

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

JANE SMITH C.A.
XYZ CO
PO BOX 55555
PASADENA CA 40512-

CARRIER

PICA Claim #: 123456789 PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JOHN SMITH	3. PATIENT'S BIRTH DATE MM DD YY: 11/05/1995 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): XYZ CO	
5. PATIENT'S ADDRESS (No., Street): 21550 VICTORY AVE	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): PO BOX 55555	
CITY: NORTHRIDGE STATE: CA	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY: PASADENA STATE: CA	
ZIP CODE: 93021- TELEPHONE (Include Area Code): ( )	
ZIP CODE: 40512- TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial): WCAB #:	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: Panel #:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: Addit Claim #:	a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [ ] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes,* return to and complete item 9 a-d.	

TIME LOG ATTACHED.
PQME Exam Requested by
Applicant & Defense Attornies
0.00 HOURS 0 UNITS

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 07/01/2018	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07/29/2021	11		ML104			$ 0.00	0		NPI	1407999170
2 07/29/2021	11		99080			$ 0.00	00		NPI	1407999170
3						$ 0.00	00		NPI	1407999170
4 This Company Does NOT have a Merchant Terminal and Can Not Accept VPayments										
5 **Please Issue a Paper Check**									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
95-3524134 [ ] [X]		[ ] YES [X] NO	$ 0.00	$ 0.00	$ 0.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
Robert L. Samson, M.D. SIGNED Robert L. Samson DATE 01/28/18	CA License #: A24781 NPI #: 1407999170 a. 1407999170 b.	(818)888-1430 Robert L. Samson, M.D. 5375 Fremantle Lane Calabasas, CA 91302 a. 1407999170 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD
FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

DIAGNOSTIC TEST RX

Date Sent: 07/20/2021 | 1234 Co

PATIENT INFORMATION

Name: JOHN SMITH **DOB:** 11/05/1995 **Male:** **Female:**

Date of Injury: 07/01/2018 **C.T.:**

Claim 1 #: 123456789 **Claim 2 #:**

WCAB 1 #: **WCAB 2 #:**

Address: 21550 VICTORY AVE

NORTHRIDGE CA 93021-

Tel:

Fax:

e-mail:

BILLING INFORMATION

Insurance Co. XYZ CO

Claims Examiner: JANE SMITH C.A. **Tel:** (818) 555-1245 **Ext:**

Insurance Address:. PO BOX 55555 PASADENA CA 40512-

EXAM INFORMATION

Exam 1. XRAY: Left Forearm

Exam 2.

Exam 3.

Reason for Proceedure: Fx

SPECIAL INSTRUCTIONS:

PATIENT INFORMATION

Claim Number

Patient's Name: JOHN SMITH **123456789**

Home Phone:

Appointment Date: _____ Time: _____

DOI: 07/01/2018

DOB: 11/05/1995 ☒ Male ☐ Female

Date Sent: 07/20/2021

Insurance Company: XYZ CO Phone: (818) 555-1245

Claims Examiner: JANE SMITH C.A. Ext:

PHYSICIAN INFORMATION

Referring Physician: Robert L. Samson, M.D.

E-Mail: rlsors@charter.net

Referring Physician Office Phone No: (818) 888-1430

WCAB #:

EXAM INFORMATION

Exam: _____

_____

History: _____

Reason for Procedure: _____

_____

_____

Special Instructions: _____

Please Refer to Renaissance Imaging

Do you require a stat call report? ☐ Yes ☐ No

☐ Phone STAT Report to: _____

☑ Fax Report to: (818) 880-4799

☑ Images on CD: **5375 Fremantle Lane, Calabasas, CA 91302**

☐ Copy to: _____

Robert L. Samson

State of California
Division of Workers' Compensation-Medical Unit
QME Appointment Notification Form

Please complete this form in its entirety. *The Administrative Director requires that you serve this appointment notification form on the employee and the claims administrator, or, if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical-legal evaluation. You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34, 41(a) (7) and (a)*

Employee Information *(Completion of this section is required)*

JOHN SMITH
Employee Name

Phone Number

21550 VICTORY AVE | **NORTHRIDGE** | **CA** | **93021-**
Employee Street Address | Employee City | State | Zip Code

C.T. Period | 07/01/2018 Date of Injury | Panel Number | 123456789 Claim or Case Number

Employer Information

Employer Name

Employer Street Address | Employer City | State | Zip Code

Claims Administrator Information *(Completion of this section is required)*

JANE SMITH C.A.
Claims Administrator Name (Insert the name of the person handling the claim)

(818) 555-1245 Phone Number | Ext.

XYZ CO
Claims Administrator Company (Insert the name of the company handling the claim)

PO BOX 55555 | PASADENA | CA | 40512-
Claims Administrator Street Address | Claims Administrator City | State | Zip Code

Exam Location

Appointment Information *(Completion of this section is required)*

Date of appointment call: | Date of Appointment: **07/29/2021** | Time of appointment:

696 HAMPSHIRE ROAD, STE 200 | **WESTLAKE VILLAGE** | **91361** | **2 HOURS**
Examination address | Examination City: | Zip Code | Duration

Records should be sent to the following address: **5375 Fremantle Lane** | **Calabasas** | **91302**
Send Records to this address: Street address or P.O. Box | City: | Zip Code

Is a certified interpreter required? Yes ☐ No ☐ If an interpreter is required, indicate language:

QME Name: Robert L. Samson, M.D. Parking: No Parking Charge

Cancellation/No Show Policy: $450.00 with notice of less than 2 business days.

5375 Fremantle Lane: For Records, Not for Exam | Calabasas | CA | 91302
QME Street Address | QME City | State | Zip Code

Date Signed: 12/28/2017 Signature of the QME: Robert L. Samson

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. §§ 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

On_____, I served this QME Appointment Notification Form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by: **OR by Fax:**

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

FAX
Method of Service

Person or firm served | Street Address or Fax Number

City | State | Zip Code

FAX
Method of Service

Person or firm served | Street Address or Fax Number

City | State | Zip Code

FAX
Method of Service

Person or firm served | Street Address or Fax Number

City | State | Zip Code

MAIL
Method of Service

JOHN SMITH (Person or firm served) | **21550 VICTORY AVE** (Street Address or Fax Number)

NORTHRIDGE (City) | **CA** (State) | **93021-** (Zip Code:)

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

Date: _____ at CALABASAS, California.

Type or print name ANNA SAMSON

Signature Anna M Samson

State of California
Division of Workers' Compensation-Medical Unit
QME Appointment Notification Form

Please complete this form in its entirety. *The Administrative Director requires that you serve this appointment notification form on the employee and the claims administrator, or, if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical-legal evaluation. You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34, 41(a) (7) and (a)*

Employee Information *(Completion of this section is required)*

JOHN SMITH
Employee Name

Phone Number

21550 VICTORY AVE Employee Street Address | **NORTHRIDGE** Employee City | **CA** State | **93021-** Zip Code

C.T. Period | 07/01/2018 Date of Injury | Panel Number | 123456789 Claim or Case Number

Employer Information

Employer Name

Employer Street Address | Employer City | State | Zip Code

Claims Administrator Information *(Completion of this section is required)*

JANE SMITH C.A.
Claims Administrator Name (Insert the name of the person handling the claim)

(818) 555-1245 Phone Number | Ext.

XYZ CO
Claims Administrator Company (Insert the name of the company handling the claim)

PO BOX 55555 Claims Administrator Street Address | PASADENA Claims Administrator City | CA State | 40512- Zip Code

Exam Location

Appointment Information *(Completion of this section is required)*

Date of appointment call: | Date of Appointment: **07/29/2021** | Time of appointment:

18350 ROSCOE BLVD., STE 318 Examination address | **NORTHRIDGE** Examination City: | **91325** Zip Code | **2 HOURS** Duration

Records should be sent to the following address: **5375 Fremantle Lane** Street address or P.O. Box | **Calabasas** City: | **91302** Zip Code

Send Records to this address:

Is a certified interpreter required? Yes ☐ No ☐ If an interpreter is required, indicate language:

QME Name: Robert L. Samson, M.D. Parking: $4.00 with stamped ticket

Cancellation/No Show Policy: $450.00 with notice of less than 2 business days.

5375 Fremantle Lane: For Records, Not for Exam QME Street Address | Calabasas QME City | CA State | 91302 Zip Code

Date Signed: 12/28/2017 Signature of the QME: Robert L. Samson

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. §§ 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

On_____, I served this QME Appointment Notification Form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by: **OR by Fax:**

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

FAX
Method of Service

Person or firm served | Street Address or Fax Number

City | State | Zip Code

FAX
Method of Service

Person or firm served | Street Address or Fax Number

City | State | Zip Code

FAX
Method of Service

Person or firm served | Street Address or Fax Number

City | State | Zip Code

MAIL
Method of Service

JOHN SMITH (Person or firm served) | **21550 VICTORY AVE** (Street Address or Fax Number)

NORTHRIDGE (City) | **CA** (State) | **93021-** (Zip Code:)

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

Date: _____ at CALABASAS, California.

Type or print name ANNA SAMSON

Signature Anna M Samson

Quest Diagnostics

90054243-5 8786123-3

ROBERT SAMSON, M.D.
ACCOUNT #:
NAME: 5375 FREMANTLE LN
ADDRESS:
CITY, STATE, ZIP: CALABASAS, CA 91302-3113
TELEPHONE #: 818-888-1430 Fax: 818-880-4799

BILL TO:
- ☐ MY ACCOUNT
- ☐ PATIENT
- ☐ MEDICARE
- ☐ RAILROAD MEDICARE
- ☐ Medi-Cal
- ☐ Lab Card/Select
- ☒ OTHER INSURANCE

PRINT PATIENT NAME (LAST, FIRST, MIDDLE): JOHN SMITH

PATIENT ID / REGISTRATION #: 123456789

DATE OF BIRTH (M M D D YEAR): 11/05/1995

SEX:

ROOM #:

LAB REFERENCE #:

PATIENT SOCIAL SECURITY #: - -

PATIENT PHONE #: ( )

PATIENT STREET ADDRESS: 21550 VICTORY AVE

APT. # KEY #:

CITY: NORTHRIDGE STATE: CA ZIP: 93021-

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT: XYZ CO

INSURED ADDRESS: PO BOX 55555

CITY: PASADENA STATE: CA ZIP: 40512-

DID YOU KNOW

Patient Service Center location and appointment scheduling information is on the back.

Each sample should be labeled with at least two patient identifiers at time of collection.

DATE COLLECTED | TIME ☐ AM ☐ PM | TOTAL VOL/HRS. ____ ML ____ HR | ☐ Fasting ☐ Non Fasting

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)

( ) 1407999170 SAMSON,ROBERT L

Worker's Comp Claim #: 123456789

Claims Examiner: JANE SMITH C.A. **Tel #:** (818) 555-1245

Lab : **Lab Fax:**

Date Sent: 07/20/2021 **Lab Tel:**

PRIMARY INSURANCE

RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ DEPENDENT: WORKER'S COMP PATIENT

INSURANCE COMPANY NAME / IPA NAME: XYZ CO

INSURANCE COMPANY ADDRESS: PO BOX 55555 CITY: PASADENA ST: CA ZIP: 40512-

INSURANCE ID #: 123456789

GROUP # / DATE OF INJURY: 07/01/2018

MEDICARE #:

MEDI-CAL #:

EMPLOYER NAME / EMPLOYER #:

☐ ADDIT'L PHYS.: Dr. NPI/UPIN

NON-PHYSICIAN PROVIDER: NAME I.D.#

☐ Fax Results to: ( )

Send Duplicate Report to: Client # OR NAME: ADDRESS: CITY: STATE ZIP

Medicare Limited Coverage Tests
@ = May not be covered for the reported diagnosis.
F = Has prescribed frequency rules for coverage.
& = A test or service performed with research/experimental kit.
B = Has both diagnosis and frequency-related coverage limitations.

Provide signed ABN when necessary

ICD Codes (enter all that apply)

PANEL COMPONENTS ON BACK

ORGAN / DISEASE PANELS

34392	☐ Electrolyte Panel	S
10256	☐ Hepatic Function Panel	S
10165	☐ Basic Metabolic Panel w/eGFR	S
10231	☐ Comp Metabolic Panel w/eGFR	S
B 7600	☐ Lipid Panel (Fasting Specimen)	S
B 14852	☐ Lipid Panel w/Reflex D-LDL	S
@ 20210	☐ Obstetric Panel w/Reflex	Y,L,S
@ 10306	☐ Hepatitis Panel, Acute w/Reflex	S
10314	☐ Renal Functional Panel w/eGFR	S

HEMATOLOGY

@ 510	☐ Hemoglobin	L
@ 509	☐ Hematocrit	L
@ 1759	☐ CBC (Hgb, Hct, RBC, WBC, Plt)	L
@ 6399	☒ CBC w/Diff (Hgb, Hct, RBC, WBC, Plt, Diff)	L
B 8847	☐ PT with INR	B
@ 763	☐ PTT, activated	B

OTHER TESTS

7788	☐ ABO Group & Rh Type	Y
@ 237	☐ AFP Tumor Marker	S
223	☐ Albumin	S
234	☐ Alkaline Phosphatase	S
823	☐ ALT	S
243	☐ Amylase	S
249	☒ ANA w/Reflex Titer	S
795	☐ Antibody Scr, RBC w/Reflex ID	Y
822	☐ AST	S
285	☐ Bilirubin, Direct	S
287	☐ Bilirubin, Total	S
4420	☒ C-Reactive Protein CRP	S
@ 29493	☐ CA 27.29	S
@ 29256	☐ CA 125	S
303	☐ Calcium	S
11173	☒ CCP Ab IgG	S
B 978	☐ CEA	S
B 334	☐ Cholesterol, Total	S
374	☐ CK, Total	S
375	☐ Creatinine w/eGFR	S
402	☐ DHEA Sulfate, Immunoassay	S
B 8293	☐ Direct LDL Cholesterol	S
4021	☐ Estradiol	S
@ 457	☐ Ferritin	S
466	☐ Folic Acid	S
470	☐ FSH	S
B 482	☐ GGT	S
8477	☐ Glucose, Gestational Screen (50g), 135 cutoff	GY
19833	☐ Glucose, Gestational Screen (50g), 140 cutoff	GY
B 484	☐ Glucose, Plasma	GY
B 483	☐ Glucose, Serum	S
8435	☐ hCG, Serum, Qual	S
B 8396	☐ hCG, Serum, Quant	S
B 496	☐ Hemoglobin A1c	L
B 16802	☐ Hemoglobin A1c w/eAg	L
499	☐ Hep B Surface Ab Qual	S
498	☐ Hep B Surface Ag w/Reflex Confirm	S
8472	☐ Hep C Virus Ab	S
B 19728	☐ HIV-1/HIV-2 Scr w/Reflexes	S
31789	☐ Homocysteine, Cardiovascular	S
10124	☐ hs CRP	S
561	☐ Insulin	S
549	☐ Immunofixation (IFE)	S
@ 7573	☐ Iron (Total), IBC, % Sat	S
@ 571	☐ Iron, Total	S
593	☐ LDH	S
599	☐ Lead (B)	TN
615	☐ LH	S
606	☐ Lipase	S
6646	☐ Lyme Disease Ab w/Reflex to Blot (IgG, IgM)	S
622	☐ Magnesium	S
6517	☐ Microalbumin, Random Urine w/Creat	
B 11290	☐ Occult Blood, Feces - FIT InSure®1	
718	☐ Phosphorus	S
733	☐ Potassium	S
745	☐ Progesterone	S
746	☐ Prolactin	S
B 5363	☐ PSA, Total	S
793	☐ Reticulocyte Count, Automated	L
4418	☒ Rheumatoid Factor	S
799	☐ RPR (Monitoring) w/Reflex Titer	S
36126	☐ RPR (DX) w/Reflex Confirm	S
802	☐ Rubella IgG	S
809	☒ Sed Rate by Mod West	L
15983	☐ Testosterone, Total, LC/MS/MS	SR
873	☐ Testosterone, Total, Male	SR
5081	☐ Thyroid Peroxidase Antibodies (TPO)	S
B 896	☐ Triglycerides	S
B 899	☐ TSH	S
B 36127	☐ TSH w/Reflex T4, Free	S
34429	☐ T3, Free	S
859	☐ T3, Total	S
B 861	☐ T3 Uptake	S
B 867	☐ T4 (Thyroxine), Total	S
B 866	☐ T4 (Thyroxine), Free	S
6448	☐ UA, Dipstick Only	U
7909	☐ UA, Dipstick w/Reflex Microscopic	U
5463	☐ UA, Complete (Dipstick & Microscopic)	U
@ 3020	☐ UA, Complete, w/Reflex Culture	1
294	☐ Urea Nitrogen (BUN)	S
905	☐ Uric Acid	S
916	☐ Valproic Acid	SR
4439	☐ Varicella-Zoster Virus Ab (IgG)	S
7065	☐ Vitamin B12/Folic Acid	S
927	☐ Vitamin B12	S
17306	☐ Vitamin D (QuestAssureD™ /25-OH) LC/MS/MS	SR
91935	☐ Vitamin D (QuestAssureD™ for Infants) 25-Hydroxyvitamin D, LC/MS/MS (≤ 2 yrs)	SR

MICROBIOLOGY

Source (Required)

4550	☐ Culture, Aerobic Bacteria*	
4446	☐ Culture, Aerobic & Anaerobic*	
4485	☐ Culture, Group A Strep*	
5617	☐ Culture, Group B Strep*	
4558	☐ Culture, Genital*	
394	☐ Culture, Throat*	
@ 395	☐ Culture, Urine, Routine* (Inc. Indwelling Cath.)	

Amplified Specimen Type (Aptima)
☐ Endocervical ☐ Urethral ☐ Urine

11363	☐ Chlamydia & N. gonorrhoeae RNA, TMA	

Stool Pathogens (Campy, Salm/Shigella, Shiga toxins w/Reflex)*

10108	☐ Culture, Stool,	
34838	☐ *H. pylori* Ag, EIA Stool	
14839	☐ *H. pylori* Urea Breath Test	HB
681	☐ O & P w/Permanent Stain	

* Additional charge for ID and Susceptibilities

ADDITIONAL TESTS: (INCLUDE COMPLETE TEST NAME AND ORDER CODE) **Reflex tests are performed at an additional charge.**

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COMMENTS, CLINICAL INFORMATION:

TOTAL TESTS ORDERED

Physician Signature: Robert L. Samson

For any patient of any payor (including Medicare and Medicaid), only order those tests which are medically necessary for the diagnosis and treatment of the patient.

PEELED

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NAME:
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Physician's Return-to-Work & Voucher Report

For injuries occurring on or after January 1, 2013

☒ The Employee is P&S from all conditions and the injury has caused permanent partial disability

Employee Last Name	Employee First Name	MI	Date of Injury
SMITH	JOHN		07/01/2018

Claims Administrator:	Claims Representative
XYZ CO	**JANE SMITH C.A.**

Employer name:	Employer Street Address:

Employer City:	State	Zip Code	Claim No.
			123456789

☐ The Employee can return to regular work

☐ The Employee can work with restrictions:

⊙ **See Other Restrictions below**

	1-2 hours	2-4 hours	4-6 hours	6-8 hours	None
Stand	☐	☐	☐	☐	☒
Walk	☐	☐	☐	☐	☒
Sit	☐	☐	☐	☐	☒
Bend	☐	☐	☐	☐	☒
Squat	☐	☐	☐	☐	☒
Climb	☐	☐	☐	☐	☒
Twist	☐	☐	☐	☐	☒
Reach	☐	☐	☐	☐	☒
Crawl	☐	☐	☐	☐	☒
Drive	☐	☐	☐	☐	☒
Reach	☐	☐	☐	☐	☒
None R/L/Bilat Hand(s) (circle): Grasp	☐	☐	☐	☐	☒
None R/L/Bilat Hand(s) (circle): Push/Pull	☐	☐	☐	☐	☒

Lift/Carry Restrictions: May not lift/carry at a height of _____ more than _____ lbs. for more than _____ hours per day.

Other Restrictions:

If a Job Description has been provided, please complete: Job Description provided of: ☐ *Regular* ☐ *Modified* ☐ *Alternative Work*

Job Title: _____ *Work Location* _____

Are the Work Duties compatible with the activity restrictions set forth in the provided job description? ☐ *Yes* ☐ *No, explain below*

Physician's Name	Robert L. Samson, M.D.	Role of Doctor (PTP, QME, AME)	PQME
Physician's Signature	Robert L. Samson	Date	

DWC AD Form 10133.36 (Effective 1/13)

State of California
Division of Workers' Compensation-Medical Unit
QME/AME Report Time Frame Extension Request

File this form with the Division of Workers' Compensation-Medical Unit 5 days before your report is due to be served on the parties and send a copy of this form to the employee and claims administrator.The QME may not be entitled to payment for evaluations which are not submitted in a timely manner. (Labor Code § 4062.5.) Review 8 Cal. Code Regs. § 38(i) regarding extension of time for supplemental report. If you need further information, please call us at (510) 286-3700 or 1-800-794-6900. Legibly Print or Type the information requested in this form.You may fax this request, along with the completed proof of service, to (510) 622-3467.

Completion of this section is required

Date of Physical Evaluation (*Required*): 07/29/2021 Date Report will be served (*Required*): _____

☑ Request for 30 day extension. *Indicate the reason for the request below :*

☑ Lab or test results not received. Type of Test: X-Rays, Neurodiagnostic Testing

☐ Report of consulting physician not received. Specialist Type: _____

☐ Request for 15 day extension. *Indicate the reason for the request below:*

☐ Medical emergency of the evaluator or evaluator family member.
☐ Death in evaluator's family.
☐ Natural disaster/other community catastrophe interrupted office.

Completion of this section is required

Employee's Name JOHN SMITH Date of Injury 07/01/2018

Claims Administrator **JANE SMITH C.A.** Claim No. 123456789 Panel No. _____

QME Name Robert L. Samson, M.D. CA Lic. No. A-24781

Date Signed 12/28/2017 QME Signature Robert L. Samson

5375 Fremantle Lane	Calabasas	CA	91302
QME Street Address	QME City	QME State	QME Zip Code

Telephone Number 818-888-1430 Fax Number 818-880-4799

FOR DWC USE ONLY

( ) Extension approved ( ) Extension denied and notice mailed to evaluator and parties

Medical Director: _____ Date _____

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

On 12/28/2017, I served this QME/AME Report Time Frame Extension Request with the original, or a true and correct copy, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by: FAX

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

FAX — Method of Service
DWC-Med Unit — Person or firm served
Street Address
(510) 622-3467 — City
State
Zip Code

Method of Service — Person or firm served — Street Address
City — State — Zip Code

Method of Service — Person or firm served — Street Address
City — State — Zip Code

Method of Service — Person or firm served — Street Address
City — State — Zip Code

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

Date: 12/28/2017 at Calabasas, California.

Type or print name Robert L Samson, MD / Anna Samson

Signature Anna M Samson