

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF GUAM

LUCKY PHYLLA

Plaintiff

vs.

MICHAEL ASTRUE  
COMMISSIONER OF  
SOCIAL SECURITY

Defendant

CIVIL ACTION NO. 1:10-CV-12345

**CERTIFICATION**

The undersigned, as Chief, Court Case Preparation and Review Branch 4, Office of Appellate Operations, Office of Disability Adjudication and Review, Social Security Administration, hereby certifies that the documents annexed hereto constitute a full and accurate transcript of the entire record of proceedings relating to this case.



PATRICK J. HERBST

Date: May 11, 2010

## Court Transcript Index

Civil Action Number: 1:10-CV-12345

Claimant: Lucky Phylla

Account Number: 987-56-4321

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DATE: May 11, 2010

The documents and exhibits contained in this administrative record are the best copies obtainable.

## Court Transcript Index

Civil Action Number: 1:10-CV-12345

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### Exhibits

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DATE: May 11, 2010

The documents and exhibits contained in this administrative record are the best copies obtainable.



Refer to: TLC

Office of Disability Adjudication  
and Review  
5107 Leesburg Pike  
Falls Church, VA 22041-3255  
Telephone: (703) 605-8000  
Date: **JAN 20 2010**

## NOTICE OF APPEALS COUNCIL ACTION

This is about your request for review of the Administrative Law Judge's decision dated July 31, 2009.

### We Have Denied Your Request for Review

We found no reason under our rules to review the Administrative Law Judge's decision. Therefore, we have denied your request for review.

This means that the Administrative Law Judge's decision is the final decision of the Commissioner of Social Security in your case.

### Rules We Applied

We applied the laws, regulations and rulings in effect as of the date we took this action.

Under our rules, we will review your case for any of the following reasons:

- The Administrative Law Judge appears to have abused his or her discretion.
- There is an error of law.
- The decision is not supported by substantial evidence.
- There is a broad policy or procedural issue that may affect the public interest.
- We receive new and material evidence and the decision is contrary to the weight of all the evidence now in the record.

### What We Considered

In looking at your case, we considered the reasons you disagree with the decision and the additional evidence listed on the enclosed Order of Appeals Council. The Appeals Council has also considered the additional evidence submitted, but concluded that this additional

evidence does not provide a basis for changing the Administrative Law Judge's decision.

### **If You Disagree With Our Action**

If you disagree with our action, you may ask for court review of the Administrative Law Judge's decision by filing a civil action.

If you do not ask for court review, the Administrative Law Judge's decision will be a final decision that can be changed only under special rules.

### **How to File a Civil Action**

You may file a civil action (ask for court review) by filing a complaint in the United States District Court for the judicial district in which you live. The complaint should name the Commissioner of Social Security as the defendant and should include the Social Security number(s) shown at the top of this letter.

You or your representative must deliver copies of your complaint and of the summons issued by the court to the U.S. Attorney for the judicial district where you file your complaint, as provided in rule 4(i) of the Federal Rules of Civil Procedure.

You or your representative must also send copies of the complaint and summons, by certified or registered mail, to the Social Security Administration's Office of the General Counsel that is responsible for the processing and handling of litigation in the particular judicial district in which the complaint is filed. The names, addresses, and jurisdictional responsibilities of these offices are published in the Federal Register (70 FR 73320, December 9, 2005), and are available on-line at the Social Security Administration's Internet site, <http://policy.ssa.gov/poms.nsf/links/0203106020>.

You or your representative must also send copies of the complaint and summons, by certified or registered mail, to the Attorney General of the United States, Washington, DC 20530.

### **Time To File a Civil Action**

- You have 60 days to file a civil action (ask for court review).
- The 60 days start the day after you receive this letter. We assume you received this letter 5 days after the date on it unless you show us that you did not receive it within the 5-day period.
- If you cannot file for court review within 60 days, you may ask the Appeals Council to extend your time to file. You must have a good reason for waiting more than 60 days to ask for court review. You must make the request in writing and give your reason(s) in the request.

You must mail your request for more time to the Appeals Council at the address shown at the

top of this notice. Please put the Social Security number(s) also shown at the top of this notice on your request. We will send you a letter telling you whether your request for more time has been granted.

**About The Law**

The right to court review for claims under Title II (Social Security) is provided for in Section 205(g) of the Social Security Act. This section is also Section 405(g) of Title 42 of the United States Code.

The right to court review for claims under Title XVI (Supplemental Security Income) is provided for in Section 1631(c)(3) of the Social Security Act. This section is also Section 1383(c) of Title 42 of the United States Code.

The rules on filing civil actions are Rules 4(c) and (i) in the Federal Rules of Civil Procedure.

**If You Have Any Questions**

If you have any questions, you may call, write, or visit any Social Security office. If you do call or visit an office, please have this notice with you. The telephone number of the local office that serves your area is (501)525-6927. Its address is:

Social Security  
112 Corporate Terrace  
Hot Springs, AR 71913-7247

ORIGINAL SIGNED BY

Enclosure: Order of Appeals Council

cc:

Social Security Administration  
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

**ORDER OF APPEALS COUNCIL**

**IN THE CASE OF**

**CLAIM FOR**

\_\_\_\_\_  
(Claimant)

\_\_\_\_\_  
Supplemental Security Income

\_\_\_\_\_  
(Wage Earner)

\_\_\_\_\_  
(Social Security Number)

The Appeals Council has received additional evidence which it is making part of the record.  
That evidence consists of the following exhibits:

Exhibit AC-1      10F-Medical records from Geneva General  
Hospital

Date: **JAN 20 2010**

**REQUEST FOR REVIEW OF HEARING DECISION/ORDER**

(Do not use this form for objecting to a recommended ALJ decision.)

(Take or mail the signed original to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)

See Privacy Act Notice

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT
3. SOCIAL SECURITY CLAIM NUMBER	4. SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (Complete ONLY in Supplemental Security Income Case)

5. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:  
The decision of the ALJ is not supported by substantial evidence of record. Due to my medical and mental health conditions I am unable to perform any substantial gainful activity.

**ADDITIONAL EVIDENCE**

If you have additional evidence submit it with this request for review. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. If you request an extension of time, you should explain the reason(s) you are unable to submit the evidence or legal argument now. If you neither submit evidence or legal argument now nor within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence of record.

**IMPORTANT: Write your Social Security Claim Number on any letter or material you send us.**

**SIGNATURE BLOCKS:** You should complete No. 6 and your representative (if any) should complete No. 7. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 7.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

6. CLAIMANT'S SIGNATURE	DATE	7. REPRESENTATIVE'S SIGNATURE	<input checked="" type="checkbox"/> ATTORNEY <input type="checkbox"/> NON-ATTORNEY
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TEL ( )

02

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART	
8. Request received for the Social Security Administration on _____ by: _____ (Date) (Print Name)	
_____ (Title)	_____ (Address)
_____ (Servicing FO Code)	_____ (PC Code)
9. Is the request for review received within 65 days of the ALJ's Decision/Dismissal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. If "No" checked: (1) attach claimant's explanation for delay; and (2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.	
11. Check one: <input type="checkbox"/> Initial Entitlement <input type="checkbox"/> Termination or other	12. Check all claim types that apply: <input type="checkbox"/> Retirement or survivors (RSI) <input type="checkbox"/> Disability-Worker (DIWE) <input type="checkbox"/> Disability-Widow(er) (DIWW) <input type="checkbox"/> Disability-Child (DIWC) <input type="checkbox"/> SSI Aged (SSIA) <input type="checkbox"/> SSI Blind (SSIB) <input type="checkbox"/> SSI Disability (SSID) <input type="checkbox"/> Health Insurance-Part A (HIA) <input type="checkbox"/> Health Insurance-Part B (HIB) <input type="checkbox"/> Title VIII Only (SVB) <input type="checkbox"/> Title VIII/Title XVI (SVB/SSI) <input type="checkbox"/> Other - Specify: _____
APPEALS COUNCIL OFFICE OF HEARINGS AND APPEALS, SSA 5107 Leesburg Pike FALLS CHURCH, VA 22041 - 3255	

September 3, 2009

Social Security Administration  
112 Corporate Terrace  
Hot Springs, AR 71913

Re: [REDACTED]

SSN: [REDACTED]

Dear Sir/Madam:

Enclosed you will find the Request for Review of Hearing Decision/Order to appeal [REDACTED] denial of SSI benefits at the hearing level. Also enclosed are copies of [REDACTED] records from the Geneva General Hospital in Geneva, New York. These records are from November 1986, showing the skull fracture he received when he was dropped as an infant and from June 1991 showing the injuries he sustained when he, apparently, jumped out of a moving vehicle as a four and a half year old child. Please make these a part of [REDACTED] disability claim file. They were not available to be submitted prior to the hearing because the hospital in New York had not yet located the records.

If I need to do anything further or if you have questions or comments, please let me know.

Very truly yours,

[REDACTED]  
Enc:

pc: Appeals Council  
Office of Hearings and Appeals, SSA  
5107 Leesburg Pike  
Falls Church, VA 22041-3255



**SOCIAL SECURITY ADMINISTRATION**

Refer To: [REDACTED]

Office of Disability Adjudication and Review  
SSA ODAR Hearing Ofc  
Rm 2405 Federal Bldg  
700 West Capitol Ave  
Little Rock, AR 72201-3227

Date: July 31, 2009

**NOTICE OF DECISION – UNFAVORABLE**

I have made the enclosed decision in your case. Please read this notice and the decision carefully.

**If You Disagree With The Decision**

If you disagree with my decision, you may file an appeal with the Appeals Council.

**How to File an Appeal**

To file an appeal you or your representative must request that the Appeals Council review the decision. You must make the request in writing. You may use our Request for Review form, HA-520, or write a letter.

You may file your request at any local Social Security office or a hearing office. You may also mail your request right to the **Appeals Council, Office of Disability Adjudication and Review, 5107 Leesburg Pike, Falls Church, VA 22041-3255**. Please put the Social Security number shown above on any appeal you file.

**Time to File an Appeal**

To file an appeal, you must file your request for review **within 60 days** from the date you get this notice.

The Appeals Council assumes you got the notice 5 days after the date shown above unless you show you did not get it within the 5-day period. The Council will dismiss a late request unless you show you had a good reason for not filing it on time.

**Time to Submit New Evidence**

You should submit any new evidence you wish to the Appeals Council to consider with your request for review.

See Next Page

### **How an Appeal Works**

Our regulations state the rules the Appeals Council applies to decide when and how to review a case. These rules appear in the Code of Federal Regulations, Title 20, Chapter III, Part 416 (Subpart N).

If you file an appeal, the Council will consider all of my decision, even the parts with which you agree. The Council may review your case for any reason. It will review your case if one of the reasons for review listed in our regulation exists. Section 416.1470 of the regulation lists these reasons.

Requesting review places the entire record of your case before the Council. Review can make any part of my decision more or less favorable or unfavorable to you.

On review, the Council may itself consider the issues and decide your case. The Council may also send it back to an Administrative Law Judge for a new decision.

### **The Appeals Council May Review The Decision On Its Own**

The Appeals Council can review my decision even without your request to do so. If it decides to do that, the Council will mail you a notice about its review within 60 days from the date of this notice.

### **If No Appeal and No Appeals Council Review**

If you do not appeal and the Council does not review my decision on its own motion, you will not have a right to court review. My decision will be a final decision that can be changed only under special rules.

### **New Application**

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with my decision and you file a new application instead of appealing, you might lose some benefits, or not qualify for any benefits. My decision could also be used to deny a new application for insurance benefits, if the facts and issues are the same. So, if you disagree with this decision, you should file an appeal within 60 days.

**If You Have Any Questions**

If you have any questions, you may call, write or visit any Social Security office. If you visit an office, please bring this notice and decision with you. The telephone number of the local office that serves your area is (501)525-6927. Its address is Social Security, 112 Corporate Terrace, Hot Springs, AR 71913-7247.

Enclosures:  
Decision Rationale

cc:

**SOCIAL SECURITY ADMINISTRATION  
Office of Disability Adjudication and Review**

**DECISION**

**IN THE CASE OF**

**CLAIM FOR**

\_\_\_\_\_  
(Claimant)

\_\_\_\_\_  
Supplemental Security Income

\_\_\_\_\_  
(Wage Earner)

\_\_\_\_\_  
(Social Security Number)

**JURISDICTION AND PROCEDURAL HISTORY**

On October 5, 2007, the claimant filed an application for supplemental security income, alleging disability beginning December 28, 1999. The claim was denied initially on December 20, 2007, and upon reconsideration on February 8, 2008. Thereafter, the claimant filed a written request for hearing on April 25, 2008 (20 CFR 416.1429 *et seq.*). The claimant appeared and testified at a hearing held on May 27, 2009, in Hot Springs, Arkansas. Also appearing and testifying were Dianne G. Smith, an impartial vocational expert, and \_\_\_\_\_, the claimant's step-father. The claimant is represented by \_\_\_\_\_, an attorney.

**ISSUES**

The issue is whether the claimant is disabled under section 1614(a)(3)(A) of the Social Security Act. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Although supplemental security income is not payable prior to the month following the month in which the application was filed (20 CFR 416.335), the undersigned has considered the complete medical history consistent with 20 CFR 416.912(d).

After careful consideration of all the evidence, the undersigned concludes the claimant has not been under a disability within the meaning of the Social Security Act since October 5, 2007, the date the application was filed.

**APPLICABLE LAW**

Under the authority of the Social Security Act, the Social Security Administration has established a five-step sequential evaluation process for determining whether an individual is disabled (20 CFR 416.920(a)). The steps are followed in order. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

At step one, the undersigned must determine whether the claimant is engaging in substantial gainful activity (20 CFR 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. "Substantial work activity" is work activity that involves doing significant physical or mental activities (20 CFR 416.972(a)). "Gainful work activity" is work that is usually done for pay or profit, whether or not a profit is realized (20 CFR 416.972(b)). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that he has demonstrated the ability to engage in SGA (20 CFR 416.974 and 416.975). If an individual engages in SGA, he is not disabled regardless of how severe his physical or mental impairments are and regardless of his age, education, and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the undersigned must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe" (20 CFR 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work (20 CFR 416.921; Social Security Rulings (SSRs) 85-28, 96-3p, and 96-4p). If the claimant does not have a severe medically determinable impairment or combination of impairments, he is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

At step three, the undersigned must determine whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.920(d), 416.925, and 416.926). If the claimant's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement (20 CFR 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the undersigned must first determine the claimant's residual functional capacity (20 CFR 416.920(e)). An individual's residual functional capacity is his ability to do physical and mental work activities on a sustained basis despite limitations from his impairments. In making this finding, the undersigned must consider all of the claimant's impairments, including impairments that are not severe (20 CFR 416.920(e) and 416.945; SSR 96-8p).

Next, the undersigned must determine at step four whether the claimant has the residual functional capacity to perform the requirements of his past relevant work (20 CFR 416.920(f)). The term past relevant work means work performed (either as the claimant actually performed it or as it is generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. In addition, the work must have lasted long enough for the claimant to learn to do the job and have been SGA (20 CFR 416.960(b) and 416.965). If the claimant has the residual functional capacity to do his past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 416.920(g)), the undersigned must determine whether the claimant is able to do any other work considering his residual functional capacity, age, education, and work experience. If the claimant is able to do other work, he is not disabled. If the claimant is not able to do other work and meets the duration requirement, he is disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given the residual functional capacity, age, education, and work experience (20 CFR 416.912(g) and 416.960(c)).

### **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

After careful consideration of the entire record, the undersigned makes the following findings:

- 1. The claimant has not engaged in substantial gainful activity since October 5, 2007, the application date (20 CFR 416.971 *et seq.*).**
- 2. The claimant has the following severe impairments: idiopathic scoliosis of the spine status post posterior spinal fusion surgery from T4 to L4; reading disorder; mathematics disorder; borderline range of intelligence; and adjustment disorder with mixed emotional features (20 CFR 416.920(c)).**

After careful consideration of the evidence, the Administrative Law Judge finds that the claimant's combination of medically determinable impairments as delineated above would impose more than a slight abnormality and have more than a minimal effect on the claimant's ability to do basic physical and/or mental work activities and would thus be "severe" within the meaning of the regulations.

- 3. The claimant does not have an impairment or combination of impairments that meets or medically equals one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.925 and 416.926).**

After a thorough review of the evidence, the Administrative Law Judge finds no evidence to show the existence of any physical impairment(s) that meets the criteria of 1.04 or any other of the listed impairments described in Appendix 1 of the Regulations (20 CFR, Part 404, Subpart P, Appendix 1, Regulation No. 4). Further, no treating or examining physician has mentioned findings equivalent in severity to the criteria of any listed physical impairment. In reaching this conclusion, the Administrative Law Judge has also considered the opinions of the State agency medical consultants who evaluated this issue at the initial and reconsideration levels of the administrative process and reached the same conclusion, (20 CFR 404.1512 and 416.812; SSA 96-6P).

The claimant's mental impairments do not meet or medically equal the requirements of any of the listed impairments described in Appendix 1 of the Regulations (20 CFR, Part 404, Subpart P, Appendix 1, Regulation No. 4). The medical evidence establishes that the claimant has exhibited some of the features of the "A" criteria of listing 12.05. However, a review of the relevant "D" criteria of listing 12.05 indicates that none of the functional limitation categories are manifested at a degree which satisfied the full requirements of such a listing.

In addition, the "B" criteria of listing 12.05 are not met because the claimant does not have a valid verbal, performance, or full scale IQ of 59 or less. When the claimant was tested with the Wechsler Adult Intelligence Test-III in December, 2007, the claimant's Verbal IQ was listed at 71, his Performance IQ at 85 and his Full Scale IQ at 76.

The "paragraph C" criteria of listing 12.05 are not met because the claimant does not have a valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function.

Finally, to satisfy the "D" criteria of listing 12.05, the mental impairments must result in at least two of the following: marked restriction of activities of daily living; marked difficulties in maintaining social functioning; marked difficulties in maintaining concentration, persistence, or pace; or repeated episodes of decompensation, each of extended duration. A marked limitation means more than moderate but less than extreme. Repeated episodes of decompensation, each of extended duration, means three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks.

The claimant has reported that he helped out around the house doing dishes and laundry; he was able to cook, drive and go shopping by himself; and he had friends he spent time with. However, the claimant had limitations due to his reading and mathematics disorder and the claimant had been found to function in the borderline range of intelligence. Accordingly, the Administrative Law Judge finds that the claimant has no more than "mild" limitations in activities of daily living and "social functioning" and moderate limitations in "concentration, persistence and pace". There is no evidence of deterioration or decompensation in work or work-like settings.

The limitations identified in the "paragraph D" criteria of listing 12.05 criteria are not a residual functional capacity assessment but are used to rate the severity of mental impairments at steps 2 and 3 of the sequential evaluation process. The mental residual functional capacity assessment used at steps 4 and 5 of the sequential evaluation process requires a more detailed assessment by itemizing various functions contained in the broad categories found in paragraph B of the adult mental disorders listings in 12.00 of the Listing of Impairments (SSR 96-8p). Therefore, the following residual functional capacity assessment reflects the degree of limitation the undersigned has found in the "paragraph D" mental function analysis.

**4. After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform light work as defined in 20 CFR 416.967(b). The claimant can occasionally lift 20 pounds and 10 pounds frequently; sit about 6 hours per 8 hour workday; and stand/walk for 6 hours per 8 hour workday. The claimant would be limited to unskilled work, in that interpersonal contact incidental to**

**work performed; tasks must be learned by rote; requiring limited judgment; little supervision for routine matters; and detailed supervision for non-routine matters. In addition, the claimant's learning disorder suggested that formal classroom training would not be a good training method; rather on the job training would be better. In addition, the claimant would perform better on work performed slowly and correctly rather than quickly.**

In making this finding, the undersigned has considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 416.929 and SSRs 96-4p and 96-7p. The undersigned has also considered opinion evidence in accordance with the requirements of 20 CFR 416.927 and SSRs 96-2p, 96-5p, 96-6p and 06-3p.

In assessing the claimant's medically determinable impairments and their impact on the claimant's ability to perform work functions, the Administrative Law Judge also considered the claimant's subjective allegations, giving careful consideration to all avenues presented that relate to such matters as:

1. The nature, location, onset, duration, frequency, radiation and intensity of any pain;
2. precipitating and aggravating factors (e.g., movement, activity, environmental conditions);
3. type, dosage, effectiveness and adverse side-effects of any pain medications;
4. treatment, other than medication, for relief of pain;
5. functional restrictions; and
6. the claimant's daily activities.

(20 CFR 404.1529 and 416.929). Consideration was also given to all the evidence presented related to the claimant's prior work history and the observations of non-medical third parties, as well as treating and examining physicians related to the above matters. Polaski v. Heckler, 739 F.2d 1320, 1322, 751 F.2d 943, 948 (8<sup>th</sup> Cir. 1984).

In considering the claimant's symptoms, the undersigned must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)--i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques--that could reasonably be expected to produce the claimant's pain or other symptoms.

Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant's pain or other symptoms has been shown, the undersigned must evaluate the intensity, persistence, and limiting effects of the claimant's symptoms to determine the extent to which they limit the claimant's ability to do basic work activities. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the undersigned must make a finding on the credibility of the statements based on a consideration of the entire case record.

At the hearing in this matter, the claimant alleged disabling symptoms and/or limitations related to scoliosis and residual back pain, learning disabilities, and headaches.

The claimant testified that he graduated from Lake Hamilton High School in 2006. He indicated that he received special education services for most of his classes while in high school. The last two years of high school, he was in high school for half the day and then spent the rest of the time at the Hot Springs Rehabilitation Center. He received training in food service and he was able to complete the program. He worked at a local hospital cafeteria through an internship while in the rehabilitation center; however, he did not get hired at the hospital. The claimant was told by the hospital staff that he was not fast enough. He has attempted to get jobs at several other businesses around town without success. He further indicated that on occasion he had difficulty completing job applications and would have to take them home for assistance.

The claimant indicated that he had trouble understanding what other people were asking him to do and he had trouble asking questions to seek help. He has also suffered from scoliosis and underwent surgery in 2001. His back continued to cause him pain, he had a hard time bending over, and standing up for more than 30 to 60 minutes would cause his back to hurt. While working in the food service program, he had pain in his back due to the standing and would have to go and lie down to help relieve the pain. Due to his back pain, he was also limited in how much he could lift.

The claimant also testified that he suffered from headaches on a weekly basis. Working too fast, hot conditions and prolonged standing aggravated the headaches. Sometimes he had to lie down to get rid of a headache, but other times over the counter medication would relieve the pain. Also, turning his head from side to side hurts his back and neck, especially when he was driving.

In regards to his activities of daily living, the claimant testified that he was currently living with her mother and step-father. He did not have a check account or a bank account, but he was able to make change and go to the store. He also has a driver's license with no restrictions. In a Function Report – Adult that the claimant completed in October, 2007, the claimant indicated that he took care of a dog and cat, was able to prepare simple meals, was able to do laundry, wash dishes and other house hold cleaning, able to drive a car and ride a bike, able to shop in a store, spent time watching television and playing video games, and spent time with friends. The claimant indicated that he had difficulty getting his shoes on, had no experience with money and was forgetful with spoken instructions. He believed that he could walk for about 20 minutes before needing to rest, could pay attention for 20 minutes, and was able to finish what he started. He also indicated that he was pretty good at following written instructions and got along well with authority figures (Ex. 4E).

As required by the Regulations (20 CFR 404.1513(e)(2) and 416.913(e)(2)) and Polaski v. Heckler, the Administrative Law Judge has also considered the observations of non-medical sources and third parties in relation to how the claimant's impairments affect his ability to work. In that regard, the testimony of \_\_\_\_\_, the claimant's step father, has been carefully considered. Notably, the testimony of this witness, who was in the hearing room for claimant's testimony, for the most part, appeared to merely corroborate the testimony of the claimant regarding the severity and nature of his symptoms.

testified that he has known the claimant since he was about 9 months old. From his observations, the claimant had difficulty with his communication skills and understanding other people and he was unable to bend over due to the rod in his back. The claimant had a few friends that he would socialize with, but spent most of his time watching television and playing video games. The claimant had assisted him in the past doing yard work for other people. The claimant did a good job with tasks, but it took a lot out of him and would take him longer than normal to complete the job. The claimant got easily overwhelmed and worried a lot about things.

When considered in conjunction with other substantial evidence as outlined in this decision, it is the conclusion of the Administrative Law Judge that the testimony of this witness appeared to be based on uncritical acceptance of the claimant's complaints and/or a potential desire to see the claimant receive benefits. Specifically, the testimony of this witness is found to be inconsistent with other substantial evidence in this claim, including the objective medical evidence and is therefore not persuasive.

It must be noted that proof of a disabling impairment must be supported by at least some medical evidence. However, the evidence of record in this claim does not support the allegations of the claimant regarding the nature, severity and duration of his medically determinable impairments. It must be noted that while the claimant's statements regarding the nature and severity of his impairment(s) and its limiting effects is evidence that must be considered, a symptom is not objective medical evidence and is not a medically determinable impairment. No symptom by itself can establish the existence of such impairment or be the basis of a finding of disability (SSR 96-4p and 96-7p).

It is also fully acknowledged by the Administrative Law Judge that the claimant may well experience some degree of discomfort and/or impairment as a result of his medically determinable impairments. Further, while the claimant's allegations regarding the nature and severity of his condition(s) cannot be disregarded solely on the basis of an inconsistency or absence of medical evidence, such factors may be used to contradict the claimant's subjective complaints regarding the nature, severity and overall duration of his symptoms.

After careful consideration of the evidence, the undersigned finds that the claimant's medically determinable impairments could reasonably be expected to cause the alleged symptoms; however, the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are not credible to the extent they are inconsistent with the above residual functional capacity assessment for the reasons explained below.

In terms of the claimant's alleged disabling impairments, the undersigned Administrative Law Judge has very thoroughly considered the objective medical evidence. The record shows that the claimant underwent posterior spinal fusion surgery from T4 to L4 in January, 2001 at Arkansas Children's Hospital due to a diagnosis of idiopathic scoliosis of the spine. At a follow up in March, 2001, Dr. noted that the claimant's incision was well healed and even though he did have some shoulder height discrepancy, he was able to correct it passively when he tried. The claimant reported being able to ride his bike, but did complain of some numbness

around the incision and some pain in the left shoulder when lifting weights. An X-ray of his spine revealed scoliosis rods that extended from the upper dorsal spine to the mid and low lumbar spine but no acute abnormality. Dr. [REDACTED] noted that the claimant's scoliosis was much improved and his spinal fusion was stable (Ex. 1F).

The claimant underwent a psychological screening evaluation for the Arkansas Rehabilitation Services in November, 2004. The claimant reported being in resource classes since 5<sup>th</sup> grade, had no work experience, and was interested in learning how to cook. [REDACTED] the psychological examiner, noted that learning disorder symptoms, especially very slow processing, interfered with the claimant's test taking ability. He believed that the claimant had somewhat more ability than he was able to demonstrate. According to the test results, the claimant was barely literate, had very poor spelling ability, had borderline numerical ability, had close to average abstract reasoning ability, low average verbal receptive intelligence and borderline nonverbal intellectual functions. Based on a school history of recourse classes and the test results, he diagnosed the claimant with a reading disorder and a mathematics disorder. He indicated that the learning disorders had resulted in numerous areas of functional impairment, especially for any academic, training or vocational task requiring anywhere close to average reading and mathematics ability. However, [REDACTED] believed that the claimant had potential for rehabilitation, he would probably do best in some type of on the job training, he appeared to have enough cognitive ability to learn by being shown and told how to do something, and he would do better on work that did not require quick processing and a high rate of production (Ex. 3F).

The claimant was then enrolled in the Hot Springs Rehabilitation Center in January, 2005 in the cafeteria training program. A work evaluation – medical completed on January 24, 2005, indicated that the claimant would have problems lifting up to 85 pounds, pushing, pulling, stooping, twisting, bending, crawling, climbing and with his vision. However, he would not have a problem with reaching, use of hands and arms, fine and gross coordination, standing for 8 hours, walking, hearing, and speech. The restrictions were based on the claimant's past scoliosis with surgical correction, limited bending of the back, moderate myopia and tension headaches. He was to avoid strenuous labor and/or exercise. The claimant was discharged in June, 2006 as a volitional drop out (Ex. 3F).

X-rays of the claimant's lumbar spine and cervical spine taken on October 31, 2007 revealed moderately severe thoracolumbar scoliosis with corrective frontal rod present extending from T4 to L4. Otherwise, the X-ray report indicated a negative lumbar spine without fractures, degenerative changes or acute findings. As to an X-ray of the claimant's cervical spine, the report noted a mild straightening of the cervical lordosis, but otherwise a negative cervical spine (Ex. 4F).

A general physical examination was performed on the claimant by Dr. [REDACTED] on November 29, 2007. At that evaluation, the claimant reported that he was disabled because he was unable to pick up anything over 50 pounds due to a scoliosis repair of his back. He stated that he was able to bend and lift, but his back was weak and he could not pick up more than 50 pounds without pain. He had no problems standing and said he could stand for three to four hours and walk without any limitation. During his physical examination, Dr. [REDACTED] noted that the

claimant's range of motion in his lumbar spine was reduced, but the range of motion was within normal limits in all of his extremities. He noted no muscle weakness and no muscle atrophy and his limb functions were normal. Dr. [redacted] diagnosed the claimant with severe scoliosis of the spine status post surgical repair with rods; limitation of motion of twisting and bending due to surgical repair; and mental retardation with a probable IQ of 80. Dr. [redacted] further opined that the claimant would have moderate limits with physical duties, in that he could lift 40 to 50 pounds once an hour but not every 5 minutes. He also believed the claimant would have severe limitations with comprehension of most jobs (Ex. 5F).

The claimant underwent a Mental Diagnostic Evaluation and Intellectual Assessment with [redacted] PhD, on December 3, 2007. The claimant's mother reported that the claimant's speech was impaired and he stuttered. She also indicated that his socialization skills were not good, he was slow to communicate and he didn't handle stress well. The claimant had no past history of psychiatric treatments and was not taking any medication. It was also reported that the claimant lived with his family; he helped out around the house doing dishes and laundry; he was able to cook, drive and go shopping by himself; and he had friends he spent time with. The claimant graduated high school in resource classes and graduated the vocational-rehabilitation school in 2006, where he trained in food service. [redacted] noted that the claimant's mood was normal, his affect was appropriate, his speech was slow, and his thought processes and content were logical and appropriate (Ex. 6F).

Results from the Wechsler Adult Intelligence Scale (WAIS-III) revealed a Verbal IQ of 71, a Performance IQ of 85 and a Full Scale IQ of 76. [redacted] diagnosed the claimant with adjustment disorder with mixed emotional features and a global assessment of functioning between 60 and 70, which was indicative of moderate to more mild symptoms. Dr. [redacted] also felt that the claimant's mental impairments did not appear to significantly interfere with the claimant's day to day adaptive functioning; the claimant communicated and interacted in a socially adequate manner although not as finessed as most people would like, he did make good eye contact and his communication was effective although somewhat slow; he would be able to cope with the cognitive demands of most work like tasks; and he was able to complete tasks within an acceptable timeframe with the possible exception of written expression which was slow. Finally, Dr. [redacted] believed that the claimant would be able to manage funds without assistance (Ex. 6F).

In regard to any other alleged disabling conditions and/or symptoms as alleged by the claimant, as noted in detail in this discussion above, there is no objective medical evidence from which to conclude the claimant has required any more than intermittent evaluation and treatment at most.

The overall nature and severity of the claimant's impairments have not been as severe, debilitating and/or resistant to improvement with medical treatment intervention as alleged by the claimant. It must be emphasized that the Administrative Law Judge is bound by the Social Security Act and applicable regulations in reaching a final conclusion on the issue of disability.

The claimant has described daily activities which are not limited to the extent one would expect, given the complaints of disabling symptoms and limitations. In a Function Report, he indicated the ability to prepare meals, do household chores, drive a car and maintain social relationships

with people outside of his family (Ex. 4E). The claimant reported to Dr. [REDACTED] that he helped out around the house doing dishes and laundry; he was able to cook, drive and go shopping by himself (Ex. 6F). The record shows and the claimant confirmed in his testimony, that he spent time watching television, driving a car and playing video games. The performance of these activities is inconsistent with a conclusion that he claimant does not have sufficient concentration, persistence or pace to perform the basic mental activities of work.

The claimant did undergo surgery for the alleged impairment, which certainly suggests that the symptoms were genuine. While that fact would normally weigh in the claimant's favor, it is offset by the fact that the record reflects that the surgery was generally successful in relieving the symptoms. Records from Arkansas Children's Hospital from March, 2001 showed that the claimant's scoliosis was much improved and his spinal fusion was stable. The claimant did complain of numbness around the incision and some pain in his left shoulder when lifting weights, but no complaints of back pain (Ex. 1F). The claimant was to return to see Dr. [REDACTED] in six months, but there was no indication in the file that the claimant followed-up on recommendations made by the treating doctor, which suggests that the symptoms may not have been as serious as has been alleged in connection with this application and appeal. The record also reveals relatively infrequent trips to the doctor for his allegedly disabling symptoms since his last appointment at Arkansas Children's Hospital in 2001.

Despite the complaints of allegedly disabling symptoms, the claimant has not taken any medications for those symptoms. The claimant testified that he will take over the counter pain medication to help relieve his headaches, but there was no indication of any prescription medication for back pain.

The Arkansas Rehabilitation Services believed that the claimant had potential for rehabilitation, even though he would be limited due to a reading and mathematics disorder. A work evaluation completed in January, 2005 found that the claimant would have problems with lifting up to 85 pounds and limitations involving his back related to his back surgery, but he had no problems with the use of his extremities, coordination or speech (Ex. 3F). In fact, the claimant testified that he was able to perform and complete the requirements of the food service program. The claimant explained to Dr. [REDACTED] in November, 2007 that he was disabled because he was not able to pick up anything over 50 pounds. He further indicated that he had no problems standing and that he could stand for three to four hours and walk without any limitations. In a Function Report completed one month earlier, the claimant indicated that he was only walk for about 20 minutes before needing to rest (Ex. 4E). The claimant testified at the hearing that he could only stand up for about 30 to 60 minutes before his back would begin hurting. Although the inconsistent information provided by the claimant may not be the result of a conscious intention to mislead, nevertheless the inconsistencies suggest that the information provided by the claimant generally may not be entirely reliable.

In fact, Dr. [REDACTED] believed that the claimant was only moderately limited in relation to his physical problems (Ex. 5F). X-rays taken in October, 2007 also failed to reveal the type of significant clinical and laboratory abnormalities one would expect if the claimant were in fact disabled due to his scoliosis (Ex. 4F).

Given the claimant's allegations of totally disabling symptoms, one might expect to see some indication in the treatment records of restrictions placed on the claimant by treating doctors. Yet a review of the record in this case reveals no restrictions recommended by the treating doctor. The record contains an opinion from a non-treating doctor which supports the residual functional capacity reached in this decision. Dr. [redacted] believed that the claimant could lift 40 to 50 pounds once an hour, but not every 5 minutes and that he would have severe limitations with comprehension of most jobs (Ex. 5F). Dr. [redacted] confirmed that the claimant was functioning in the borderline range of intelligence, but based on his adaptive functioning, he believed that the claimant would be able to cope with the cognitive demands of most work like tasks and he was able to complete tasks within an acceptable timeframe with the possible exception of written expression (Ex. 6F).

The residual functional capacity conclusions reached by the physicians employed by the State Disability Determination Services also supported a finding of 'not disabled.' Although those physicians were non-examining, and therefore their opinions do not as a general matter deserve as much weight as those of examining or treating physicians, those opinions do deserve some weight, particularly in a case like this in which there exist a number of other reasons to reach similar conclusions.

The evidence establishes that the claimant, despite his impairments, has adequate limb function, mobility and range of motion and his activities of daily living are not unduly restricted. His physical and/or mental symptoms, limitations and/or restrictions do not preclude him from the performance of simple work activity. Although he is marginally illiterate, there is no indication in the record that the claimant is not able to learn tasks by rote which requires few variables or little judgment and that he can follow simple, direct and concrete supervision.

Upon careful consideration, the Administrative Law Judge finds that the claimant has the residual functional capacity to perform work at the light exertional level but with non-exertional limitations related to his borderline intellectual functioning and his learning disorders.

- 5. The claimant has no past relevant work (20 CFR 416.965).**
- 6. The claimant was born on [redacted] and was 21 years old, which is defined as a younger individual age 18-49, on the date the application was filed. (20 CFR 416.963).**
- 7. The claimant has at least a high school education and is able to communicate in English (20 CFR 416.964).**
- 8. Transferability of job skills is not an issue because the claimant does not have past relevant work (20 CFR 416.968).**
- 9. Considering the claimant's age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that the claimant can perform (20 CFR 416.969 and 416.969a).**

In determining whether a successful adjustment to other work can be made, the undersigned must consider the claimant's residual functional capacity, age, education, and work experience in conjunction with the Medical-Vocational Guidelines, 20 CFR Part 404, Subpart P, Appendix 2. If the claimant can perform all or substantially all of the exertional demands at a given level of exertion, the medical-vocational rules direct a conclusion of either "disabled" or "not disabled" depending upon the claimant's specific vocational profile (SSR 83-11). When the claimant cannot perform substantially all of the exertional demands of work at a given level of exertion and/or has non-exertional limitations, the medical-vocational rules are used as a framework for decision-making unless there is a rule that directs a conclusion of "disabled" without considering the additional exertional and/or non-exertional limitations (SSRs 83-12 and 83-14). If the claimant has solely non-exertional limitations, section 204.00 in the Medical-Vocational Guidelines provides a framework for decision-making (SSR 85-15).

If the claimant had the residual functional capacity to perform the full range of light work, a finding of "not disabled" would be directed by Medical-Vocational Rule 202.20. However, the claimant's ability to perform all or substantially all of the requirements of this level of work has been impeded by additional limitations.

To determine the extent to which these limitations erode the occupational base of unskilled work at the light level, the Administrative Law Judge asked the vocational expert whether jobs existed in the national economy for an individual with the claimant's age, education and work experience and residual functional capacity. The vocational expert testified that given all of those factors the individual would be able to perform the requirements of representative occupations such as light housekeeping or shirt presser. The vocational expert estimated the existence of approximately 1,800 in the Arkansas economy, 15,000 assembler of housekeeping jobs in the regional economy and 300,000 in the national economy. As to shirt presser jobs, the vocational expert estimated the existence of approximately 1,600 jobs in the Arkansas economy, 2,500 in the regional economy and 300,000 in the national economy. The vocational expert further indicated that the light housekeeping positions would not be paced jobs and the shirt presser position would not be fast paced.

Pursuant to SSR 00-4p, the vocational expert's testimony is consistent with the information contained in the *Dictionary of Occupational Titles*.

Based on the testimony of the vocational expert, the undersigned concludes that, considering the claimant's age, education, work experience, and residual functional capacity, the claimant is capable of making a successful adjustment to other work that exists in significant numbers in the national economy. A finding of "not disabled" is therefore appropriate under the framework of the above-cited rule.

**10. The claimant has not been under a disability, as defined in the Social Security Act, since October 5, 2007, the date the application was filed (20 CFR 416.920(g)).**

**DECISION**

Based on the application for supplemental security income filed on October 5, 2007, the claimant is not disabled under section 1614(a)(3)(A) of the Social Security Act.

  
\_\_\_\_\_  
Administrative Law Judge

July 31, 2009

Date



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(The following is a transcript in the hearing held before \_\_\_\_\_, Administrative Law Judge, Office of Hearings and Appeals, Social Security Administration, on May 27, 2009, at Hot Springs, Arkansas in the case of \_\_\_\_\_, Social Security Number \_\_\_\_\_. The Claimant appeared in person and was represented by \_\_\_\_\_ Attorney. Also present were \_\_\_\_\_ Vocational Expert; and \_\_\_\_\_ witness for the Claimant; and \_\_\_\_\_, observer.)

(The hearing commenced at 9:07 a.m., on May 27, 2009.)

OPENING STATEMENT BY ADMINISTRATIVE LAW JUDGE:

ALJ: This is a hearing in the case of Mr. \_\_\_\_\_, Social Security number \_\_\_\_\_. Mr. \_\_\_\_\_ is a claimant for SSI. The hearing is being held in Hot Spring, Arkansas, on May 27, 2009, at 9:05 a.m. Mr. \_\_\_\_\_ my name is Bob Neighbors. I'm an Administrative Law Judge. Mr. \_\_\_\_\_ is present in the hearing room with his attorney, Miss \_\_\_\_\_. The claimant's mother, Miss \_\_\_\_\_ and his stepfather, Mr. \_\_\_\_\_, are present as witnesses on his behalf. Miss \_\_\_\_\_ is present at my request. Miss \_\_\_\_\_ is an independent vocational expert witness. Miss \_\_\_\_\_ any objection to the proposed exhibits?

ATTY: No, sir.

ALJ: They'll be admitted. Do you anticipate any additional?

ATTY: No, sir.

ALJ: Very good.

(Exhibits, previously identified, were received into evidence and made a part of the record thereof).

ALJ: If you plan to testify, please raise your right hand and be sworn. If you're going to testify, you got to take the oath. Are you going to testify?

OBS: No.

ALJ: All right. Call your first.

ATTY: Thank you. Claimant called,

ALJ: All right.

(The Claimant, \_\_\_\_\_, having been first duly sworn, testified as follows:)

EXAMINATION OF CLAIMANT BY ADMINISTRATIVE LAW JUDGE:

Q Kevin, state your name for the record, please.

A \_\_\_\_\_ s.

Q Where do you live?

A \_\_\_\_\_

Q And you live with your mom and your step dad?

A Yes.

Q How long, well, I guess I have you always lived with your mom and your step dad since you were a little baby?

A Yes.

Q And you went to high school at Lake Hamilton?

A Yes.

Q And graduated in 2005? Is that right?

A 2006.

Q Well, I wrote down the wrong date. I'm sorry. All right. You graduated in 2006, and right now you are twenty --

A Two.

Q -- two. When you were in high school, well, what year did you get to Lake Hamilton, fifth grade?

A When I first went to Lake Hamilton I was in second grade.

Q In second grade, okay. And then you stayed there for the rest of your schooling?

A Yeah.

Q And at Lake Hamilton you were in special education?

A Yes.

Q When you were in high school which classes were you in special education for?

A Practically for reading, math, what else? I think science. Practically almost all the --

Q All the classes?

A Yeah, all the classes.

Q Okay. And then the last couple of years they had you going to school half a day and then going to training at the rehab the rest of the day?

A Yeah.

Q Is that the way it worked?

A Practically like, yeah, like it was most; practically it was practically all the way to lunch and I had probably like two classes and that's all I had. Practically it was like a little over half, not much of the day.

Q At school or at the rehab?

A At the rehab.

Q Okay. And you went there for two years?

A Yeah.

Q All right. What were they training you to do?

A Food service like cooking, baking, frying.

Q All right. Did you finish that program?

A Yes.

Q And did they help you try to get a job after that?

A Not, well, not that, not really much, not really. It kind of, they were, they were helping just a little. It wasn't really helping me that much. It just --

Q All right. Since, well, at the rehab I guess you worked in the kitchen.

A Yeah.

Q And then since leaving the rehab have you worked anywhere else?

A No.

Q You told me yesterday about you worked at National Park Medical Center for a while?

A Yeah, that was the internship. That was when I was in the rehab. They took me to, to a internship to try to get a job there.

Q Okay. In the kitchen at National Park Medical Center?

A Yeah.

Q And what did they tell you at National Park Medical Center?

A They told me I wasn't fast enough for the job.

Q All right. So they wouldn't hire you?

A No.

Q All right. And since that time have you tried to get work other places?

A Yes.

Q Where all have you tried to get work?

A A lot of places, restaurants, grocery stores, some I don't know, I think a hardware store and like (INAUDIBLE).

Q All right. And have you had interviews at any of these places?

A Yeah, some of them. I had a interview at Olive Garden, okay, I know I had more, I just don't remember. I don't remember the others.

Q Okay. But there have been others?

A Yeah.

Q But nobody has hired you yet?

A No.

Q And I guess you've continued all this time to look for a job?

A Yeah.

Q When you go someplace to get an application for a job, do you sit down right there and fill out the application or do you take it home with you?

A I, sometimes, sometimes I do it in the restaurant and it depends if it's, if I can't do the whole thing I usually take it home.

Q All right. Most times do you get help filling out a job application?

A Yes.

Q Who helps you?

A My step dad and my mom.

Q All right. What about like, you've applied at Wal-Mart before?

A Yes.

Q You do those applications on a computer, don't you?

A Yeah.

Q And were you able to do that one by yourself?

A Not really. Last time, the first time when I done it they asked for questions on it and that helped, I had to have help on it. The other times, the other time I filled out application they changed it up and it was a little easier because they didn't ask those questions.

Q Okay. But the other time you were able to do it by yourself?

A Yeah.

Q All right. Now, what kind of problems in your day to day life do your education and your learning problems give you?

A Like trying to communicate with people.

Q Do you often times have trouble understanding what people are telling you?

A Yeah. And if people ask you to do things do you have trouble understanding what they are asking you to do?

Q Yes. If you want to ask a question about what you're supposed to do, do you have trouble with asking the question sometimes?

A Yes.

Q You also have scoliosis?

A Yes, I did and I had surgery on it.

Q All right. And they did surgery on you at Children's Hospital in 2001?

A Yeah, I think it was, yeah.

Q Okay. And you've got rods and things in your back?

A Yes.

Q And is your spine still curved a little bit?

A It shouldn't.

Q Shouldn't be?

A Yeah, it shouldn't be.

Q Does your back give you any problems now?

A Right now it's in the, it's hurting a little now how I'm sitting right now.

Q Does it, does it make it sometimes when you can't do things?

A Yes.

Q What kinds of things does your back make it where you can't sit?

A Like hard to, I have a hard time, I have a more hard time to bend over and more harder time trying to get up or like, for example, when I'm sleeping if I don't have a comfortable bed my back hurts so much, it feels like I can't get up.

Q All right. And if you stand up for a long time does it make your back hurt?

A Yes.

Q How long can you stand up before your back starts hurting?

A Somewhere around 30 to a hour.

Q All right. And when you were training at the rehab, the food service job had you working eight hours a day with a break?

A Yes.

Q And that was pretty much a stand up job?

A Yes.

Q Were you able to do that without your back hurting?

A No, I wasn't able to.

Q Did some days by the end of the shift did you have to go to your room then and lie down?

A Yeah. Yes, I do. Like usually like half of that week I used to usually go to my room and lay down.

Q Okay. Because of your back hurting?

A Yeah.

Q All right. And does your back, does it also limit how much you can pick up?

A Yes.

Q If you try to pick up some things it hurts your back?

A Yeah.

Q All right. And you get headaches a lot?

A Yes.

Q In a week, how many times will you have a headache?

A I don't know. Probably almost probably five times a week.

Q All right.

A Every, like every, no way, no. No, it depends what I'm doing, too. It depends. If I'm just watching TV, if I'm like doing some work like some work like in the heat and stuff I get headaches quite easily. And sometimes when I do a lot of work fast it gives me a headache.

Q Like when you were telling me about when you were having to serve the food at the rehab --

A Yeah.

Q -- and make sure all the food, that there was enough food out and during lunchtime when it got kind of fast and stressful, is that

the kind of thing that brings on a headache?

A Yes.

Q And if you, if you have a job where you stand up for a long time, does that make your head hurt?

A Yes.

Q And I think I read in your file that turning your head from side to side makes your head hurt.

A It doesn't really do that. It hurts my neck and my back when I do it. It's mostly, it's practically when I drive it does, it hurts. When I turn my head the, it's not the way you look behind you. It's just like when you look out on your side of the window, on your side mirror, look on that side, I can't really turn my neck that well.

Q Okay. And that makes your neck and your back hurt?

A Yeah.

Q All right. And I want to go back and talk about the headaches for just a minute. When you have a headache what does it feel like?

A It depends how bad I get it. The worst I got is when my head is pounding and I have a hard time. I lay down trying to get rid of it and I just can't get rid of it because it's so pounded and it takes a while. Usually I have to take, have to wait, have to take like some more medicine to make it go away much more, much more faster.

Q And do they get that bad very much?

A Since the, since now they ain't been getting that bad because I've been catching it, I've been catching my head when it starts to hurt a little. I've been taking the medicine and I haven't been getting that much, that much painful headaches.

Q Okay. And if you catch it early enough, do you take ibuprofen?

A No.

Q If you catch it early enough and take that, then it doesn't get so bad you have to lie down?

A Yes.

Q All right. But if you don't catch it in time then they get that bad?

A Yes.

Q Now what kinds of things, what, is there anything you want the Judge to know about you and your conditions and your ability to work or not to work?

A I'm not really, I'm not really saying, I'm not really saying not. I'm not really saying I can't really work, I can't really work permanently. I can work a little, not much. It's just I got a limit I can work because if I work to, if I get to a limit, I end up getting headaches and my back hurt and I just --

Q You're not saying that you can't do anything?

A Yeah.

Q You're just saying that it's all day, every day?

A Yeah.

Q It's more than you think you can handle. Now do you have a checkbook?

A No.

Q No? And do you have a bank account?

A No.

Q Are you able to make change and go to the store and pay for things?

A Yes.

Q Can you do that by yourself and --

A Yes.

Q And you do have a driver's license?

A Yes.

Q Does it have any restrictions about night driving or anything like that?

A No.

Q Is there anything else that you think the Judge should know about you that I haven't asked you about? If there's not --

A I think, yeah, I think not.

Q All right.

ATTY: Nothing further, Judge, at this time.

ALJ: Okay. Call your next.

ATTY: All right. I'll call his step dad,

ALJ: All right.

(The Witness, having been first duly sworn, testified as follows:)

EXAMINATION OF WITNESS 1 BY ATTORNEY:

Q Mr. for the record, state your name, please.

A My name is.

Q And how long have you been part of life?

A Since he was about a year, nine months to a year.

Q All right. And have you lived in the same house with him since that time?

A Yes.

Q All right. What kinds of difficulties have you observed having that impact his ability to hold a job?

A Well, his communication skills. He had a real hard time communicating, understanding people and just having a regular conversation, as you can see when you were talking to him. You know, his eye contact with other people is just ain't there. His posture has affected taking care of himself as far as being able to bend down and wash his feet. He has to lean against the wall and bring his feet up to was his feet. Just a lot of learning disabilities. I believe that is going to (INAUDIBLE) life. Just to maintain a job he can't do normal speed.

Q Does he have friends that he socializes with now?

A He does have a couple friends that he, he's only got one or two friends.

Q All right. Any girlfriend that you know of?

A No.

Q And what kinds of stuff like do you see do?

A Well, the things that I see him do on a daily basis is watch TV and Play Station 2. As far as drugs and things, (INAUDIBLE). As far as riding a bicycle, he can ride a bicycle.

Q Now has helped you from time to time about doing yard work for people?

A Yes. He helps mow a lawn and I have a self-propelled mower that he would use most of the time (INAUDIBLE). It wasn't a push mower. It was self-propelled. Even doing that after an hour he was

(INAUDIBLE).

Q All right. And as far as, as far as getting out and communicating with people, have you witnessed any misunderstandings or instances where he wasn't getting his point across to people?

A He has a hard time explaining things. Explaining things to people, you know, yeah. I think gets overwhelmed, something small. He worries. I just notice that he does that a lot.

Q Is he a worrier?

A Yes. He worries without a doubt.

Q And have you noticed that when he does something it takes longer than what would be considered an average amount of time?

A Yes, definitely.

Q What kind of things?

A As far as doing dishes it normally takes the average person, you know, an hour to do dishes and it's two and a half hours.

Q Does he do a good job?

A He does a good job. He does a good job.

Q Is there anything else that you think that the Judge needs to know about and his abilities or inabilities that you don't think we've covered?

A Well, I feel that, I mean I don't know if his posture has, I think, a lot to do with it. I think when he does go into an interview they automatically see his posture and that's just not human, the way he's seen. His posture is going to affect a lot of things in his life and it's a permanent thing, and I feel like the little pains that he has now, the headaches, the getting out of bed, you know, he'll get

out of bed and uh, oh, oh, now (INAUDIBLE). If he gets a hold of a job he might be able to work an hour or something like that, but not to make a living. There's no way that is going to be able to work.

Q Okay.

ATTY: That's all I have, Judge.

(The Vocational Expert, having been first duly sworn, testified as follows:)

EXAMINATION OF VOCATIONAL EXPERT BY ADMINISTRATIVE LAW JUDGE:

Q Miss [redacted] would you tell us your name, please?

A [redacted].

ALJ: Miss [redacted]'s qualifications are in the file. I find that she is a qualified vocational expert witness.

BY ADMINISTRATIVE LAW JUDGE:

Q Miss [redacted], apparently [redacted] has no work history which would qualify his past relevant work so we'll proceed directly to the first hypothetical. Please assume an individual 22 years of age with a high school diploma, but with several resource classes. Assume marginal literacy. Yeah, assume, I'm sorry, assume reading and mathematics disorders. He does have a full scale IQ of 71. Assume a light exertional residual functional capacity. That is able to stand and walk six hours out of an eight-hour work day, sit six hours out of an eight-hour work day, lift and carry 20 pounds occasionally, 10 pounds frequently. Most of what follows, a lot of the non exertional limitations I'm going to give come from the Arkansas Rehabilitation Service. That's part of Exhibit 3F. But first, Miss [redacted] please assume the individual is limited to unskilled work. That is can have

interpersonal contact which is incidental to the work performed. Tasks must be learned by rote and require limited judgment. The individual would require little supervision for routine tasks with detailed supervision for non routine tasks. According to the Arkansas Rehabilitation Service the individual is limited, learning disorders suggest that formal classroom training would not be a good training method. The individual would do better in on the job training. Would be better on work that requires that work be performed slowly, carefully, more slowly, carefully and correctly rather than very quickly. That's from Arkansas Rehabilitation Service. I'm jumping around really bad on this and I apologize to everybody for that, but as far as the education is concerned, add to that the individual has completed an Arkansas Rehabilitation Service course in food service, that is primarily cooking and baking. Based on these limitations, are there any jobs that exist in significant numbers that such an individual could perform?

A Yes, sir. Within those limits there are unskilled, light jobs that he could perform, Your Honor. Examples would be any of your, let me get my record materials, Your Honor. Any of your light housekeeping jobs. These are not paced jobs, Your Honor, which I'm assuming that would fit within that limitation that you have there. And we have over 15,000 in the region and over 300,000 nationally.

Q Do you have Arkansas numbers?

A Yes, sir. We have over 1800.

Q Okay.

A This is the light ones, Your Honor, not the medium level.

Q All right.

A Okay. And also jobs such as your shirt pressers. Again, these are not fast-paced jobs. Over 1,600 in the region and over 30,000 nationally.

Q I'd rather have Arkansas than the region if you have it.

A Okay. Sixteen-hundred, that's for Arkansas, Your Honor.

Q Okay.

A And over 2,500 in the region and over 30,000 nationally. I'm sorry.

Q All right. Okay. For the same hypothetical, same age, education and no past relevant work as hypothetical number one, assume an ability to stand and walk four hours out of an eight-hour work day, sit two hours out of an eight-hour work day, poor ability to maintain concentration, persistence and pace. Are there any jobs that exist in significant numbers that such an individual could perform?

A No, sir.

ALJ: Miss [redacted] do you have anything for Miss [redacted]?

ATTY: I have a couple, yes.

ALJ: Okay.

EXAMINATION OF VOCATIONAL EXPERT BY ATTORNEY:

Q Miss [redacted], hypothetical number two that the Judge gave --

A Yes.

Q -- instead of sit two, if we were to change that to six hours out of an eight-hour day but stand only up to four and all the same parameters, are there any jobs of that type?

A No. We're not basing it on that poor rating on limitation of

concentration, persistence and pace, the jobs that he would qualify for would require that he be able to at least maintain the attention and concentration and pace for up to that minimum two-hour standard. And if it's a poor rating which is basically severe, then he wouldn't be able to work.

ALJ: Your Honor, I don't have any other questions.

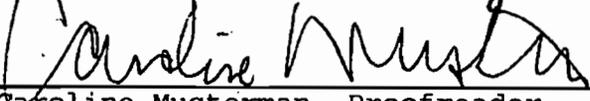
ATTY: Okay. Thank you all very much. There being nothing further, that will conclude the hearing at 9:39 a.m. Thank you.

(The hearing closed at 9:40 a.m., on May 27, 2009.)

C E R T I F I C A T I O N

I have read the foregoing and hereby certify that it is a true and complete transcription of the testimony recorded at the hearing held before Administrative Law Judge Robert L. Neighbors.

  
\_\_\_\_\_  
Pama L. Almon, Transcriber  
Free State Reporting, Inc.

  
\_\_\_\_\_  
Caroline Musterman, Proofreader  
Free State Reporting, Inc.

## DISABILITY DETERMINATION AND TRANSMITTAL

1. DESTINATION DDS <input checked="" type="checkbox"/> ODO <input type="checkbox"/> DRS <input type="checkbox"/> DOB <input type="checkbox"/> INTPSC <input type="checkbox"/>		2. DDS CODE 504	3. FILING DATE 10/05/2007	4. SSN	BIC (# CDB or D/WB CLAIM) 00
5. NAME AND ADDRESS OF CLAIMANT (include ZIP Code)				6. WES NAME (if CDB or D/WB CLAIM)	
7. TYPE CLAIM (Title II) DIE <input type="checkbox"/> FZ <input type="checkbox"/> DWB <input type="checkbox"/> CDB-R <input type="checkbox"/> CDB-D <input type="checkbox"/> RD-R <input type="checkbox"/> RD-D <input type="checkbox"/> RD <input type="checkbox"/> P-R <input type="checkbox"/> P-D <input type="checkbox"/> MOFE <input type="checkbox"/>					
8. TYPE CLAIM (Title XVI) DI <input checked="" type="checkbox"/> DS <input type="checkbox"/> DC <input type="checkbox"/> BI <input type="checkbox"/> BS <input type="checkbox"/> BC <input type="checkbox"/>					
9. DATE OF BIRTH		10. PRIOR ACTION PD <input type="checkbox"/> PT <input type="checkbox"/>		11. REMARKS Clmt Phone: DDS Received 10/17/2007	
12. DISTRICT-BRANCH OFFICE ADDRESS (include ZIP Code) Hot Springs AR District Office 112 CORPORATE TERRACE Hot Springs, AR 71913				DO-BO CODE 760	
13. DO-BO REPRESENTATIVE			14. DATE	11A. <input type="checkbox"/> Presumptive Disability	11B. <input type="checkbox"/> Impairment

### DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED

15. CLAIMANT DISABLED A. <input type="checkbox"/> Disability Began B. <input type="checkbox"/> Disability Ceased		16A. PRIMARY DIAGNOSIS BODY SYS. 01 CODE NO. 7240 Scoliosis		16B. SECONDARY DIAGNOSIS Borderline Intellectual Functioning CODE NO. 3195	
17. DIARY TYPE		MO. YR.	REASON		
18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)(216)(i) A. <input type="checkbox"/> Not Disab. for Cash Bene. Purp. B. <input type="checkbox"/> Disab for Cash Benefit Purp. Beg.			19. CLAIMANT NOT DISABLED A. <input checked="" type="checkbox"/> Through Date of Current Determination B. <input type="checkbox"/> Through _____ C. <input type="checkbox"/> Before Age 22 (CDB only)		
20. VOCATIONAL BACKGROUND			OCC YRS.	EDYRS. 12	21. VR ACTION SCIN <input type="checkbox"/> SCOUT <input checked="" type="checkbox"/> Prev Ref <input type="checkbox"/>
22. REG-BASIS CODE N32	23. MED LIST NO.	24. MOB CODE	25. REVISED DET <input type="checkbox"/>	Initial A. <input checked="" type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/>	Recon <input type="checkbox"/> DHU <input type="checkbox"/> ALJ Hearing <input type="checkbox"/> Appeals Council <input type="checkbox"/> U.S. District Court <input type="checkbox"/>
26. LIST NO. <input checked="" type="checkbox"/> A. 251		B.	C.	D.	E.
27. RATIONALE <input type="checkbox"/> See Attached SSA-4268-U4/C4 <input type="checkbox"/> Check if Vocational Rule Met. Cite Rule					
28. A. <input type="checkbox"/> Period of Disability B. <input type="checkbox"/> Disability Period C. <input type="checkbox"/> Estab Beg _____ AND D. <input type="checkbox"/> Continues E. <input type="checkbox"/> Term _____					

29. LTR/PAR NO.	30. DISABILITY EXAMINER-DDS 409 Rebekah Mooney	31. DATE 12/20/2007	32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE See RFC dated 12/17/2007	33. DATE
32A. PHYSICIAN OR MEDICAL SPEC. NAME (Stamp, Print or Type) JERRY L THOMAS, M.D.				32B. SPEC. CODE 29

34. REMARKS			MULTIPLE IMPAIRMENTS CONSIDERED	
			34A. COMBINED MULTIPLE NONSEVERE-SEVERE	
			34B. COMBINED MULTIPLE NONSEVERE-NONSEVERE	
35. BASIS CODE	36. PER. DET. CODES	37. SSA REPRESENTATIVE	SSA CODE	38. DATE

### DISABILITY DETERMINATION AND TRANSMITTAL

1. DESTINATION DDS <input checked="" type="checkbox"/> ODO <input type="checkbox"/> DRS <input type="checkbox"/> DQB <input type="checkbox"/> INT/PSC <input type="checkbox"/>		2. DDS CODE S04	3. FILING DATE 10/05/2007	4. SSN _____	BIC (if CDB or D/WB CLAIM) 00
5. NAME AND ADDRESS OF CLAIMANT (include ZIP Code)			6. WE'S NAME (if CDB or D/WB CLAIM)		
9. DATE OF BIRTH			10. PRIOR ACTION PD <input checked="" type="checkbox"/> PT <input type="checkbox"/>		
12. DISTRICT BRANCH OFFICE ADDRESS (include ZIP Code) Hot Springs AR District Office 112 CORPORATE TERRACE Hot Springs, AR 71913			DO-BO CODE 760	11. REMARKS Clmt Phone: Recon filed 01/09/2008 Recon received 01/29/2008	
13. DO-BO REPRESENTATIVE		14. DATE	11A. <input type="checkbox"/> Presumptive Disability	11B. <input type="checkbox"/> Impairment	

#### DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED

15. CLAIMANT DISABLED A. <input type="checkbox"/> Disability Began B. <input type="checkbox"/> Disability Ceased		16A. PRIMARY DIAGNOSIS DISORDER OF THE BACK		BODY SYS. 01	CODE NO. 7240	16B. SECONDARY DIAGNOSIS Borderline Intellectual Functioning		CODE NO. 3195	
17. DIARY TYPE	MO./YR.	REASON		18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)(218)(i) A. <input type="checkbox"/> Not Disab. for Cash Bene. Purp. B. <input type="checkbox"/> Disab for Cash Benefit Purp. Beg.		19. CLAIMANT NOT DISABLED A. <input checked="" type="checkbox"/> Through Date of Current Determination B. <input type="checkbox"/> Through _____ C. <input type="checkbox"/> Before Age 22 (CDB only)			
20. VOCATIONAL BACKGROUND			OCC YRS.	EDYRS. 12	GRADE 12	21. VR ACTION A. <input type="checkbox"/> SCIN B. <input checked="" type="checkbox"/> SCOUT C. <input type="checkbox"/> Prev Ref			
22. REG-BASIS CODE N32	23. MED LIST NO.	24. MOB CODE	25. REVISED DET <input checked="" type="checkbox"/>	Initial A. <input type="checkbox"/>	Recon B. <input checked="" type="checkbox"/>	DHU C. <input type="checkbox"/>	ALJ Hearing D. <input type="checkbox"/>	Appeals Council E. <input type="checkbox"/>	U.S. District Court F. <input type="checkbox"/>
26. LIST NO. <b>A. 251</b>		B.		C.		D.		E.	
27. RATIONALE <input type="checkbox"/> See Attached SSA-4268-U4/C4		<input type="checkbox"/> Check if Vocational Rule Met. Cite Rule			28. A. <input type="checkbox"/> Period of Disability B. <input type="checkbox"/> Disability Period C. <input type="checkbox"/> Estab Beg AND D. <input type="checkbox"/> Continues E. <input type="checkbox"/> Term				

29. LTR/PAR NO.	30. DISABILITY EXAMINER-DDS 670 Rebecca Walden	31. DATE 02/07/2008	32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE See RFC dated 02/07/2008	33. DATE
32A. PHYSICIAN OR MEDICAL SPEC. NAME (Stamp, Print or Type) BILL PAYNE, M.D. 32			32B. SPEC. CODE 32	

34. REMARKS			MULTIPLE IMPAIRMENTS CONSIDERED	
			34A. COMBINED MULTIPLE NONSEVERE-SEVERE	
			34B. COMBINED MULTIPLE NONSEVERE-NONSEVERE	
35. BASIS CODE	36. REV. DET. CODES	37. SSA REPRESENTATIVE	SSA CODE	38. DATE

SOCIAL SECURITY ADMINISTRATION  
SUPPLEMENTAL SECURITY INCOME  
Notice of Disapproved Claim

DATE: December 20, 2007

Claim Number: .

We are writing about your claim for Supplemental Security Income (SSI) payments. Based on a review of your health problems you do not qualify for payments on this claim. This is because you are not disabled or blind under our rules.

THE DECISION ON YOUR CASE

The following report(s) was/were used to decide this claim:

MD report received 12/05/2007  
NATIONAL PARK MEDICAL CTR. report received 11/16/2007  
HOT SPRINGS RADIOLOGY SERVICES report received 11/16/2007  
, PHD report received 12/18/2007

You said that you became disabled on 10/05/2007 because of scoliosis.

The evidence shows that while your conditions may limit your activities, your limitations are not severe enough to be considered disabling according to Social Security disability guidelines at this time.

Based on your age and your education, you can do some types of work.

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.

ABOUT THE DECISION

Doctors and other trained staff looked at this case and made this decision. They work for the state but used our rules.

Please remember that there are many types of disability programs, both government and private, which use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in this case.

**The Disability Rules**

You must meet certain rules to qualify for SSI payments based on disability. Your health problems must:

- . keep you from doing any kind of substantial work (described below), and
- . last, or be expected to last, for at least 12 months in a row, or result in death.

### **The Blindness Rules**

You must meet certain rules to qualify for SSI payments based on blindness:

- . your eyesight must be no better than 20/200 in the better eye with the use of a correcting lens, or
- . your visual fields must be restricted to 20 degrees or less.

A person can qualify for SSI benefits due to blindness even if he/she can do substantial work.

### INFORMATION ABOUT SUBSTANTIAL WORK

Generally, substantial work is physical or mental work a person is paid to do. Work can be substantial even if it is part-time. To decide if a person's work is substantial, we consider the nature of the job duties, the skills and experience needed to do the job, and how much the person actually earns.

Usually, we find that work is substantial if gross earnings average over \$900 per month after we deduct allowable amounts. A person's work may be different than before his/her health problems began. It may not be as hard to do and the pay may be less. However, we may still find that the work is substantial under our rules.

If a person is self-employed, we consider the kind and value of his/her work, including his/her part in the management of the business, as well as income, to decide if the work is substantial.

### Other Social Security Benefits

The application you filed for SSI was also a claim for Social Security benefits. We looked into this and decided you cannot get any Social Security benefits besides those you may already be getting. If you disagree with this decision, you have the right to appeal. The appeal is described in this letter.

### INFORMATION ABOUT MEDICAID

An agency of your state will advise you about the Medicaid program. If you have any questions about your eligibility for Medicaid or need immediate medical assistance, you should get in touch with the local Department of Human Services office.

### IF YOU DISAGREE WITH THE DECISION

If you disagree with this decision, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide your case.

- . You have 60 days to ask for an appeal.
- . The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- . You must have a good reason for waiting more than 60 days to ask for an appeal.
- . You have to ask for an appeal in writing. We will ask you to complete a form SSA-

561-U2, called "Request for Reconsideration". You may contact one of our offices or call 1-800-772-1213 to request this form. Or you may complete this form online at <http://www.socialsecurity.gov/disability/appeal>. Contact one of our offices if you want help.

. In addition, you have to complete a "Disability Report-Appeal" to tell us about your health problems since you filed your claim. You may contact one of our offices or call 1-800-772-1213 to request this form. Or, you may complete this report online after you complete the online Request for Reconsideration.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your SSI Claim." It contains more information about the appeal.

#### HOW THE APPEAL WORKS

You have the right to review the facts in your case. You can give us more facts to add to your file. Then we will decide your case again. You will not meet the person who will decide your case.

#### **New Application**

You have the right to file a new application at any time, but filing a new application is NOT the same as appealing this decision. If you disagree with this decision and you file a new application instead of appealing, you might lose some benefits, or not qualify for any benefits. And, we could deny the new application using this decision, if the facts and issues are the same. So, if you disagree with this decision, you should ask for an appeal within 60 days.

#### IF YOU WANT HELP WITH YOUR APPEAL

You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

#### OTHER INFORMATION

This decision refers only to your claim for Supplemental Security Income payments. You will receive a separate notice if you also filed a claim for Social Security payments.

#### IF YOU HAVE ANY QUESTIONS

If you have any questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at (501) 525-6927. We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

112 CORPORATE TERRACE  
Hot Springs, AR 71913

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Ramona Schuenemeyer  
Regional Commissioner

Enclosure: SSA Pub. No. 05-11008  
16/RGM089692/ksm706904 0009

**EXHIBIT NO. 1B**  
**PAGE: 4 OF 4**

760

Social Security Administration

Form Approved

Please read the back of the last copy before you complete this form.

OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

EXHIBIT NO. 2B  
PAGE: 1 OF 2

JAN 14 2008  
U.S. DEPARTMENT OF SOCIAL SECURITY

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person,

(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

- Title II (RSDI)
- Title XVI (SSI)
- Title XVIII (Medicare Coverage)
- Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

I appoint, or I now have, more than one representative. My main representative is

(Name of Principal Representative)

Signature (Claimant)	Address
	Fax Number (with Area Code) Date 1-8-08

E OF APPOINTMENT

... hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one:  I am an attorney.  I am a non-attorney who is eligible to receive direct fee payment.  I am not an attorney and I am ineligible to receive direct fee payment.

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney.  YES  NO

I have been disqualified from participating in or appearing before a Federal program or agency.  YES  NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date
----------------------------	------

Part IV (Optional) WAIVER OF DIRECT PAYMENT

by Attorney or Non-Attorney Eligible to Receive Direct Payment

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney or Eligible Non-Attorney (for Direct Payment) Representative)	Date
---	------

## Choosing to Be Represented

You can choose to have a representative help you when you do business with Social Security. We will work with your representative, just as we would with you. It is important that you select a qualified person because, once appointed, your representative may act for you in most Social Security matters. We give more information, and examples of what a representative may do, on the back of the "Claimant's Copy" of this form.

### Paperwork and Privacy Act Notice

The Social Security Administration (SSA) will recognize someone else as your representative if you sign a written notice appointing that person and, if he or she is not an attorney, that person signs the notice agreeing to be your representative. (You can read more about this in our regulations: 20 CFR §§ 404.1707 and 416.1507.) Giving the information this form requests is voluntary. Without it though, we may not work with the person you choose to represent you.

### How to Complete This Form

Please print or type. At the top, show your full name and your Social Security number. If your claim is based on another person's work and earnings, also show the "wage earner's" name and Social Security number. If you appoint more than one person, you may want to complete a form for each of them.

### Part I Appointment of Representative

Give the name and address of the person(s) you are appointing. You may appoint an attorney or any other qualified person to represent you. You also may appoint more than one person, but see "What Your Representative(s) May Charge" on the back of the "Claimant's Copy" of this form. You can appoint one or more persons in a firm, corporation, or other organization as your representative(s), but you may not appoint a law firm, legal aid group, corporation, or organization itself.

Check the block(s) showing the program(s) under which you have a claim. You may check more than one block. Check:

- Title II (RSDI), if your claim concerns retirement, survivors, or disability insurance benefits.
- Title XVI (SSI), if your claim concerns supplemental security income.
- Title XVIII (Medicare Coverage), if your claim concerns entitlement to Medicare or enrollment in the Supplementary Medical Insurance (SMI) plan.

If you will have more than one representative, check the block and give the name of the person you want to be the main representative.

## How To Complete This Form, continued

Sign your name, but print or type your address, your area code and telephone number, and the date.

### Part II Acceptance of Appointment

Each person you appoint (named in part I) completes this part, preferably in all cases. If the person is not an attorney, he or she must give his or her name, state that he or she accepts the appointment, and sign the form.

### Part III (Optional) Waiver of Fee

Your representative may complete this part if he or she will not charge any fee for the services provided in this claim. If you appoint a second representative or co-counsel who also will not charge a fee, he or she also should sign this part or give us a separate, written waiver statement.

### Part IV (Optional) Waiver of Direct Payment by an Attorney or a Non-Attorney Eligible to Receive Direct Payment

Your representative may complete this part if he or she is an attorney or a non-attorney who does not want direct payment of all or part of the approved fee from past-due retirement, survivors, disability insurance, or supplemental security income benefits withheld.

**Paperwork Reduction Act Statement** - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

### References

- 18 U.S.C. §§ 203, 205, and 207; and 42 U.S.C. §§ 406(a), 1320a-6, and 1383(d)(2)
- 20 CFR §§ 404.1700 et. seq. and 416.1500 et. seq.
- Social Security Rulings 88-10c, 85-3, 83-27, and 82-39

EXHIBIT NO. 2B  
PAGE: 2 OF 2

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JAN 14 2008  
EXHIBIT NO. 3B  
PAGE: 1 OF 1

**CONTRACT OF EMPLOYMENT/SOCIAL SECURITY**

Be it understood between the parties hereto that the undersigned ATTORNEY agrees to undertake and prosecute a claim for the undersigned CLIENT for Social Security Disability Benefits and/or SSI Benefits.

Be it understood between the parties hereto that the agreed upon fee when a favorable decision is issued at the initial or reconsideration levels, or at a hearing before an administrative law judge, or at any level of my disability claim, will be 25% of the total past due benefits payable to the claimant and any beneficiaries entitled to benefits under the claimant's account, or \$5,300.00, whichever is less.

Be it further understood between the parties that if no money is realized from this representation in said disability claim against the Social Security Administration, it is hereby agreed that no fee/money is owed.

Be it understood between the parties hereto that where possible, any fees will be collected directly from the amounts withheld by the Social Security Administration; however, if for any reason the amount for attorney fees is not withheld by the Social Security Administration, it will be the obligation of CLIENT to pay the approved attorney fees directly to the ATTORNEY.

Be it understood between the parties hereto that CLIENT'S heirs, personal representatives, legal guardians, and agents are bound by the terms and conditions set forth herein.

No agreement will be made with the Social Security Administration in relation to the prosecution of this claim without first obtaining the approval of CLIENT herein. CLIENT shall undertake to notify ATTORNEY of any contacts, notices, or other correspondence sent to CLIENT by the Social Security Administration.

CLIENT acknowledges receipt of a fully executed copy of this agreement by his/her signature below.

Date: 1-8-08

Social Security Number

Claimant's dependents and their ages:

none

SOCIAL SECURITY ADMINISTRATION  
SUPPLEMENTAL SECURITY INCOME  
NOTICE OF RECONSIDERATION - DISABILITY

DATE: February 8, 2008

Claim Number: :  
Reconsideration Filed: 01/09/2008

Upon receipt of your request for reconsideration we had your claim independently reviewed by a physician and disability examiner in the State agency which works with us in making disability determinations. The evidence in your case has been thoroughly evaluated; this includes the medical evidence and any additional information.

The following report(s) was/were used to decide this claim in addition to those listed on our previous notice.

HOT SPRINGS REHABILITATION CENTER report received 02/07/2008

You said that you became disabled on 10/05/2007 because of scoliosis.

The evidence shows that while your condition may cause you some problems, you do not meet the requirements to qualify for Social Security disability benefits at this time.

Based on your age and your education, you can do some types of work.

The determination on your claim was made by an agency of the State. It was not made by your own doctor or by other people or agencies writing reports about you. However, any evidence they gave us was used in making this determination. Doctors and other people in the State agency who are trained in disability evaluation reviewed the evidence and made the determination based on Social Security law and regulations.

If you believe that the reconsideration determination is not correct, you may request a hearing before an administrative law judge of the Office of Hearings and Appeals. If you want a hearing, you must request it not later than 60 days from the date you receive this notice. You may make your request through any Social Security office or on the Internet at <http://www.socialsecurity.gov/disability/appeal>. As part of the appeal process, you also need to tell us about your current medical condition. We provide a form for doing that, the Disability Report-Appeal. You may contact one of our offices or call 1-800-772-1213 to request this form. Or, you may complete the report online after you complete the online Request for Hearing by Administrative Law Judge. Read the enclosed leaflet and the attached page of this notice for a full explanation of your right to appeal.

If you request a hearing, your case will be assigned to an administrative law judge of the Office of Hearings and Appeals. The administrative law judge will let you know when and where your case will be heard.

The hearing proceedings are informal. The administrative law judge will summarize the facts in your case, explain the law, and state what must be decided. Then you will have an opportunity to explain why you disagree with the decision made in your case, to present additional evidence and to have witnesses testify for you. You can also request the administrative law judge to subpoena unwilling witnesses to appear for cross-examination and to bring with them any information about your case. You have the right to request the administrative law judge to issue a decision based on the written record without you personally appearing before him/her. If you decide not to appear at the hearing, you still have the right to submit additional evidence. The administrative law judge will base the decision on the evidence in your file plus any new evidence submitted.

In having your case heard, you can represent yourself or be represented by a lawyer, a friend, or any other person. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with this decision and you file a new application instead of appealing, you might lose some benefits, or not qualify for any benefits. So, if you disagree with this decision, you should ask for an appeal within 60 days.

This decision refers only to your claim for Supplemental Security Income payments. You will receive a separate notice if you also filed a claim for Social Security payments.

An agency of your state will advise you about the Medicaid program. If you have any questions about your eligibility for Medicaid or need immediate medical assistance, you should get in touch with your local Social Services office.

If you have any questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at (501) 525-6927. We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

112 CORPORATE TERRACE  
Hot Springs, AR 71913

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Ramona Schuenemeyer  
Regional Commissioner

Enclosure: SSA Pub. No. 70-10281

16/RLW810313/jhi050470 0087  
CC:

760

May 9, 2008, 11:45  
PAGE 1

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REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

On April 25, 2008, we talked with you and completed your REQUEST FOR HEARING for SOCIAL SECURITY BENEFITS. We stored your REQUEST FOR HEARING information electronically in our records and attached a summary of your statements.

What You Need To Do

- o Review your REQUEST FOR HEARING to ensure we recorded your statements correctly.
- o If you agree with all your statements, you may retain the REQUEST FOR HEARING for your records.
- o If you disagree with any of your statements, you should contact us within 10 days after the date of this notice to let us know.

MY NAME IS

MY SOCIAL SECURITY NUMBER IS

I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I DISAGREE WITH THE DETERMINATION MADE ON MY CLAIM FOR SSI DISABILITY/TITLE II BENEFITS BECAUSE I AM DISABLED

I HAVE NO ADDITIONAL EVIDENCE TO SUBMIT.

I WISH TO APPEAR AT A HEARING. I UNDERSTAND THAT AN ADMINISTRATIVE LAW JUDGE OF THE OFFICE OF DISABILITY ADJUDICATION AND REVIEW WILL BE APPOINTED TO CONDUCT THE HEARING OR OTHER PROCEEDINGS IN MY CASE. I ALSO UNDERSTAND THAT THE ADMINISTRATIVE LAW JUDGE WILL SEND ME NOTICE OF THE TIME AND PLACE OF A HEARING AT LEAST 20 DAYS BEFORE THE DATE SET FOR A HEARING.

IT COULD BE ESPECIALLY USEFUL IN MY CASE SINCE THE ADMINISTRATIVE LAW JUDGE WOULD HAVE AN OPPORTUNITY TO HEAR AN EXPLANATION AS TO HOW MY IMPAIRMENTS PREVENT ME FROM WORKING AND RESTRICT MY ACTIVITIES.

May 9, 2008, 11:45  
PAGE 2

NH

I AM REPRESENTED BY \_\_\_\_\_ WHO IS AN ATTORNEY.

THE REQUEST FOR HEARING IS NOT TIMELY FILED.

MY PHONE NUMBER IS

DATE April 25, 2008.

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF PERSON MAKING STATEMENT (if other than above wage earner, self-employed person, or SSI claimant)	RELATIONSHIP TO WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT <i>Attorney</i>

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

I am filing this appeal after the 65 day appeal period because:

*the volume of cases I handle, my child's illness, and my difficulty in getting in touch with the claimant, I submitted his request for a hearing fourteen days after the 65-day appeal period. Because it was due to no fault on the part of \_\_\_\_\_, I respectfully request he be allowed to continue his claim at the hearing level.*

EXHIBIT NO. 6B  
PAGE: 2 OF 2

**Paperwork Reduction Act Statement** - This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

**SIGNATURE OF PERSON MAKING STATEMENT**

Signature (First name, middle initial, last name) (Write in ink)	Date (Month, day, year) 5/5/08
SIGN HERE	Telephone Number (Include Area Code)
Mailin	
City	ZIP Code

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, City, State, and ZIP Code)	Address (Number and street, City, State, and ZIP Code)

56

I561 SUMMARY

JUNE 11, 2008

The Request for Reconsideration was received by Social Security on January 9, 2008 at 3:40:24 pm.

Claimant's name is [redacted]. The Claimant's mailing address is [redacted].  
The Claimant's phone number is ( [redacted] ) [redacted].

Claimant's Social Security Number is [redacted].

The Claimant disagrees with the determination made on his or her claim and requests reconsideration. The reasons are: DUE TO MY PHYSICAL AND MENTAL CONDITIONS I AM UNABLE TO PERFORM ANY SUBSTANTIAL GAINFUL ACTIVITY. .

The Claimant is represented by [redacted], who is an attorney. If not done so previously, the Claimant will complete and submit form SSA-1696 (Appointment of Representative) . The Representative's address is [redacted].

The Representative's phone number is [redacted] and fax number is [redacted].



Refer To:

Office of Disability Adjudication and Review  
Rm 2405 Federal Bldg  
700 West Capitol Ave  
Little Rock, AR 72201-3227  
Tel: (866)592-2549

May 5, 2009

**NOTICE OF HEARING**

I have scheduled your hearing for:

**Day:** Wednesday      **Date:** May 27, 2009      **Time:** 9:00 AM  
Central (CT)

**Room:** 22      **Address:** Rix Building  
1401 Malvern Avenue  
Hot Springs, AR 71901

**Please Arrive At The Hearing Site Thirty Minutes Early To Review Your File.**

**Please Bring Photo Identification.**

**It Is Important That You Come To Your Hearing**

I have set aside this time to hear your case. If you do not appear at the hearing and I do not find that you have good cause for failing to appear, I may **dismiss** your request for hearing. I may do so without giving you further notice.

**Complete The Enclosed Form**

Please complete and return the enclosed acknowledgment form to let me know you received this notice. Use the enclosed envelope to return the form to me within five days of the date you receive this notice. We assume you got this notice five days after the date on it unless you show us that you did not get it within the five-day period.

**If You Cannot Come to Your Scheduled Hearing**

If you cannot come to your hearing at the time and place I have set, call this office immediately. Also mail in the form right away.

If you object to the set time and place, but do not request a change at the earliest possible opportunity at which you could do so before the time set for the hearing, I will rule on your request based on our standards for deciding if there is a good reason for not timely filing a request and our standards for deciding if there is a good reason for changing the time and place of a scheduled hearing. I will apply these standards in considering any objection to the set time and place that is not timely submitted.

To request a change, you must state why you object to the time or place set. You also must state the time and place you want the hearing held. You must do this in writing.

If I find you have a good reason, I will reschedule the hearing for a time and place I set. I will also mail you another notice at least 20 days before the date of the hearing.

**Travel Costs**

When you, a representative, or needed witnesses will travel more than 75 miles one way to the hearing, we can pay certain travel costs. I am enclosing a sheet telling about our rules for doing that. Please call me if you want more information.

**Issues I Will Consider In Your Case**

The hearing concerns your application of October 5, 2007, for Supplemental Security Income (SSI) and whether you may be eligible for SSI as a disabled person under section 1614(a)(3) of the Social Security Act (Act).

Under the Act, I may find you disabled only if you have a physical or mental impairment that:

- has prevented you from doing any substantial gainful work; and
- has lasted 12 straight months or can be expected to last for that time or result in death.

To decide if you are disabled, I will follow a step-by-step process until I can make a decision. The issues in this process concern:

- any work you have done since you got sick;
- the severity of your impairment(s); and
- your ability to do the kind of work you did in the past and, considering your age, education and work experience, any other work that exists in the national economy.

Our regulations explain the rules for deciding if you are disabled and, if so, when you became disabled. These rules appear in the Code of Federal Regulations, Title 20, Chapter III, Part 416, Subpart I.

### **More About the Issues**

If I find that drug addiction and/or alcoholism is an issue, I also will decide whether it is a contributing factor material to the determination of your disability. Further, if drug addiction or alcoholism is a contributing factor material to the determination of your disability, I will find you not disabled pursuant to Sections 223(d)(2) and 1614(a)(3) of the Social Security Act as amended by Pub. L. 104-121.

If you qualify for benefits based on disability, I will also decide if your disability continues. I will consider whether there has been any medical improvement in your impairment(s) or whether one of the exceptions to medical improvement stated in the regulations applies. Unless certain exceptions apply, I will find you still disabled if you have not become able to work.

### **Remarks**

A vocational expert will testify at your hearing.

### **If You Have Objections**

If you object to the issues I have stated, or to any other aspect of the scheduled hearing, you must tell me in writing why you object. You must do this at the earliest possible opportunity before the hearing.

### **You May Submit Additional Evidence And Review Your File**

If there is more evidence you want to submit, get it to me right away. If you cannot get the evidence to me before the hearing, bring it to the hearing. If you want to see your file before the date of the hearing, call this office.

### **Your Right To Request a Subpoena**

I may issue a subpoena that requires a person to submit documents or testify at your hearing. I will issue a subpoena if it is reasonably necessary for the full presentation of your case.

If you want me to issue a subpoena, you must submit a written request. You should submit the request as soon as possible before the hearing. The request must identify the needed documents or witnesses and their location, state the important facts the document or witness is expected to prove, and indicate why you cannot prove these facts without a subpoena.

### **What Happens At The Hearing**

- You may review your file. If you wish to do so, please arrive 30 minutes before the time set for the hearing. Call us if you want more time.
- You will have a chance to testify and tell me about your case.
- You (and your representative) may submit documents, present and question witnesses, state your case, and present written statements about the facts and law.
- I will question you and any other witnesses about the issues. You and any other witnesses must normally testify under oath or affirmation.
- We will make an audio recording of the hearing.

### **My Decision**

After the hearing, I will issue a written decision explaining my findings of fact and conclusions of law. I will base my decision on all the evidence of record, including the testimony at the hearing. I will mail a copy of the decision to you.

### **If You Have Any Questions**

If you have any questions, please call or write this office. Our telephone number and address are shown on the first page of this notice.

Administrative Law Judge

#### **Enclosures:**

Form HA-504 (Acknowledgement of Receipt of Notice of Hearing)

Form HA-L84 (Vocational Expert Letter)

cc:



Refer To:

Office of Disability Adjudication and Review  
Rm 2405 Federal Bldg  
700 West Capitol Ave  
Little Rock, AR 72201-3227  
Tel: (866)592-2549

May 5, 2009

**NOTICE OF HEARING**

I have scheduled your hearing for:

**Day:** Wednesday      **Date:** May 27, 2009      **Time:** 9:00 AM  
Central (CT)

**Room:** 22      **Address:** Rix Building  
1401 Malvern Avenue  
Hot Springs, AR 71901

**Please Arrive At The Hearing Site Thirty Minutes Early To Review Your File.**

**Please Bring Photo Identification.**

**It Is Important That You Come To Your Hearing**

I have set aside this time to hear your case. If you do not appear at the hearing and I do not find that you have good cause for failing to appear, I may **dismiss** your request for hearing. I may do so without giving you further notice.

**Complete The Enclosed Form**

Please complete and return the enclosed acknowledgment form to let me know you received this notice. Use the enclosed envelope to return the form to me within five days of the date you receive this notice. We assume you got this notice five days after the date on it unless you show us that you did not get it within the five-day period.

See Next Page

### **If You Cannot Come to Your Scheduled Hearing**

If you cannot come to your hearing at the time and place I have set, call this office immediately. Also mail in the form right away.

If you object to the set time and place, but do not request a change at the earliest possible opportunity at which you could do so before the time set for the hearing, I will rule on your request based on our standards for deciding if there is a good reason for not timely filing a request and our standards for deciding if there is a good reason for changing the time and place of a scheduled hearing. I will apply these standards in considering any objection to the set time and place that is not timely submitted.

To request a change, you must state why you object to the time or place set. You also must state the time and place you want the hearing held. You must do this in writing.

If I find you have a good reason, I will reschedule the hearing for a time and place I set. I will also mail you another notice at least 20 days before the date of the hearing.

### **Travel Costs**

When you, a representative, or needed witnesses will travel more than 75 miles one way to the hearing, we can pay certain travel costs. I am enclosing a sheet telling about our rules for doing that. Please call me if you want more information.

### **Issues I Will Consider In Your Case**

The hearing concerns your application of October 5, 2007, for Supplemental Security Income (SSI) and whether you may be eligible for SSI as a disabled person under section 1614(a)(3) of the Social Security Act (Act).

Under the Act, I may find you disabled only if you have a physical or mental impairment that:

- has prevented you from doing any substantial gainful work; and
- has lasted 12 straight months or can be expected to last for that time or result in death.

To decide if you are disabled, I will follow a step-by-step process until I can make a decision. The issues in this process concern:

- any work you have done since you got sick;
- the severity of your impairment(s); and
- your ability to do the kind of work you did in the past and, considering your age, education and work experience, any other work that exists in the national economy.

Our regulations explain the rules for deciding if you are disabled and, if so, when you became disabled. These rules appear in the Code of Federal Regulations, Title 20, Chapter III, Part 416, Subpart I.

### **More About the Issues**

If I find that drug addiction and/or alcoholism is an issue, I also will decide whether it is a contributing factor material to the determination of your disability. Further, if drug addiction or alcoholism is a contributing factor material to the determination of your disability, I will find you not disabled pursuant to Sections 223(d)(2) and 1614(a)(3) of the Social Security Act as amended by Pub. L. 104-121.

If you qualify for benefits based on disability, I will also decide if your disability continues. I will consider whether there has been any medical improvement in your impairment(s) or whether one of the exceptions to medical improvement stated in the regulations applies. Unless certain exceptions apply, I will find you still disabled if you have not become able to work.

### **Remarks**

A vocational expert will testify at your hearing.

### **If You Have Objections**

If you object to the issues I have stated, or to any other aspect of the scheduled hearing, you must tell me in writing why you object. You must do this at the earliest possible opportunity before the hearing.

### **You May Submit Additional Evidence And Review Your File**

If there is more evidence you want to submit, get it to me right away. If you cannot get the evidence to me before the hearing, bring it to the hearing. If you want to see your file before the date of the hearing, call this office.

### **Your Right To Request a Subpoena**

I may issue a subpoena that requires a person to submit documents or testify at your hearing. I will issue a subpoena if it is reasonably necessary for the full presentation of your case.

If you want me to issue a subpoena, you must submit a written request. You should submit the request as soon as possible before the hearing. The request must identify the needed documents or witnesses and their location, state the important facts the document or witness is expected to prove, and indicate why you cannot prove these facts without a subpoena.

### **What Happens At The Hearing**

- You may review your file. If you wish to do so, please arrive 30 minutes before the time set for the hearing. Call us if you want more time.
- You will have a chance to testify and tell me about your case.
- You (and your representative) may submit documents, present and question witnesses, state your case, and present written statements about the facts and law.
- I will question you and any other witnesses about the issues. You and any other witnesses must normally testify under oath or affirmation.
- We will make an audio recording of the hearing.

### **My Decision**

After the hearing, I will issue a written decision explaining my findings of fact and conclusions of law. I will base my decision on all the evidence of record, including the testimony at the hearing. I will mail a copy of the decision to you.

### **If You Have Any Questions**

If you have any questions, please call or write this office. Our telephone number and address are shown on the first page of this notice.

Administrative Law Judge

#### **Enclosures:**

Form HA-L32 (Electronic Disability Claims Processing Insert)  
Form HA-504 (Acknowledgement of Receipt of Notice of Hearing)  
Barcode Sheet  
Form HA-L84 (Vocational Expert Letter)

cc:

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### When we can pay travel expenses

---

If you must travel more than 75 miles one way from your home or office to attend the hearing, we can pay certain costs. Here are the rules that apply:

- We can pay your transportation expenses such as the cost of a bus ticket or expenses for driving your car.
- In certain circumstances, you may need meals, lodging, or taxicabs. The Administrative Law Judge (ALJ) must approve these special travel costs **before the hearing unless** the costs were unexpected and unavoidable.
- The ALJ may also approve payment of similar travel expenses for your representative and any witnesses he or she determines are needed at the hearing.
- You must submit a written request for payment of travel expenses to the ALJ at the time of the hearing or as soon as possible after the hearing. List what you spent and include supporting receipts. If you requested a change in the scheduled location of the hearing to a location farther from your residence, we cannot pay you for any **additional** travel expenses.
- If you need money for travel costs in advance, you should tell the ALJ as soon as possible **before the hearing**. We can make an advance payment only if you show that without it you would not have the funds to travel to or from the hearing.
- If you receive travel money in advance, you must give the ALJ an itemized list of your actual travel costs and receipts within 20 days after your hearing.
- If we gave you an advance payment that is more than the amount you are due for travel costs, you must pay back the difference within 20 days after we tell you how much you owe us.

### **Electronic Disability Claims Processing**

Social Security is changing from a paper to an electronic disability claims process in order to improve the quality and timeliness of our decisions. Your client's disability claim file is being processed electronically. Your claimant's rights under the Social Security Act remain the same.

When your client's case is exhibited, we will forward a copy of the file to you on a compact disc (CD). We will also provide you a copy of the file on CD on the day of the hearing. Should you require a copy of the file at any other time, please contact the hearing office.

Additional evidence should be submitted within the timeframes for the submission of evidence discussed in the notice. **The preferred way to submit evidence to the electronic folder is by using one of the following three methods:**

- **Send the evidence using the Electronic Records Express (ERE) website. If you have not registered to use the ERE website, contact your local hearing office.**
- **Fax the evidence using this fax number -- (501)324-5008. Remember that the enclosed barcode must be the first page for each document being faxed.**
- **Send the evidence to the contract scanner listed below. The barcode must be the first page of each document. DO NOT SEND ORIGINAL DOCUMENTS. DOCUMENTS ARE NOT RETURNED.**

**Little Rock, AR ODAR  
P.O. Box 9034  
Mt. Vernon, IL 62864-0134**

**You may also send the evidence by mail or deliver it to the hearing office but there may be a delay in associating the evidence with the electronic file.**

**NOTE:** The attached barcode pertains to your client's disability claim file only. Please keep the original barcode sheet for submitting all documents on this case. Bar codes may be used more than once when faxing evidence into the electronic file.

Form Approved  
OMB NO. 0960-0671

**ACKNOWLEDGEMENT OF RECEIPT (NOTICE OF HEARING) SM**  
(COMPLETE THIS FORM AND RETURN IT AT ONCE IN THE ENVELOPE PROVIDED. NO POSTAGE IS NECESSARY)

Claimant: [REDACTED]	Social Security Number: [REDACTED]
Wage Earner: [REDACTED]	Administrative Law Judge: Robert L. Neighbors
Hearing Scheduled: Wednesday, May 27, 2009 at 9:00 AM Central (CT)	Hearing Office: Little Rock
Location of Hearing: Room 22  Rix Building 1401 Malvern Avenue Hot Springs, AR 71901	

(Check only one)

I will be present at the time and place shown on the Notice of Hearing. If an emergency arises after I mail this form and I cannot be present, I will immediately notify you at the telephone number shown on the Notice of Hearing.

I cannot be present at the time and place shown on the Notice of Hearing. I request that you reschedule my hearing because:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NOTE: YOUR REQUEST FOR HEARING MAY BE DISMISSED IF YOU DO NOT ATTEND THE HEARING AND CANNOT GIVE A GOOD REASON FOR NOT ATTENDING. THE TIME OR PLACE OF THE HEARING WILL BE CHANGED IF YOU HAVE A GOOD REASON FOR YOUR REQUEST.

Signature: _____	Date: _____	Area Code and Telephone Number: _____
------------------	-------------	---------------------------------------

I have recently moved. My new address is:

\_\_\_\_\_

\_\_\_\_\_

**Privacy Act Notice** The Social Security Act (sections 205(a), 702, 1631(e)(1)(A) and (B), and 1869(b)(1) and (c), as appropriate) authorizes the collection of information on this form. We need the information to continue processing your claim. You do not have to give it, but if you do not you may not be able to receive benefits under the Social Security Act. We may give out the information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the federal government. The law allows us to do this even if you do not agree to it.

**Paperwork Reduction Act Statement** - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 1 minute to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*  
Form HA 504 (09-2003) ef (10-2004)



INSERT THIS END FIRST



Please include this barcode cover sheet with any documents returned.



RQID:000000000000000000003990392 SITE:X13 DR:S  
SSN: TYPE:5032 RF:D CS:1665

Claimant:

SSN:



**SOCIAL SECURITY ADMINISTRATION**

EXHIBIT NO. 8B  
PAGE: 13 OF 14

Refer To:

Office of Disability Adjudication and Review  
Rm 2405 Federal Bldg  
700 West Capitol Ave  
Little Rock, AR 72201-3227  
Tel: (866)592-2549 / Fax: (501)324-7137

May 5, 2009

Dear Ms. [REDACTED]:

The claimant named below has an application pending for disability benefits. A hearing for the claimant is scheduled, date and time shown below.

Name of Claimant: [REDACTED] Birth date: [REDACTED] SSN: [REDACTED]

Date and Time: Wednesday, May 27, 2009 at 9:00 AM Central (CT)

You are requested to appear and give testimony as a vocational expert in the above hearing.

Address: Room 22  
Rix Building  
1401 Malvern Avenue  
Hot Springs, AR 71901

Your testimony will primarily cover the following period:

December 28, 1999 through September 30, 2004.

Your presence throughout the hearing is desired since your testimony will be based, in part, on the testimony given by the claimant and any other witnesses, including a medical advisor if needed. Enclosed are copies of some of the pertinent exhibits (and a list of these exhibits) tentatively selected for inclusion in the record of this case. Please bring this material to the hearing. For additional information concerning your testimony, please see the attachment to this form letter.

Your charges for this service should be submitted in accordance with your contract with the Social Security Administration.

Sincerely yours,

Administrative Law Judge

Enclosures

See Next Page

### IMPORTANT INFORMATION

**NOTE: IT IS REQUIRED THAT YOU DISQUALIFY YOURSELF IF YOU HAVE HAD ANY PRIOR KNOWLEDGE OF THIS CLAIMANT OR EXPERIENCE IN THIS CASE OTHER THAN AS A VOCATIONAL EXPERT FOR THE OFFICE OF DISABILITY ADJUDICATION AND REVIEW.**

While medical factors alone may justify a finding that the claimant is or is not disabled, it is necessary in some cases to consider vocational factors in order to determine whether or not the claimant is able to engage in any substantial gainful activity. Two basic questions will be presented to you at this hearing.

The first question pertains to the kind of work, if any, the claimant can do in light of prior work activity and residual functional capacity considering age, education, training and work experience. Your testimony will be predicated on various assumptions, posed at the hearing, with respect to the claimant's residual functional capacity. You will not be expected to testify as to whether or not the claimant is under a disability, since you do not have the responsibility for deciding this ultimate legal issue. You should not express any opinion regarding the impairments involved and their effects on residual functional capacity, since these are medical matters. You will be requested to furnish a rationale and complete explanation for your opinions. In forming your judgment as to whether or not the claimant could transfer vocational skills to any other type of work, please consider only work which the claimant could perform after a normal period of training, usually given to new employees, rather than after extended vocational rehabilitation.

The second questions is whether such work exists in the "national economy;" i.e., whether it exists in significant numbers either in the region where the claimant lives or in several other regions of the country. You should be prepared to testify from personal knowledge gained from vocational surveys of businesses and industries (whether such surveys were made by you or by other vocational experts) and from other current vocational resource materials.

Questions may also be asked of you by the claimant (or representative, if any).

OHA-1 ROOM 460  
OFFICE OF HEARINGS & APPEALS  
SOCIAL SECURITY ADMINISTRATION  
1301 YOUNG ST STE 130  
DALLAS TEXAS 75202-5433

REGION: \_\_\_\_\_  
IO CODE: \_\_\_\_\_  
HO: \_\_\_\_\_

RESUME OF EXPERIENCE AND BACKGROUND-VOCATIONAL EXPERT

(Print Or Type All Entries)

HOME PHONE: (501) \_\_\_\_\_

TAXPAYER IDENTIFICATION NO.  
(SSN OR EIN)

OFFICE PHONE: (501) \_\_\_\_\_

1. NAME: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

2. MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. PRESENT EMPLOYMENT

PRESENT EMPLOYER AR Rehab Services DATE EMPLOYMENT BEGAN 10/94

POSITION OR TITLE & DESCRIPTION OF DUTIES Rehab Program Specialist: Work with community rehabilitation programs in the development and implementation of assessment, work adjustment/evaluation and vocational training programs for individuals with disabilities with emphasis on the most severely disabled. (See Resume)

4. PREVIOUS RELEVANT EXPERIENCE

EMPLOYER Rehab for the Blind DATES OF EMPLOYMENT 89-94

POSITION OR TITLE & DESCRIPTION OF DUTIES Program Supervisor: Supervised and monitored provision of rehabilitation services statewide. Interviewed, hired, and trained vocational rehabilitation staff. Monitored program compliance with federal rehabilitation law. (See Resume)

(PLEASE ATTACH CONTINUATION SHEET(S), IF ADDITIONAL SPACE IS REQUIRED.)

RESUME OF EXPERIENCE AND BACKGROUND--VOCATIONAL EXPERT (CONTINUED)

5. EDUCATION

(A)	<u>UNDERGRADUATE INSTITUTION</u> (NAME AND ADDRESS)	<u>DEGREE/DATE</u>	<u>MAJOR SUBJECT</u>	
	Univ. of Mississippi Oxford, MS	BS-70	Business	
	AR Tech University Russellville, AR	BS-85	Accounting	
(B)	<u>GRADUATE INSTITUTION</u> (NAME AND ADDRESS)	<u>DATES OF ATTENDANCE</u>	<u>DEGREE</u>	<u>MAJOR SUBJECT</u>
	Mississippi State Univ. Starkville, MS	72	MED	Rehabilitaion Counseling
	Auburn University Auburn, Alabama	72	Advanced counseling courses	

ARE YOU AN EMPLOYEE OF THE FEDERAL GOVERNMENT? YES  NO

IS ANY RELATIVE AN EMPLOYEE OR OFFICER OF THE SOCIAL SECURITY ADMINISTRATION? YES  NO

IF YES, WHAT IS THE RELATIONSHIP? \_\_\_\_\_

DO YOU HAVE A CONTRACT WITH THE FEDERAL GOVERNMENT? YES  NO

IF YES, WHAT IS THE NATURE OF THIS CONTRACT? \_\_\_\_\_

**ATTENTION**

(PLEASE READ THE FOLLOWING PARAGRAPHS BEFORE SIGNING THIS FORM.)

I UNDERSTAND THAT A FALSE ANSWER TO ANY OF THE ITEMS LISTED ON MY RESUME MAY BE GROUNDS FOR TERMINATING MY BLANKET PURCHASE AGREEMENT. I FURTHER UNDERSTAND THAT FEDERAL LAW (18 U.S.C. 1001) PROVIDES THAT MAKING FALSE OR FRAUDULENT STATEMENTS OR REPRESENTATIONS ON THIS RESUME IS PUNISHABLE BY FINE OR IMPRISONMENT.

I HAVE COMPLETED THIS RESUME WITH THE KNOWLEDGE AND UNDERSTANDING THAT ANY AND ALL ITEMS CONTAINED HEREIN MAY BE SUBJECT TO VERIFICATION, AND CONSENT TO THE RELEASE OF INFORMATION CONCERNING MY PROFESSIONAL CAPABILITIES AND BACKGROUND BY EMPLOYERS, EDUCATIONAL INSTITUTIONS AND OTHER PERSONS TO THE CONTRACTING OFFICER.

**CERTIFICATION**

I CERTIFY THAT ALL OF THE STATEMENTS MADE BY ME ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND ARE MADE IN GOOD FAITH.

SIGNATURE \_\_\_\_\_

DATE 08-18-96

RESUME

WORK EXPERIENCE

REHAB PROGRAM SPECIALIST 10-94-Present: Arkansas Rehab Services  
Work in conjunction with community rehabilitation programs providing programmatic and technical assistance for certification of rehabilitation programs in compliance with the Rehabilitation Act. Assist in the development of assessment, work evaluation, and vocational training programs for individuals with multiple disabilities. Survey local industry jobs to assess need for potential training programs in specific areas; evaluate existing jobs available that would allow for direct entry without extensive retraining. Public relations activities between community rehabilitation programs, vocational rehabilitation staff, and industry.

PROGRAM SUPERVISOR 1989-1994: Division Services Blind.  
Supervise and monitor provision of vocational rehabilitation services statewide with eleven vocational rehabilitation counselors and five youth services counselors. Responsible for maintaining compliance with federal and state regulations. Allocate federal monies for purchase of rehabilitation services statewide. Function as arbitrator for unresolved client/counselor disputes. Also responsible for hiring and training of vocational rehabilitation staff.

REHAB COUNSELOR 1973-1989: AR Rehabilitation Services/  
Spinal Cord Commission. Worked a caseload of all disability groups including severely disabled SSDI recipients with ultimate goal of employment. Client population included back injuries, spinal cord injured, alcohol-drug abuse, head injuries, mentally retarded/developmentally delayed, blind/visually impaired and others. Responsibilities included counseling/guidance, vocational assessment, evaluation, arranging feasible training programs, and job placement.

( )

Made recommendations to employers on job modifications to allow individuals with disabilities opportunities to transfer skills to new work environment; recommendations on modifications to buildings to reduce architectural barriers and provide access to more job opportunities. Coordinated services between different providers, veterans, workmans compensation, insurance, other agencies and vocational rehabilitation.

OTHER WORK  
EXPERIENCE

Machine Operator--Vendo Company, Aurora, Ill.  
production line, screw assembly.  
Solder--Western Electric, Aurora, Ill.  
solder relay wires on production line.  
Winder--Ram Golf, Pontotoc, MS  
Wound golf balls on production machine, lifting  
30-50 lbs. boxes.  
Secretary--Allied Enterprises, New Albany, Ms.  
Cashier--WalMart, Forest City, AR  
Packager--Valmac Industries, Russellville, AR  
Package frozen chicken parts on assembly line  
Teacher--Capital City Business College, Russellville,  
AR. Taught accounting, economics, math.  
Other Experience--waitress, janitor, nursing  
home aide, grocery store stocker, telemetry  
monitor.

EDUCATION

Arkansas Tech University, B.S. Accounting 1985.  
Mississippi State University, MED. Rehabilitation  
Counseling 1972.  
Auburn University, 9 qtr hours advanced counseling  
1972.  
University of Mississippi, B.S. Business & Commerce  
1970.

RELATED  
CONTINUED  
EDUCATION

Medical Aspects of Disability  
Placement of Sheltered Workshop Clients  
Seminar/Placement of Severely Disabled  
Interpersonal Skills Training  
Human Sexuality and Disability  
Transactional Analysis  
Pain Management  
Stress Management  
Goal Setting  
Psychology of Disability  
Burn Out  
Med Aspects of Spinal Cord Injury  
American Sign Language  
Transition of Youth/Disabilities  
Arbitration/Intervention Skills  
How to Manage People  
Motivating People  
Grievance Prevention  
Executive Leadership  
Rehab Act Amendments  
Aids in the Workplace  
Workers Comp and ADA  
Job Placement  
Rehab of Persons with Chronic Mental Illness  
Basic Dysrhythmia  
Wage and Hour Seminar  
Crisis Intervention  
Traumatic Brain Injury  
ARS Training Institute: Focusing on Motivation,  
Overcoming and Coping with Learning Disabilities  
Bridge to Employment: Changing Role of the  
Employment Specialist  
Reengineering the Rehab Process  
Job Development and Job Accommodation  
Employment Strategies for Persons with Mental  
Illness  
The Changing Face of Leadership  
Brain Injury Association Conference  
Attention Deficit Disorders  
Fair Labor Standards Act Compliance  
Work Force Development  
Jobs For The Future

October 16, 2007, 11:41  
PAGE 1

CLAIMANT:

APPLICATION SUMMARY FOR SUPPLEMENTAL SECURITY INCOME

On October 16, 2007, you applied for Supplemental Security Income and any federally administered State supplementation under title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under title XIX of the Social Security Act. We have stored your application electronically in our records.

What You Need To Do

- o Review this summary to ensure we recorded your statements correctly.
- o If you agree with all your statements, you should keep this summary for your records.
- o If you disagree with any of your statements, you should contact us within 10 days after the date of this summary to let us know.

o IDENTIFICATION

My name is [redacted] My social security number is [redacted]

My date of birth is [redacted]

I have not used any other name or social security number(s).

I am not blind.

I am disabled. My disability began on December 28, 1999.

I was disabled prior to age 22.

I am a United States citizen by birth.

I never lived outside the United States.

I never was married.

o FUGITIVE FELON AND PAROLE OR PROBATION VIOLATION INFORMATION

October 16, 2007, 11:41  
PAGE 2

CLAIMANT:

The following statements describe my fugitive felon/parole or probation violator status as of October 5, 2007.

I have not been accused or convicted of a felony or an attempt to commit a felony.

I am not on parole or probation under Federal or State law.

o LIVING ARRANGEMENTS

The following statements describe my living arrangements as of October 1, 2007.

I began living at

I live in a house/apartment/mobile home/houseboat.

I live with others.

I do not expect these arrangements to change.

o RESOURCES

This report of resources is valid for any and all SSI claims in which I am involved.

I do not own any type of resource.

o INCOME

This report of income is valid for any and all SSI claims in which I am involved.

I receive or expect to receive the following income from October 1, 2007 to continuing:

Social Security:

Amount \$0.00

From: October 2007 To: October 2007

I do not receive any other type of income.

o ELIGIBILITY FOR OTHER BENEFITS

I do not currently get food stamps.

IMPORTANT REMINDER

Penalty of Perjury

October 16, 2007, 11:41

PAGE 3

CLAIMANT:

You declared under penalty of perjury that all the information on this summary is true and correct to the best of your knowledge. Anyone who knowingly gives a false or misleading statement about a material fact in an application, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

We will check your statements and compare our records with records from other State and Federal agencies, including the Internal Revenue Service to make sure you are paid the correct amount.

We will process this application for Supplemental Security Income as quickly as possible. You should hear from us within \_\_\_\_\_ days. If you do not hear from us by then, please get in touch with us.

We will let you know if we need more information to decide if you are eligible for SSI payments. In the meantime, if you move or change your mailing address, you--or someone for you-- should report the change to the office shown.

Always give the Social Security number when writing or telephoning about this claim. If you have any questions about this claim, we will be glad to help you.

If you have a question or something to report, call (\_\_\_\_) \_\_\_\_\_ and ask for \_\_\_\_\_. If you call or visit our office, please have this summary with you. For general information about Social Security, visit our web site at [www.socialsecurity.gov](http://www.socialsecurity.gov) on the Internet.

You may visit or write to the Social Security Office at:

SOCIAL SECURITY  
112 CORPORATE TERRACE  
HOT SPRINGS AR 71913

NH NAME  
INPUT 04/22/09  
RUN DATE 04/22/09 V:11/23/07  
CONTROL

SN: EXHIBIT NO. 28 PG 001  
DO:X13 UNIT:JWMS DEKO MOD:07

EVENT ICERS EARNINGS RECORD  
TID CERTIFIED EARNINGS RECORD  
ALERTS PRIOR CLAIM DATA DOES NOT EXIST ON DRAMS  
FILING DATE USED BY SYSTEM EQUALS ONSET DATE  
INFORMTNL NO EARNINGS AFTER 1951 FOUND ON THE EARNINGS RECORDS  
NO EARNINGS OF ANY KIND FOUND  
DISABILITY EXCLUSION 20/40 INSURED TEST NOT MET  
DISABILITY NON-EXCLUSION 20/40 INSURED TEST NOT MET  
DISABILITY EXCLUSION SPECIAL AGE 24 INSURED TEST NOT MET  
DISABILITY NON-EXCLUSION SPECIAL AGE 24 INSURED TEST NOT MET  
DISABILITY EXCLUSION FULLY INSURED STATUS NOT MET  
DISABILITY NON-EXCLUSION FULLY INSURED STATUS NOT MET  
PRIOR CLAIM STATUS - A  
ID INFO REQ NAM REQ SEX:M REQ DATE OF BIRTH:  
DATES DATE OF ONSET:12/28/1999  
DIB INPUT MBR/INPUT DATA  
ONSET:12/28/1999 DENIAL/DISALLOWANCE:90  
INS STAT DISABILITY: EXCL REQ QC:06 EXCL HAS:000  
NON-EXCL REQ QC:06 NON-EXCL HAS:000  
TOT COV SSA QC  
1937 THRU 1950 QC: 0  
WAGE QC AFTER 1946:NONE WAGE QC AFTER 1950:NONE  
SE QC:NONE AG QC:NONE  
TOT EARN SSA  
TOT AFTER 1936: NONE  
TOT AFTER 1950: NONE

QRY DATE: 04/22/09 AN: —DOC: X13 UNIT: JWMS PG: 001 DEQR  
INPUT: YRS REQ: 1992-2009; COVERED DETAILS; NON-COVERED DETAILS; PENSION;  
SPECIAL WAGE PAYMENT; EMPLOYER ADDRESS EXHIBIT NO: 3D  
MEF: NA: DOB: , SX: M AK: PAGE: 1 OF 3  
DETAIL COVERED FICA EARNINGS AND EMPLOYER NAME AND ADDRESS FOR YEARS  
REQUESTED  
NO COVERED FICA EARNINGS POSTED FOR YEARS REQUESTED  
DETAIL NON-COVERED EARNINGS AND W-2 PENSION DATA AND EMPLOYER NAME AND  
ADDRESS FOR YEARS REQUESTED  
NO NON-COVERED EARNINGS AND W-2 PENSION DATA POSTED FOR YEARS REQUESTED  
REMARKS  
CLAIMS ACTIVITY--SEE MBR  
CLAIMS ACTIVITY--SEE SSR

---





## DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

---

### (3367) ID/Prior Filings

---

#### Identifying Information

1. Name of Person whose Social Security Record this Claim is being filed:

His or Her Social Security Number:         

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Male**

Date Of Birth:         

2. Claimant's Alleged Onset Date: **12/28/1999**

3. Potential Onset Date (if different from above):

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

#### Miscellaneous Information

6. Protective Filing Date: **10052007**

Date Last Insured (DIB/Freeze case):

Beginning of Prescribed Period (DWB):

End of Prescribed Period:

Controlling Date:

Closed Period Case: **No**

#### Prior Filing Information

7. Prior Filing(s): **No**

If Yes, and you are not sending the prior folder, enter the following:

---

### (3367) Presumptive

---

The Presumptive Disability page details are not being displayed here because there is no PD on this case.

---

**(3367) Observations**

---

9. Observations/Perceptions:

How was the Interview Conducted? **Teleclaim with claimant**

If the claimant had difficulty with the following, explain in Observations, or show "No" or "Not observed/perceived." (Explain any "No" answers that you think would assist the DDS in making a decision):

Hearing: **No**

Reading: **Not observed/perceived**

Breathing: **No**

Understanding: **No**

Coherency: **No**

Concentrating: **No**

Talking: **No**

Answering: **No**

Other (specify):

Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

---

**(3367) Development**

---

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? No

12. Is DDS capability development needed? No

Remarks:

Name of Interviewer: **R. Wacaster**

Phone Number: **501-525-2476 ext. 3015**

Name of Person Completing Form: **R. Wacaster**

Date: **10/16/2007**

---

**Form SSA-3367 EDCS**

## DISABILITY REPORT - ADULT - Form SSA-3368

---

### (3368) Section 1 - Information About the Disabled Person

---

A. Name:

B. Social Security Number:

C. Daytime Telephone Number (If you do not have a number where we can reach you, give us a daytime number where we can leave a message.):

or number

D. Give the name of a friend or a relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help you with your claim.

Name:

Relationship:

Address:

Daytime Phone:

E. What is your height without shoes? **6'**

F. What is your weight without shoes? **160 lbs.**

G. Do you have a medical assistance card? **No**

If "YES", show the number here:

H. Can you speak and understand English? **Yes**

If "NO", what is your preferred language?

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

If you cannot speak and understand English, is there someone we may contact who speaks and understands English and will give you messages?

(If "YES", is this the same person as in "D" above? If it is, show "SAME" below, if not complete below.)

---

I. Can you read and understand English? **Yes**

J. Can you write more than your name in English? **Yes**

---

**(3368) Section 2 - Your Illnesses, Injuries, or Conditions and How They Affect You**

---

A. What are the illnesses, injuries, or conditions that limit your ability to work?

**Scoliosis**

B. How do your illnesses, injuries, or conditions limit your ability to work?

**i am unable to lift over 50 lbs. i have trouble turning my head.**

C. Do your illnesses, injuries, or conditions cause you pain or other symptoms? **Yes**

D. When did your illnesses, injuries, or conditions first interfere with your ability to work? **12/28/1999**

E. When did you become unable to work because of your illnesses, injuries, or conditions?

**12/28/1999**

F. Have you ever worked? **No**

G. Did you work at any time after the date your illnesses, injuries, or conditions first interfered with your ability to work?

H. If "Yes," did your illnesses, injuries, or conditions cause you to:

work fewer hours?

change your job duties?

make any job-related changes such as your attendance, help needed, or employers?

Explain:

I. Are you working now?

If "NO," when did you stop working?

J. Why did you stop working?

---

**(3368) Section 3 - Information About Your Work**

---

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

\* = Longest Job Held

Longest Job Held	Job Title	Type of Business	Dates Worked (From-To)	Hours Per Day	Days Per Week	Rate of Pay/Per
------------------	-----------	------------------	------------------------	---------------	---------------	-----------------

B. Which job did you do the longest?

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.):

D. In this job, did you:

Use machines, tools, or equipment?

Use technical knowledge or skills?

Do any writing, complete reports, or perform duties like this?

E. In this job, how many total hours each day did you:

Walk?

Stand?

Sit?

Climb?

Stoop? (Bend down & forward at waist.):

Kneel? (Bend legs to rest on knees.):

Crouch? (Bend legs & back down & forward.):

Crawl? (Move on hands & knees.):

Handle, grab or grasp big objects?

Reach?

Write, type or handle small objects?

F. Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.):

G. Heaviest weight lifted:

H. Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday.):

I. Did you supervise other people in this job?

How many people did you supervise?

What part of your time was spent supervising people?

Did you hire and fire employees?

J. Were you a lead worker?

A. Have you been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries, or conditions that limit your ability to work?

**Yes**

B. Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work?

**No**

C. List other names you have used on your medical records:

Tell us who may have medical records or other information about your illnesses, injuries, or conditions.

D. List each Doctor/HMO/Therapist. Include your next appointment:

E. List each Hospital/Clinic. Include your next appointment:

Name:	<b>ARKANSAS CHILDREN'S HOSPITAL</b>		
Address:	<b>ATTENTION: MEDICAL RECORDS 800 MARSHALL STREET LITTLE ROCK, AR 72202</b>		
Phone:	<b>501-364-1152</b>		
Inpatient Date In 1:	<b>2001</b>	Inpatient Date Out 1:	<b>2001</b>
Inpatient Date In 2:		Inpatient Date Out 2:	
Inpatient Date In 3:		Inpatient Date Out 3:	
Outpatient Date First Visit:		Outpatient Date Last Visit:	
Emergency Room Dates of Visits:			
Next Appointment:			
Your Hospital/Clinic Number:			
Reasons for Visits:	<b>scoliosis</b>		
What treatment did you receive?	<b>surgery</b>		
What doctors do you see at this hospital/clinic on a regular basis?			

F. Does anyone else have medical records or information about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else?

No

---

---

**(3368) Section 5 - Medications**

---

Do you currently take any medications for your illnesses, injuries, or conditions? No

If "YES," please tell us the following: (Look at your medicine containers, if necessary.)

Name of Medicine	Prescribed By (Name of Doctor)	Reason For Medicine	Side Effects You Have
------------------	-----------------------------------	---------------------	-----------------------

---

**(3368) Section 6 - Tests**

---

Have you had, or will you have, any medical tests for your illnesses, injuries, or conditions?

No

If "YES," please tell us the following: (Give approximate dates, if necessary.)

Kind of Test	When Was/Will Test Be Done? (Month, day, year)	Where Done	Who Sent You For This Test
--------------	--	------------	----------------------------

---

**(3368) Section 7 - Education/Training Information**

---

A. Highest grade of school completed: **12th grade**

Approximate date completed: **2004**

B. Did you attend special education classes? Yes

If "YES",

Name of School: LAKE HAMILTON HIGH SCHOOL	
Address: ATTENTION: PRINCIPAL 280 WOLF STREET PEARCY, AR 71964	
Dates Attended: 1994	To: 2004
Type of Program: i was unable to keep up in regular classes i had problems reading	

C. Have you completed any type of special job training, trade or vocational school?

No

If "YES", what type?

Approximate date completed:

**(3368) Section 8 - Vocational Rehabilitation, Employment, or Other Support Services Information**

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services, or other support services to help you go to work?

Yes

Name of Organization: HOT SPRINGS REHABILITATION CENTER		
Name of Counselor:		
Address: ATTN: MEDICAL RECORDS P. O. BOX 1358 HOT SPRINGS, AR 71902		
Daytime Phone Number: 501-624-4411		
Dates Seen: 2005	To: 08/31/2007	
Types of Services or Tests Performed: i was studying food service		

---

**(3368) Section 9 - Remarks**

---

Use this section for any additional information you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the blocks there.

Name of person completing this form:	Date Form Completed (Month, day, year):
Address (Number and street, City, State, Zip Code): ----- ----- -----	
e-mail address (optional): ----- -----	

**Form SSA-3368 EDCS**

DISABILITY DETERMINATION FOR SOCIAL SECURITY

EXHIBIT NO. 3E  
PAGE: 1 OF 2

070710260001615

PAIN AND OTHER SYMPTOMS

RE: \_\_\_\_\_ SSN: \_\_\_\_\_ CASE#: 0831108

BARBARA COBB/409



RQID: J-000011KAP000 SITE: S04 DR: S  
SSN: \_\_\_\_\_ DCTYPE: 0220 RF: D CS: 182f

1. Do you suffer from unusual fatigue? NO  YES \_\_\_\_\_ (If YES, date you first noticed it? \_\_\_\_\_).

Do you require naps or rest? NO  YES \_\_\_\_\_

If YES, how often? \_\_\_\_\_ Once a day (How long? \_\_\_\_\_)

\_\_\_\_\_ Twice or more a day (How long? \_\_\_\_\_)

\_\_\_\_\_ Can only get out of bed for medical appointments, etc.

2. Describe your pain or other symptoms: pain when moving head side to side/Back pain from rods in back

3. Does the pain interfere with your sleep? NO  YES \_\_\_\_\_

4. Where is your pain located? lower neck

5. How long does the pain usually last? Only when moving head side to side

6. How often do you have the pain or other symptoms? 2 or 3 Daily

7. What activities or circumstances cause the pain or other symptoms? Driving, or when I try to move my head side to side

8. About how long can you do the following before the pain occurs?

Stand/walk 2 hours Sit 2 hours

9. What makes the pain or other symptoms worse? Standing for long period  
Lifting ~~Bending~~ to pick something up

10. What helps the pain or other symptoms besides medication? rest, take it easy

11. Please list the medications you are now taking for your pain and/or other symptoms:

NAME OF MEDICINE	DOSAGE AND HOW OFTEN TAKEN	SIDE EFFECTS
Ibuprofen	Depends on pain	none

12. Have you had to discontinue a medication for your disability because of side effects?  
 If so, what is the name of that medication? no

13. Have you ever been prescribed a special treatment that didn't work (such as a TENS Unit or an ESI Stimulator)? NO  YES   
 If YES, what was the treatment? \_\_\_\_\_

14. Is there anything else about your pain and/or symptoms we should know?

I have pain when I stand or walk for long periods. Solesiosis in back had operation. Rods put in.

15. [Signature] 10/22/07  
 (Signature of Claimant) (Date)

If this form was completed by someone other than the disability claimant, please give that person's name, relationship to claimant and daytime phone number.

\_\_\_\_\_  
 (Name) (Relationship) (Date)

PAIN

Social Security Administration  
0831108/409

070710260001616 Form Approved: OMB No. 0960-0681



RQID: I 000011KA0000 SITE: S04 DR: S  
SSN: TYPE: 0075 RF: D CS: 9fe4

**FUNCTION REPORT - ADULT**  
**BARBARA COBB/409**

*How your illnesses, injuries, or conditions limit your activities*

**SECTION A - GENERAL INFORMATION**

1. NAME OF DISABLED PERSON

2. SOCIAL SECURITY NUMBER

3. 10/22/07  
Date

4. YOUR DAYTIME TELEPHONE NUMBER (If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you)

Area Code Phone Number  
Check if this is:  Your Number  
 Message Number  
 None

5. a. Where do you live? (Check one.)

House  Apartment  Boarding House  Nursing Home  
 Shelter  Group Home  Other (What?) Mobile home

b. With whom do you live? (Check one.)

Alone  With Family  With Friends  Other (Describe relationship)

**SECTION B - INFORMATION ABOUT DAILY ACTIVITIES**

6. Describe what you do from the time you wake up until going to bed. Eat Breakfast, watch TV, look for work, Eat lunch, Playstation 2, and Eat Supper

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other?  Yes  No

If YES, for whom do you care, and what do you do for them?

8. Do you take care of pets or other animals?  Yes 0716260001616 No

If YES, what do you do for them? *feed dog and cat*

9. Does anyone help you care for other people or animals? \_\_\_ Yes  No

If YES, who helps and what do they do to help?

10. What were you able to do before your illnesses, injuries, or conditions that you CANNOT do now?

*run, stand for long periods, hiking, some Amusement rides, lifting objects*

11. Do the illnesses, injuries, or conditions affect your sleep?  Yes \_\_\_ No

If YES, how? *headaches*

12. PERSONAL CARE (Check here \_\_\_ if NO PROBLEM with personal care.)

a. Explain how your illnesses, injuries, or condition affect your ability to:

Dress *can't bend in stand positions when putting*  
*on shoes.*

Bathe *can't bend in stand positions when washing*  
*feet.*

Care for hair *none*

Shave *none*

Feed self *none*

Use the toilet *none*

Other? *none*

- 070710260001616  
b. Do you need any special reminders to take care of personal needs and grooming? \_\_\_ Yes  No

If YES, what type of help or reminders are needed?

- c. Do you need help or reminders taking medicine? \_\_\_ Yes  No

If YES, what kind of help is needed?

13. MEALS

- a. Do you prepare your own meals?  Yes \_\_\_ No  
If yes, what kind of food is prepared (for example, sandwiches, frozen dinners, or complete meals with several courses)? *Sandwiches, Frozen dinners*

How often do you prepare food or meals? (For example, daily, weekly, monthly.) *Daily*

How long does it take you? *Depend on type of food*

Any changes in cooking habits since the illness, injuries, or conditions began? *NO*

- b. If NO, explain why you cannot or do not prepare meals.

14. HOUSE AND YARD WORK

- a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.) *Laundry, Dishing, cleaning*

- b. How much time does it take you, and how often do you do each of these things? *Depend on chore*

- c. Do you need help or encouragement doing these things?  Yes \_\_\_ No

If YES, what help is needed? *reminders*

d. If you don't do house or yard work, explain why not. <sup>07071 0260001616</sup>

15. **GETTING AROUND**

a. How often do you go outside? Daily

If you don't go out at all, explain why not.

b. When going out, how do you travel? (Check all that apply.)

Walk  Drive a car  Ride in a car  Ride a bicycle  
 Use public transportation  Other (Explain)

c. When going out, can you go out alone?  Yes  No  
If NO, explain why you can't go out alone.

d. Do you drive?  Yes  No  
If you don't drive, explain why not.

16. **SHOPPING**

a. If you do any shopping, do you shop: (Check all that apply.)  
 In stores  By phone  By mail  By computer

b. Describe what you shop for. Depend what I want

c. How often do you shop and how long does it take? one time a month

17. **MONEY**

a. Are you able to:

Pay bills	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Count Change	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Handle a savings account	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Use a checkbook/money orders	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Explain all "NO" answers.

No Experence

- b. Has your ability to handle money changed since the illnesses, injuries, or conditions began?  YES  NO

If YES, explain how the ability to handle money has changed.

18. **HOBBIES AND INTERESTS**

- a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.) Watching TV, Playing Playstation 2, friends, smiw

- b. How often and how well do you do these things? Weekly

- c. Describe any changes in these activities since the illnesses, injuries, or conditions began. Not being able to stand long periods

19. **SOCIAL ACTIVITIES**

- a. Do you spend time with others? (In person, on the phone, on the computer, etc.)  Yes  No

If YES, describe the kinds of things you do with others. ride in car, watch TV, Play play station 2

How often do you do these things? 2 time a month

- b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.) None

Do you need to be reminded to go places?  Yes  No

How often do you go and how much do you take part?

Do you need someone to accompany you?  Yes  No

c. Do you have any problems getting along with family, friends, neighbors, or others? \_\_\_ Yes  No

If YES, explain.

d. Describe any changes in social activities since the illnesses, injuries, or conditions began:

None

**SECTION C – INFORMATION ABOUT ABILITIES**

20. a. Circle any of the following items that your illnesses, injuries, or conditions affect:

- |  |  |   |                  |
|--|--|---|------------------|
| <input checked="" type="checkbox"/> Lifting        | <input checked="" type="checkbox"/> Standing | <input checked="" type="checkbox"/> Walking | Sitting          |
| <input checked="" type="checkbox"/> Stair Climbing | <input checked="" type="checkbox"/> Kneeling | Squatting                                   | Reaching         |
| Using hands  | Seeing                                       | Hearing                                     | Talking          |
| <input checked="" type="checkbox"/> Bending        | Memory                                       | Concentration                               | Completing Tasks |
| Understanding                                      | Following Instructions                       | Getting Along with Others                   |                  |

Please explain how your illness, injuries or conditions affect each of the items you circled. (For example, you can only lift: how many pounds, or you can only walk: how far).

b. Are you  right-handed? \_\_\_ left-handed?

c. How far can you walk before needing to stop and rest? 20 min.  
If you have to rest, how long before you can resume walking? 10 min.

d. For how long can you pay attention? 20 min.

e. Do you finish what you start? (For example: a conversation, chores, reading, watching a movie)  Yes \_\_\_ No

f. How well do you follow written instructions? (For example, as a recipe)  
pretty good

g. How well do you follow spoken instructions? Sometimes I forget I suppose to do

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers) good

i. Have you ever been fired or laid off from a job because of problems getting along with other people?  Yes  No

If YES, explain.

j. If YES, give name of employer.

How well do you handle stress?  
Sometime well

k. How well do you handle changes in routine?  
good

l. Have you noticed any unusual behavior or fears?  Yes  No

If YES, explain. riding public Transportation

21. Do you use any of the following?  
(Please check all that apply.)

Crutches

Walker

Wheelchair

Other (Explain)

Cane

Brace/Splint

Artificial Limb

Hearing Aid

Glasses/Contact Lenses

Artificial Voice Box

Which of these was prescribed by a doctor?

glasses

When was it prescribed? 3 years

When do you need to use these aids?

Driving

**SECTION D - REMARKS** 001616

Use this section for any **added information** that you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), **be sure to complete the fields at the bottom of this page.**

10/22/07  
Date (Month, Day, Year)

\_\_\_\_\_  
*email address (optional)*

\_\_\_\_\_  
*City, State, and Zip*

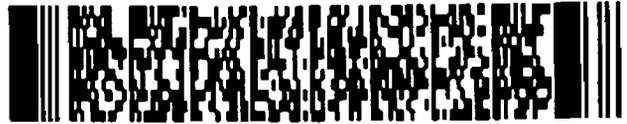
070710260001617

To whom it may concern-

my name is [redacted]  
I've been helping [redacted] with understanding  
Some of these questions on his forms.  
His Mother and I feel like [redacted]  
needs to have a mental evaluation  
done. We feel like [redacted] has other  
disabilities other than his SKoleoses.  
We do not know how to go about getting  
this information. If you could help us  
we would greatly appreciate this. Thank you  
very much for you time.

Social Security Administration  
0831108/409

070710260001617 Form Approved: OMB No. 0960-0578



RQID: 1.000011KAN000 SITE: S04 DR: S  
SSN: ICTYPE: 1080 RF: D CS: 7498

**WORK HISTORY REPORT**  
**BARBARA COBB/409**

**SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON**

**A. NAME (First, Middle Initial, Last)**

**B. SOCIAL SECURITY NUMBER**

S

**C. YOUR DAYTIME TELEPHONE NUMBER** (If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)

Check if this is:  Your Number  
 Message Number  
 None

Area Code Phone Number

**SECTION 2 - INFORMATION ABOUT YOUR WORK**

List all of the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

	Job Title	Type of Business	Dates Worked From	Dates Worked To
1.	None			
2.				
3.				
4.				
5.				
6.				
7.				
8.				

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Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

<b>JOB TITLE NO. 1</b>			
<b>Rate of Pay</b>	<b>Per (Check One)</b>		<b>Hours per day</b>
\$ ___ Hour ___ Day ___ Week ___ Month ___ Year			<b>Days per week</b>

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

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In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

**Lifting and Carrying** (Explain what you lifted, how far you carried it, and how often you did this?)

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Check the **heaviest** weight lifted:

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 20 lbs \_\_\_ 50 lbs \_\_\_ 100 lbs. or more \_\_\_ Other \_\_\_

Check weight you **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 25 lbs \_\_\_ 50 lbs. or more \_\_\_ Other \_\_\_

Did you supervise other people in this job? \_\_\_ YES (Complete items below) \_\_\_ NO (Skip to next page)

How many people did you supervise? \_\_\_\_\_

What part of your time was spent supervising people? \_\_\_\_\_

Did you hire and fire employees? \_\_\_ YES \_\_\_ NO

Were you a lead worker? \_\_\_ YES \_\_\_ NO

070710260001617  
Give us more information about Job No. 2 listed on Page 1. Estimate hours and pay, if you need to.

<b>JOB TITLE NO. 2</b>					
<b>Rate of Pay</b>	<b>Per (Check One)</b>			<b>Hours per day</b>	<b>Days per week</b>
\$ _____	<b>Hour</b>	<b>Day</b>	<b>Week</b>	<b>Month</b>	<b>Year</b>

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

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In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

**Lifting and Carrying** (Explain what you lifted, how far you carried it, and how often you did this?)

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Check the heaviest weight lifted:

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 20 lbs \_\_\_ 50 lbs \_\_\_ 100 lbs. or more \_\_\_ Other \_\_\_

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 25 lbs \_\_\_ 50 lbs. or more \_\_\_ Other \_\_\_

Did you supervise other people in this job? \_\_\_ YES (Complete items below) \_\_\_ NO (Skip to next page)

How many people did you supervise? \_\_\_\_\_

What part of your time was spent supervising people? \_\_\_\_\_

Did you hire and fire employees? \_\_\_ YES \_\_\_ NO

Were you a lead worker? \_\_\_ YES \_\_\_ NO

070710260001517  
Give us more information about Job No. 3 listed on Page 1. Estimate hours and pay, if you need to.

<b>JOB TITLE NO. 3</b>					
<b>Rate of Pay</b>	<b>Per (Check One)</b>			<b>Hours per day</b>	<b>Days per week</b>
\$ ___ Hour ___ Day ___ Week ___ Month ___ Year	___	___	___		

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

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In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

**Lifting and Carrying** (Explain what you lifted, how far you carried it, and how often you did this?)

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Check the heaviest weight lifted:

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 20 lbs \_\_\_ 50 lbs \_\_\_ 100 lbs. or more \_\_\_ Other \_\_\_

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 25 lbs \_\_\_ 50 lbs. or more \_\_\_ Other \_\_\_

Did you supervise other people in this job? \_\_\_ YES (Complete items below) \_\_\_ NO (Skip to next page)

How many people did you supervise? \_\_\_\_\_

What part of your time was spent supervising people? \_\_\_\_\_

Did you hire and fire employees? \_\_\_ YES \_\_\_ NO

Were you a lead worker? \_\_\_ YES \_\_\_ NO

070710260001617

Give us more information about Job No. 4 listed on Page 1. Estimate hours and pay, if you need to.

<b>JOB TITLE NO. 4</b>			
<b>Rate of Pay</b>	<b>Per (Check One)</b>		<b>Hours per day</b>
\$ ___ Hour ___ Day ___ Week ___ Month ___ Year			<b>Days per week</b>

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

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In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this?)

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Check the heaviest weight lifted:

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 20 lbs \_\_\_ 50 lbs \_\_\_ 100 lbs. or more \_\_\_ Other \_\_\_

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 25 lbs \_\_\_ 50 lbs. or more \_\_\_ Other \_\_\_

Did you supervise other people in this job? \_\_\_ YES (Complete items below) \_\_\_ NO (Skip to next page)

How many people did you supervise? \_\_\_\_\_

What part of your time was spent supervising people? \_\_\_\_\_

Did you hire and fire employees? \_\_\_ YES \_\_\_ NO

Were you a lead worker? \_\_\_ YES \_\_\_ NO

070710760001617  
Give us more information about Job No. 5 listed on Page 1. Estimate hours and pay, if you need to.

<b>JOB TITLE NO. 5</b>			
<b>Rate of Pay</b>	<b>Per (Check One)</b>		<b>Hours per day</b>
\$ ___ Hour ___ Day ___ Week ___ Month ___ Year			<b>Days per week</b>

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

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In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

**Lifting and Carrying** (Explain what you lifted, how far you carried it, and how often you did this?)

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Check the heaviest weight lifted:

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 20 lbs \_\_\_ 50 lbs \_\_\_ 100 lbs. or more \_\_\_ Other \_\_\_

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 25 lbs \_\_\_ 50 lbs. or more \_\_\_ Other \_\_\_

Did you supervise other people in this job? \_\_\_ YES (Complete items below) \_\_\_ NO (Skip to next page)

How many people did you supervise? \_\_\_\_\_

What part of your time was spent supervising people? \_\_\_\_\_

Did you hire and fire employees? \_\_\_ YES \_\_\_ NO

Were you a lead worker? \_\_\_ YES \_\_\_ NO

070710260001617  
Give us more information about Job No. 6 listed on Page 1. Estimate hours and pay, if you need to.

<b>JOB TITLE NO. 6</b>			
<b>Rate of Pay</b>	<b>Per (Check One)</b>		<b>Hours per day</b>
\$ ___ Hour ___ Day ___ Week ___ Month ___ Year			<b>Days per week</b>

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

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In this job, did you:

Use Machines, tools or equipment?	___ YES	___ NO
Use Technical Knowledge or skills?	___ YES	___ NO
Do any writing, complete reports or perform duties like this?	___ YES	___ NO

In this job, how many total hours each day did you:

Walk? _____	Kneel? (Bend legs to rest on knees) _____
Stand? _____	Crouch? (Bend legs & back down and forward) _____
Sit? _____	Crawl? (Move on hands & knees) _____
Climb? _____	Handle, grab or grasp big objects? _____
Stoop? (Bend down and forward at waist) _____	Reach? _____
	Write, type or handle small objects? _____

**Lifting and Carrying** (Explain what you lifted, how far you carried it, and how often you did this?)

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Check the heaviest weight lifted:

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 20 lbs \_\_\_ 50 lbs \_\_\_ 100 lbs. or more \_\_\_ Other \_\_\_

Check weight you frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday)

\_\_\_ Less than 10 lbs \_\_\_ 10 lbs \_\_\_ 25 lbs \_\_\_ 50 lbs. or more \_\_\_ Other \_\_\_

Did you supervise other people in this job? \_\_\_ YES (Complete items below) \_\_\_ NO (Skip to next page)

How many people did you supervise? \_\_\_\_\_

What part of your time was spent supervising people? \_\_\_\_\_

Did you hire and fire employees? \_\_\_ YES \_\_\_ NO

Were you a lead worker? \_\_\_ YES \_\_\_ NO

070710260001617  
SECTION 3 - REMARKS

Use this section for any information that you did not have space for in other parts of the form. Show the page number of the part you are continuing.

**BE SURE TO COMPLETE THE BOTTOM OF THIS PAGE**

Lined area for writing remarks.

10/22/07  
Date you completed this form

*email address (optional)*

*City, State, and Zip*      J

**WORK**

## DISABILITY REPORT - APPEAL - Form SSA-3441

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### (3441) Section 1 - Information About the Disabled Person

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- A. Name: \_\_\_\_\_
- B. Social Security Number: \_\_\_\_\_
- C. What is your daytime telephone number? (If you do not have a number where we can reach you, give us a daytime number where we can leave a message.):  
\_\_\_\_\_ **your number**
- D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help with your claim.

Name:	
Relationship:	
Address:	
Daytime Phone:	

---

### (3441) Section 2 - Information About Your Illnesses, Injuries, or Conditions

---

Date of Last Disability Report: 10/16/2007

A. Has there been any change (for better or worse) in your illnesses, injuries, or conditions since you last completed a disability report? **No**

If "YES," please describe in detail:

Approximate date the change(s) occurred:

B. Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions since you last completed a disability report? **No**

If "YES," please describe in detail:

Approximate beginning date:

C. Do you have any new illnesses, injuries, or conditions since you last completed a disability report? **No**

If "YES," please describe in detail:

Approximate beginning date:

---

**(3441) Section 3 - Information About Your Medical Records**

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A. Since you last completed a disability report, have you seen or will you see a doctor/hospital/clinic or anyone else for the illnesses, injuries, or conditions that limit your ability to work?

**No**

B. Since you last completed a disability report, have you seen or will you see a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work?

**No**

C. List other names you have used on your medical records.

Tell us who may have medical records or other information about your illnesses, injuries, or conditions since you last completed a disability report:

D. List each Doctor/HMO/Therapist. Include your next appointment.

---

E. List each Hospital/Clinic. Include your next appointment.

F. Since you last completed a disability report, does anyone else have medical records or information about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else?

**Yes**

Name:	<b>Hot Springs Rehabilitation Center</b>		
Address:	<b>105 Reserve hot springs, AR 71901</b>	Date First Visit:	<b>about 2005</b>
		Date Last Visit:	<b>about 2007</b>
Phone:		Next Appointment:	<b>none</b>
Claim Number:			
Reasons for Visits:	<b>Went through training program for kitchen work.</b>		

**(3441) Section 4 - Medications**

Are you currently taking any medications for your illnesses, injuries, or conditions? **Yes**

If "YES," please tell us the following: (Look at your medicine containers, if necessary.)

Name of Medicine	If Prescribed, Give Name of Doctor	Reason For Medicine	Side Effects You Have
<b>Ibuprofen</b>		<b>I have a lot of headaches. This helps.</b>	<b>none</b>

**(3441) Section 5 - Tests**

Since you last completed a disability report, have you had any medical tests for your illnesses, injuries, or conditions or do you have any such tests scheduled?

No

If "YES," please tell us the following: (Give approximate dates, if necessary.)

Kind of Test	When Was/Will Test Be Done? (Month, day, year)	Where Done (Name of Facility)	Who Sent You For This Test?
--------------	---	----------------------------------	-----------------------------

---

**(3441) Section 6 - Updated Work Information**

---

A. Have you worked since you last completed a disability report?

No

If "YES," you will be asked to give details on a separate form.

---

**(3441) Section 7 - Information About Your Activities**

---

A. How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?

**Scoliosis makes it hard to lift, bend or turn my head. I have trouble doing a lot of normal things because of this. I can't read well or understand what I read, so I have trouble doing things like filling out applications. I haven't passed my driving test yet.**

B. What changes have occurred in your daily activities since you last completed a disability report? (If none, show "None")

**none**

---

**(3441) Section 8 - Education/Training Information**

---

Have you completed any special job training, trade or vocational school since you last completed a disability report?

No

If "YES," describe what type:

Approximate date completed:

---

**(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services Information**

---

Since you last completed a disability report, have you participated in the Ticket Program or another program of vocational rehabilitation services, employment services, or other support services to help you go to work?

No

If "Yes," complete the following information:

---

---

**(3441) Section 10 - Remarks**

---

Use this section for any additional information you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

**I was dropped as a baby and had a skull fracture. I was in the hospital at Geneva General in Geneva, NY. I had back surgery in 2001 at Arkansas Children's Hospital. They put a rod in my back.\* This report was completed on the Internet using i3441 (Public) by: Report Completer Name: [redacted] Report Completer Address: [redacted] Report Completer Phone Number: [redacted] Report Completer Email Address: nuu Internet medical report submitted on: 01/09/2008**

---

**I DECLARE UNDER PENALTY OF PERJURY THAT I HAVE EXAMINED ALL THE INFORMATION ON THIS FORM, AND ON ANY ACCOMPANYING STATEMENTS OR FORMS, AND IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

**I UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.**

Signature of claimant or person filing on claimant's behalf (parent, guardian)	Date (Month, day, year)
Address (Number and street, city, state and ZIP code)	e-mail Address (optional)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

Form SSA-3441 EDCS

## DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

---

### (3367) ID/Prior Filings

---

#### Identifying Information

1. Name of Person whose Social Security Record this Claim is being filed:

His or Her Social Security Number: \_\_\_\_\_

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Male**

Date Of Birth: \_\_\_\_\_

2. Claimant's Alleged Onset Date:

3. Potential Onset Date (if different from above):

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

#### Miscellaneous Information

6. Protective Filing Date:

Date Last Insured (DIB/Freeze case): \_\_\_\_\_

Beginning of Prescribed Period (DWB):

End of Prescribed Period:

Controlling Date:

Closed Period Case:

#### Prior Filing Information

7. Prior Filing(s):

If Yes, and you are not sending the prior folder, enter the following:

---

### (3367) Presumptive

---

The Presumptive Disability page details are not being displayed here because there is no PD on this case.

---

**(3367) Observations**

---

9. Observations/Perceptions:

How was the Interview Conducted? **No contact with claimant**

Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

---

**(3367) Development**

---

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed?

Remarks:

Name of Interviewer: **T. Hunter**

Phone Number: \_\_\_\_\_

Name of Person Completing Form: **T. Hunter**

Date: **01/28/2008**

---

**Form SSA-3367 EDCS**

## DISABILITY REPORT - APPEAL - Form SSA-3441

---

### (3441) Section 1 - Information About the Disabled Person

---

A. Name: \_\_\_\_\_

B. Social Security Number: \_\_\_\_\_

C. What is your daytime telephone number? (If you do not have a number where we can reach you, give us a daytime number where we can leave a message.):

\_\_\_\_\_ir number

D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help with your claim.

Name:

Relationship:

Address:

Daytime Phone:

--	--

---

### (3441) Section 2 - Information About Your Illnesses, Injuries, or Conditions

---

Date of Last Disability Report: **01/28/2008**

A. Has there been any change (for better or worse) in your illnesses, injuries, or conditions since you last completed a disability report? **No**

If "YES," please describe in detail:

Approximate date the change(s) occurred:

B. Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions since you last completed a disability report? **No**

If "YES," please describe in detail:

Approximate beginning date:

C. Do you have any new illnesses, injuries, or conditions since you last completed a disability report? **No**

If "YES," please describe in detail:

Approximate beginning date:

---

**(3441) Section 3 - Information About Your Medical Records**

---

A. Since you last completed a disability report, have you seen or will you see a doctor/hospital/clinic or anyone else for the illnesses, injuries, or conditions that limit your ability to work?

**No**

B. Since you last completed a disability report, have you seen or will you see a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work?

**No**

C. List other names you have used on your medical records.

Tell us who may have medical records or other information about your illnesses, injuries, or conditions since you last completed a disability report:

D. List each Doctor/HMO/Therapist. Include your next appointment.

---

E. List each Hospital/Clinic. Include your next appointment.

---

F. Since you last completed a disability report, does anyone else have medical records or information about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else?

No

---



---

**(3441) Section 4 - Medications**

---

Are you currently taking any medications for your illnesses, injuries, or conditions? **Yes**

If "YES," please tell us the following: (Look at your medicine containers, if necessary.)

Name of Medicine	If Prescribed, Give Name of Doctor	Reason For Medicine	Side Effects You Have
<b>ibuprofen</b>		<b>headaches and back pain. I take a lot of it.</b>	<b>none</b>

---

**(3441) Section 5 - Tests**

---

Since you last completed a disability report, have you had any medical tests for your illnesses, injuries, or conditions or do you have any such tests scheduled?

No

If "YES," please tell us the following: (Give approximate dates, if necessary.)

Kind of Test	When Was/Will Test Be Done? (Month, day, year)	Where Done (Name of Facility)	Who Sent You For This Test?

---

**(3441) Section 6 - Updated Work Information**

---

A. Have you worked since you last completed a disability report?

No

If "YES," you will be asked to give details on a separate form.

---

**(3441) Section 7 - Information About Your Activities**

---

A. How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?

**Can't read much. Limited in turning head and bending, so have trouble doing much physically. Have lots of headaches, so can't concentrate.**

B. What changes have occurred in your daily activities since you last completed a disability report? (If none, show "None")

No change

---

**(3441) Section 8 - Education/Training Information**

---

Have you completed any special job training, trade or vocational school since you last completed a disability report?

No

If "YES," describe what type:

Approximate date completed:

---

**(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services Information**

---

Since you last completed a disability report, have you participated in the Ticket Program or another program of vocational rehabilitation services, employment services, or other support services to help you go to work?

No

If "Yes," complete the following information:

---

---

**(3441) Section 10 - Remarks**

---

Use this section for any additional information you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

**null\* This report was completed on the Internet using i3441 (Public) by: Report Completer  
Name: { \_\_\_\_\_ } Report Completer Address: \_\_\_\_\_  
Report Completer Phone Number: Report Completer Email Address: null Internet medical  
form submitted on: 04/25/2008**

---

**I DECLARE UNDER PENALTY OF PERJURY THAT I HAVE EXAMINED ALL THE INFORMATION ON THIS FORM, AND ON ANY ACCOMPANYING STATEMENTS OR FORMS, AND IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

**I UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.**

Signature of claimant or person filing on claimant's behalf (parent, guardian)	Date (Month, day, year)
Address (Number and street, city, state and ZIP code)	e-mail Address (optional)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

**Form SSA-3441 EDCS**

## DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

---

### (3367) ID/Prior Filings

---

#### Identifying Information

1. Name of Person whose Social Security Record this Claim is being filed:

\_\_\_\_\_

His or Her Social Security Number: \_\_\_\_\_

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Male**

Date Of Birth: \_\_\_\_\_

2. Claimant's Alleged Onset Date:

3. Potential Onset Date (if different from above):

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

#### Miscellaneous Information

6. Protective Filing Date: **10/05/2007**

Date Last Insured (DIB/Freeze case):

Beginning of Prescribed Period (DWB):

End of Prescribed Period:

Controlling Date:

Closed Period Case:

#### Prior Filing Information

7. Prior Filing(s):

If Yes, and you are not sending the prior folder, enter the following:

---

### (3367) Presumptive

---

The Presumptive Disability page details are not being displayed here because there is no PD on this case.

---

**(3367) Observations**

---

9. Observations/Perceptions:

---

**(3367) Development**

---

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed? **No**

Remarks:

Name of Interviewer: **R. Longinotti**

Phone Number: **501-525-2476 ext. 3013**

Name of Person Completing Form:

Date:

**Form SSA-3367 EDCS**

**MEDICAL RECORDS**

**FROM**

**ARKANSAS CHILDREN'S HOSPITAL**

**DATED**

**JULY 31, 2000 to MARCH 22, 2001**

**57 pages**

**SUBMITTED BY**



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

DIAGNOSTIC RADIOLOGY

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: 14 Sex: C-M  
MFN: \_\_\_\_\_  
Adm #: \_\_\_\_\_ Financial Class: INS  
Room: \_\_\_\_\_ Loc: ORTCL Adm Date: 03/22/2001

Diagnosis: SCOLIOSIS  
Pertinent History/Reason For Procedure? F/U SCOLIOSIS

Could Patient Be Pregnant?

Date/Time Exam Taken: 03/22/2001 0835  
Ordering MD: \_\_\_\_\_  
Attending MD: \_\_\_\_\_

Exams: 1. SPINE, ENTIRE, 2 VIEWS 000452217

STANDING AP/LATERAL SPINE: 3/22/01 #6

Patient has undergone correction of scoliosis since prior study of 1/12/01. Scoliosis rods extend from the upper dorsal spine to the mid and low lumbar spine. There is slight residual scoliotic curve, right convex in the lower dorsal spine and left convex in the lumbar spine, but the curvatures have markedly decreased since the prior films. Pedicle hooks, scoliosis rods and pedical screws are all intact, and the pedicle hooks are in good position.

A left convex upper dorsal scoliotic curvature remains.

IMPRESSION: Patient status post recent scoliosis surgery. No acute abnormality.

D: 3/22/01 - T: 3/26/01

Trans By: RAD.TCM  
Printed: 03/27/2001 (1424) Batch 132590



ARKANSAS CHILDREN'S HOSPITAL  
800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

EXHIBIT NO. 1F  
PAGE: 3 OF 58

ORTHOPAEDIC CLINIC NOTE

NAME: \_\_\_\_\_  
ACCOUNT#: \_\_\_\_\_  
MR #: \_\_\_\_\_

DATE: 03/22/2001

HISTORY OF PRESENT ILLNESS: \_\_\_\_\_ is 14+8 years of age and seen in followup of posterior spinal fusion in January of this year. He has some complaints regarding numbness around the incision. Also, he tends to hold his right shoulder lower than his left. He has some pain in the left shoulder when lifting weights. He has having no problems other than that. He has been able to ride his bike. Mom has limited his activities, however. He has had no neurovascular changes.

PHYSICAL EXAMINATION: On examination today, his incision is well healed. He does indeed have a shoulder height discrepancy, but he is able to correct it passively when he tries. The wound is nontender. The hardware is not prominent.

X-rays today show a well maintained correction.

IMPRESSION: Status post spinal fusion for scoliosis.

PLAN: My plan for him is to continue his activity limitations including no trampoline, bungee jumping and water skiing. We will check him back in six weeks and repeat the x-rays and make sure he is continuing to do well postoperatively.

Attending Physician

PCP:  
Referring Physician:  
dict: 03/22/2001      tran: 03/24/2001      job id:  
RDB/MDQ34



162.5      52.5

14+8 y/o. WM s/p post. spinal fusion 1/01. Has complaints of loss of sensation on skin adjacent to scar on back. Also he is holding his right shoulder lower than left and has pain in ~~right~~<sup>left</sup> shoulder when he lifts right one up. He is having no problems walking, running, riding bike. Man is limited some activities - trampoline, stinging, paralysis of fingers & toes.

Ht-162.5, wt-52.5

Back - incision healing well; NT to palpate; <sup>touch</sup> ↓ sensation on both sides of scar from about 2cm to about 10cm of the scar, with a width of ↓ sensation of about 5cm along the length. Forward flexion limited to about mid thigh.

Spine - much improved scoliosis & spinal fusion hardware in place.

① Scoliosis - s/p post. spinal fusion - stable

① RTC 6 wks

② Limit activity - ~~trampoline~~  
<sub>for 6 months s/p surgery</sub> & water skiing

③ Encourage leveling of shoulders

~~heel~~

M3

ADMISSION RECORD

ARKANSAS CHILDREN'S HOSPITAL  
800 MARSHALL STREET  
LITTLE ROCK, ARKANSAS 72202-3591

MEDICAL RECORD # \_\_\_\_\_ ACCOUNT # \_\_\_\_\_

ADMIT DATE 01/12/01	ADMIT TIME 0538	LOCATION SDC	ROOM/BED	DISCHARGE DATE 1/16/01	DISCHARGE TIME
------------------------	--------------------	-----------------	----------	---------------------------	----------------

DATE OF BIRTH	AGE 14	SEX M	RACE C	MAR S	RELIGION CATHOLIC
---------------	-----------	----------	-----------	----------	----------------------

REASON FOR ADMISSION  
**SCOLIOSIS**

CLINICAL ATTENDING PHYSICIAN	CLINICAL PHYSICIAN SERVICE
------------------------------	----------------------------

TEACHING ATTENDING	TEAM
--------------------	------

REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN	ADMIT DR
---------------------	------------------------	----------

GUARANTOR	PRIMARY INSURANCE AETNA PO BOX 2095 BISMARCK, ND 58502 (800) 225-3593
-----------	---

REL:	INS
------	-----

GUARANTOR EMPLOYER	SECONDARY INSURANCE
--------------------	---------------------

REL: GRANDMOTHER

LIVING WILL INFORMATION PRESENTED: \_\_\_\_\_ LIVING WILL ON FILE: \_\_\_\_\_ IF NO, IS HELP NEEDED IN WRITING A LIVING WILL: \_\_\_\_\_  
 CHAMPUS MESSAGE SIGNED, ATTACHED: \_\_\_\_\_ MEDICARE MESSAGE GIVEN: \_\_\_\_\_

I, \_\_\_\_\_, know that \_\_\_\_\_ is suffering from a condition requiring hospital care and do hereby voluntarily consent to such medical care consisting of routine diagnostic procedures and medical treatment by Dr. \_\_\_\_\_, residents and interns (doctors in their first year of service), and the assistants or designees as are necessary in their judgment. I understand that my child's blood may be drawn for diagnostic tests ordered by the physicians and that any blood remaining after the completion of these tests may be retained and used by the physicians of the Arkansas Children's Hospital for medical or dental education, research or advancement of medical or dental science. I understand that no blood will be taken for these purposes only without my specific permission.

I realize that among those who attend patients at this hospital are medical, nursing and other health care personnel in training who may be present during patient care as a part of their education. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as the result of treatments or examinations in this hospital.

I understand that the hospital shall not be liable for the loss of any money or the loss of or damage to any other personal property.

I authorize the release of the information concerning this hospitalization as may be required for processing hospital or medical insurance claims, or for audits to verify such claims, and to the referring agency, referring physician and/or family physician.

I give permission to Arkansas Children's Hospital to contact his/her home school for information or to make arrangements for schooling needs. I also give permission to hospital staff to provide any necessary schooling assistance while he/she is in the hospital. I understand that it may be necessary to disclose pertinent basic medical information to the school.

I hereby authorize payment directly to Arkansas Children's Hospital and/or the attending physician or surgeon or third-party benefits otherwise payable to me. I understand that I am financially responsible to the hospital and/or doctor for the above named patient and I agree to pay to Arkansas Children's Hospital and/or the doctor all amounts incurred by the above named patient not covered by a third-party payor. Arkansas Children's Hospital and/or the attending physician or surgeon is hereby authorized to take any and all necessary action to collect, in their own names, said benefits directly from the third-party payor.

I CONSENT THAT ANY LEGAL ACTION TO COLLECT PAYMENT FOR SERVICES RENDERED MAY BE BROUGHT IN FULASKI COUNTY, ARKANSAS, AND ARKANSAS VENUE LAWS ARE EXPRESSLY

Witness \_\_\_\_\_ Date \_\_\_\_\_ Signature of Patient or Adult Legally Responsible for Minor Child Patient: \_\_\_\_\_

\*If necessary refer to Consent of Patient Policy - Section K, Administrative Procedure Manual.

ADMISSION RECORD

chart



ARKANSAS CHILDREN'S HOSPITAL  
800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

---

DISCHARGE SUMMARY

NAME: MR #:   
ADMITTED: 01/12/2001 ACCOUNT#:   
DISCHARGE: 01/16/2001

ADMITTING DIAGNOSIS(ES):

DISCHARGE DIAGNOSIS(ES): Scoliosis.

PROCEDURES: Posterior spinal fusion.

HISTORY OF PRESENT ILLNESS: The patient is a 14-year-old male who is followed by Dr. for idiopathic scoliosis of the spine. Due to the nature of the patient's curve, his age, and his skeletal immaturity, Dr. had a discussion with the patient's parents and it was decided upon posterior spinal fusion. The procedure was discussed in detail with the family. The risks, benefits, and possible complications were discussed. Informed consent was obtained and placed on the patient's chart.

HOSPITAL COURSE: The patient was taken to the operating room on January 13, 2001, and underwent an uncomplicated posterior spinal fusion. Please see the separately dictated operative note. Postoperatively, the patient did very well. He was admitted to the Intensive Care Unit overnight for monitoring and was transferred out on the next day after discontinuation of his arterial line and the central venous line. The patient was transfused with two units during his postoperative stay, and his hematocrit at the time of discharge was 30.8. The patient's wound remained clean and dry. He slowly progressed through physical therapy until he was ambulating around the department without difficulty. The patient was on patient-controlled analgesia for the first several days and then that was discontinued, and he was controlled well on oral pain medications. The patient started out n.p.o. except for ice chips and we slowly advanced the patient's diet until he was eating by the time of discharge without difficulty either. The patient was anxious for discharge by January 16, 2001.

DISCHARGE INSTRUCTIONS: They are going to be given bandages for daily dressing changes; the nurse instructed them. DISCHARGE MEDICATIONS: The patient's pain medication is oxycodone 5 to 10 mg

COPY



ARKANSAS CHILDREN'S HOSPITAL  
800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

DISCHARGE SUMMARY

NAME:

MR#:

CONTINUED...

p.o. q.4h. p.r.n. FOLLOW-UP: They will return to the clinic to see Dr. Blasier in six weeks.

Resident

Attending Physician

cc: M.D.

PCP: M.D.

Referring Physician: M.D.

dict: 01/16/2001  
SG/MDQ34

tran: 01/17/2001

job id:

COPY



ARKANSAS CHILDREN'S HOSPITAL  
800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

DISCHARGE SUMMARY

NAME: MR #:   
ADMITTED: 01/12/2001 ACCOUNT#: :   
DISCHARGE: 01/16/2001

ADMITTING DIAGNOSIS(ES):

DISCHARGE DIAGNOSIS(ES): Scoliosis.

PROCEDURES: Posterior spinal fusion.

HISTORY OF PRESENT ILLNESS: The patient is a 14-year-old male who is followed by Dr. or idiopathic scoliosis of the spine. Due to the nature of the patient's curve, his age, and his skeletal immaturity, Dr. had a discussion with the patient's parents and it was decided upon posterior spinal fusion. The procedure was discussed in detail with the family. The risks, benefits, and possible complications were discussed. Informed consent was obtained and placed on the patient's chart.

HOSPITAL COURSE: The patient was taken to the operating room on January 13, 2001, and underwent an uncomplicated posterior spinal fusion. Please see the separately dictated operative note. Postoperatively, the patient did very well. He was admitted to the Intensive Care Unit overnight for monitoring and was transferred out on the next day after discontinuation of his arterial line and the central venous line. The patient was transfused with two units during his postoperative stay, and his hematocrit at the time of discharge was 30.8. The patient's wound remained clean and dry. He slowly progressed through physical therapy until he was ambulating around the department without difficulty. The patient was on patient-controlled analgesia for the first several days and then that was discontinued, and he was controlled well on oral pain medications. The patient started out n.p.o. except for ice chips and we slowly advanced the patient's diet until he was eating by the time of discharge without difficulty either. The patient was anxious for discharge by January 16, 2001.

DISCHARGE INSTRUCTIONS: They are going to be given bandages for daily dressing changes; the nurse instructed them. DISCHARGE MEDICATIONS: The patient's pain medication is oxycodone 5 to 10 mg



ARKANSAS CHILDREN'S HOSPITAL  
800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

DISCHARGE SUMMARY

NAME:

MR#:

CONTINUED...

p.o. q.4h. p.r.n. FOLLOW-UP: They will return to the clinic to see  
Dr. six weeks.

Resident

Attending Physician

cc: I.D.

PCP: M.D.

Referring Physician: M.D.

dict: 01/16/2001  
SG/MDQ34

tran: 01/17/2001

job id:

### Arkansas Children's Hospital Discharge Summary Note

Date: 1/16/01 Time: \_\_\_\_\_

**Do Not Use Abbreviations.** Use Language that patients understand. Authors must sign and date each entry.

Principal Diagnosis: (Condition after study that caused the admission.)

Scot/Tors??

Secondary Diagnosis: (Any condition that occurs during the admission or coexists at admission.)

Principal Procedure: (Performed for definitive treatment rather than diagnostic purposes or to take care of a complication.  
The principal procedure is that procedure most related to the principal diagnosis.)

Porter's sptual fusion

Secondary Procedures: (Carries an operative or anesthetic risk or requires highly trained personnel, facilities or equipment.)

Physician Instructions:

Change bandage daily until wound dry

Prescription filled at Arkansas Children's Hospital  Yes  No

Discharge Medications:

Dose & Frequency

Duration

Oxycodone 5-10 mg every 4-6 hrs as needed

Outpatient medications ordered for home use must be relabeled in the Outpatient Pharmacy. Any medications brought from home are to be returned to guardian at discharge.

Condition on Discharge: \_\_\_\_\_ Discharge Summary Dictated on: 1/16/01  
Date

[Signature] M.D.  
Physician Signature

Follow up Appointments:

Community Physician

Local Health Dept

320-1195  
ACH Outpatient Clinic

Dr [Signature] - 6 wks ACH Ortho March 1st @ 9am

Respiratory - Nutrition - Social Work - Occupational Therapy - Respiratory Therapy - Child Life

320-1100

I understand the instructions given to me regarding home care for my child.

140

SE

Parent/Guardian



ARKANSAS CHILDREN'S HOSPITAL  
800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

---

OPERATIVE REPORT

NAME:

MR#:

ACCOUNT#:

DATE OF SURGERY: 01/12/2001

SURGEON: M.D.

ASSISTANTS(S): M.D.

PREOPERATIVE DIAGNOSIS: Idiopathic scoliosis.

POSTOPERATIVE DIAGNOSIS: Idiopathic scoliosis.

PROCEDURE(S): Posterior spinal fusion T4 to L4.

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 1800 cc.

COMPLICATIONS: None.

HISTORY: This is a 14-year-old male who had a school screening positive exam back in May 2000. He was referred to Dr. and was noted to have a somewhat painful idiopathic scoliosis. Any abnormal pathology was ruled out with MRI. Based upon the large curve and the painful nature of it, the patient and his family decided upon operative intervention. Risks, benefits and possible complications were all discussed. Informed consent was obtained and placed on the chart.

OPERATIVE NOTE: The patient was taken to the operating room and placed on the table. Anesthesia began all their monitoring lines. Once this was done, patient was placed prone on the spinal table. The back was prepped and draped in the usual sterile fashion. A ruler was used to draw out a straight longitudinal line from the upper thoracic to lower lumbar spine. A sharp incision was carried out with a scalpel and then dissection down to the spinous processes was carried out with electrocautery. The spine posterior elements were then removed of soft tissue attachment with a combination of electrocautery and Cobb elevator. Once this was done, localizing x-rays were taken and checked to assure positioning. Once we were in place, the following hardware was applied using the AO set; upgoing pedicle hooks bilateral at 4, left



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800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

---

OPERATIVE REPORT

NAME: \_\_\_\_\_  
MR: \_\_\_\_\_  
DATE OF SURGERY: 01/12/2001

CONTINUED...

6, left 8, bilateral at 10. Downgoing laminar hook at 6, upgoing on the right at 6, upgoing laminar hook on the right at 12, downgoing lamina at 1, downgoing lamina at the left on 1, on the left at 2, on the up right lamina hook at 2, upgoing hooks on the left at 3 and 4, and downgoing on the right at 4. Once these were in place, the rod was contoured and cut to measure. It was placed in first on the left and the proper amount of distraction correction was applied and all the screws were tightened into place. The rod on the right was then applied in similar fashion, once Dr. \_\_\_\_\_ was pleased with the correction obtained and torque wrench had been used to finally tighten down all the locking nuts. Throughout this whole procedure, electrical monitoring was performed and we were assured that everything went well by the technician. Once this was complete, \_\_\_\_\_ were applied, one in the upper thoracic and one in the thoracolumbar area. These were locked into place. The wound was repeatedly thoroughly irrigated throughout the procedure as well as hemostasis performed. Once this was done, a file was used to roughen up all exposed bony surfaces. Four bottles of allograft bone chips were then applied and packed down throughout the \_\_\_\_\_ of the spine and \_\_\_\_\_ throughout all the hardware and all the exposed bony surfaces which had just been roughened up and were bleeding. Once this was completed, the deep fascia was closed with #1 Vicryl. Deep subcutaneous tissue was closed with 2-0. A drain was then placed. Subcuticular tissue was closed with 2-0 and then skin was closed with 4-0, all Vicryl. The wound was then thoroughly dressed with Steri-Strips, 4 x 4s and covered with Bioclusive. The patient was then placed over supine onto his bed. AP and lateral of the spine and chest were then taken and reviewed by Dr. \_\_\_\_\_. Once we were pleased with this, anesthesia awoke the patient. He tolerated the procedure well. He was extubated in the operating room. He was noted to actively flex and extend his toes and feet on command. He was then taken to the intensive care unit in good condition. He



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OPERATIVE REPORT

NAME:  
MR:  
DATE OF SURGERY: 01/12/2001

CONTINUED...

tolerated the procedure well. Dr. \_\_\_\_\_ was present for and directed all key portions of this case.

Resident

Attending Physician

cc: DR. \_\_\_\_\_

PCP:  
Referring Physician: \_\_\_\_\_

dict: 01/12/2001  
SG/MDQ34

tran: 01/12/2001

job id: \_\_\_\_\_

ARKANSAS CHILDREN'S HOSPITAL  
PRE / POST ANESTHETIC CONSULT

240"  
Robinson

Diagnosis: Scoliosis

Planned Procedure: Scoliosis repair Scheduled Date: 1/12/01

Surgeon: \_\_\_\_\_  
History Obtained From:  Mom  Dad  Chart  Other

Previous Anesthetics: T+A 13 yrs ago Problems:  Yes  No

Family History Anesthetic Problems / Medical Problems:  Yes  No

REVIEW OF SYSTEMS

Perinatal History: Premature, Full Term, Apnea/Bradycardia, BPD, Congenital Anomalies  
WNL

HEENT: Rhinorrhea, URI, Snores, Deaf, Blind, Cleft Lip/Palate, ATH  
WNL

Respiratory: Asthma, Bronchitis, Cough, Pneumonia, Home O<sub>2</sub>/CPAP, Abnormal Airway  
WNL

Cardiovascular: Murmur, Dysrhythmias, Hypertension, Congenital Heart Disease  
WNL

Neurological: Seizures, Cerebral Palsy, Dev Delay, MR, Behavior Dis, Spina Bif, Down  
WNL

Musculoskeletal: Contractures, Muscle Disease, Scoliosis, Hypotonia, Spasticity  
WNL

Hematology / Oncology: Sickle Cell, Bleeding Problems, Immune Deficiency, Anemia  
WNL

Gastrointestinal / Hepatic: GE Reflux, NV, Jaundice  
WNL

Genitourinary / Ob-Gyn: UTIs, Kidney Disease, Date of LMP: \_\_\_\_\_ Menarche:  Yes  No  
WNL

Endocrine / Metabolic: Diabetes, Thyroid, Recent Steroids  
WNL

Other: Hearing Aid, Glasses, Contacts, Crutches, Other Prosthesis  
Alcohol, Drugs, Tobacco drugs  
X3 None

Preferred Name: \_\_\_\_\_ Age: yr 14 mo 53.7 wk 160 cm

BP: 105/59 P 75 R 16 T 36.6 SpO<sub>2</sub> 99 %

LAB: NA  HCG: Pos \_\_\_\_\_ Neg TAC

NPO: Solids 2250 Liquids 9325 Time: 1/11 1/12 Full Stomach:  Apple juice

Allergies: None  Latex Allergy:  Latex Precautions:   
NKA

Current Medications: \_\_\_\_\_ None:  Last doses: \_\_\_\_\_

Premedication: versed 15mg PO  
Time: \_\_\_\_\_

HEENT: airway Class II  
thyromental distance 4 cm  
neck motion FROM  
teeth Intact  
other \_\_\_\_\_

Lungs: clear

Heart: RR 18

Neuro: Alert, cooperative

Other: \_\_\_\_\_  
IV \_\_\_\_\_

ANESTHESIA PLAN: General  Regional  Local  Sedation   
Induction: IV  Inhalation  IM  Other \_\_\_\_\_

Alternatives / Advantages Explained: Yes  No   
Risks Explained: Yes  No

Risks: tooth damage, sore throat, nausea, vomiting, paralysis, cardiac arrest, brain damage, death, malignant hyperthermia, eye damage, nerve injury, allergic reactions, infections, bleeding, pneumothorax

Legal Guardian: \_\_\_\_\_

Resident / RN: \_\_\_\_\_ Time: 1025 Date: 1/12/01

Remarks: 5 pckts + manual, reviewed pt. ready for GA

Anesthesiologist: \_\_\_\_\_ Time: 630 Date: 1/12/01

ASA Status: 1 2 3 4 5 6 E

POST ANESTHETIC CONSULT  
Comments: Chart reviewed

No Complications  See progress notes

Anesthesiologist: \_\_\_\_\_ Time: 0830 Date: 02.11.01



**ARKANSAS CHILDREN'S HOSPITAL**

ORA  
 BEG X  
 END  
 ANESTHESIA: \_\_\_\_\_  
 SURGEN: \_\_\_\_\_  
 AREA: \_\_\_\_\_  
 PREPARED / DOSE: \_\_\_\_\_  
 TIME: \_\_\_\_\_  
 PO IV SC CT: \_\_\_\_\_  
 ALLERGIES: NONE  
 MENTAL STATUS: alert, anxious, awake, calm, happy, sleepy, sedate  
 OPERATIONS: \_\_\_\_\_

11:30 11:45 11:50 11:55 12:00 12:05 12:10 12:15

TIME	SpO2	HR	RR	Temp	SpO5	HCT	WE (kg)	Age	PACU Time in
11:30	100	110	18	37.5	40	35	10	4	2
11:45	100	110	18	37.5	40	35	10	4	2
11:50	100	110	18	37.5	40	35	10	4	2
11:55	100	110	18	37.5	40	35	10	4	2
12:00	100	110	18	37.5	40	35	10	4	2
12:05	100	110	18	37.5	40	35	10	4	2
12:10	100	110	18	37.5	40	35	10	4	2
12:15	100	110	18	37.5	40	35	10	4	2
TOTAL									

**Respirator**: S Spontaneous  
**VILI/BB**: A Assisted  
**CPAP**: V Continuous  
**PEEP**: V Ventilation  
**ETT Size**: N O RAE Cuff  
**Lead**: cm Typed  
**LMA Size**: Artery O N  
**Brain sounds**:  
**Blade**:  
**Fiberoptic**: Bulbair LL Wand  
**Adopting Staff**:  
**Involvement**:

I have evaluated the patient and find them suitable / unsuitable for anesthesia at this time  
 M.D.  NPO verified

**Discharge Time**: \_\_\_\_\_ **Room**: \_\_\_\_\_ **MD**: \_\_\_\_\_  
**By Standard Order to ASC**: \_\_\_\_\_ **RN**: \_\_\_\_\_ **Receiving N/A**: \_\_\_\_\_

Received at post-OP SPINAL TUBES  
 VSS. ON S/S FOR V/S SPINAL TUBES

PACU Number	PASS	Adm	15	DC
1000	2	2	2	2
	7	1	2	2
	7	1	2	2
	7	1	2	2
	7	1	2	2
<b>TOTAL</b>	<b>30</b>	<b>10</b>	<b>12</b>	<b>12</b>

ARKANSAS CHILDREN'S HOSPITAL  
LITTLE ROCK, ARKANSAS  
PROGRESS NOTES

Date 3/12/01

Notes Should Be Signed By Physician

1/12/01

RAN

13yo Wm c scoliosis who is now  
s/p spinal fusion (posterior)

PMHx  $\phi$

PSHx  $\phi$

All  $\phi$

Meeds.  $\phi$

4.7  $\frac{14}{43}$  211

PE Heent NCAT Peria

CV RR R  $\phi$  m pulses UE/UE 2+ = (B)

Lung CTAB

Abd soft NP

GU Foley in place

Ext  $\phi$  C/C/E

PIV X2 IJ dual lumen

A/P 13yo Wm c scoliosis s/p <sup>post</sup> spinal fusion

① Will follow c ortho.

② PCA

③ NPO / D5 1/2 NS + 20KCl @ 125cc/hr

④ AnCef

⑤ Incentive spirometer

⑥ Um wean to keep pox > 95%

*[Signature]*

Unit

EXHIBIT NO. 1F  
OF 38

ARKANSAS CHILDREN'S HOSPITAL  
LITTLE ROCK, ARKANSAS  
**PROGRESS NOTES**

CCM Attending Note  
1/13/01

Attending - S. Anand

*Dis 1-14*

Date	Notes Should Be Signed By Physician
1/13/01	<p>14 year old who was admitted for post-operative bleeding and post-operative respiratory complications following a spinal fusion surgery. Overnight he has been monitored closely in the ICU and he had a spike in his temperature to 38.5, although at this time his vital signs show a temperature of 37.2, heart rate of 113, respiratory rate of 16, B/P 120/45. He remains on a ventmask with a <math>f_{iO_2}</math> 0.30 and his oxygen saturations have remained 97%. On physical exam he is somnolent but arousable, his pupils are 2 mm, equal, round and reactive to light. He is moving all extremities. His GCS is 15. He has good air entry into both lung fields and somewhat diminished air entry into his bases. His heart sounds are normal. Abdomen is soft and non-tender. He is moving all extremities and capillary refill is about 3 seconds. He remains on morphine PCA for analgesia, Ancef and Tylenol. He has been taking ice chips overnight and had a total intake of 2600 cc with an output of 2400 cc. This morning his CBC shows a hematocrit of 29.9, white cell count of 7,600 and platelet count of 137,000. He has had a minimal amount of drainage from his surgical site totaling about 590 cc. We plan to discuss with the orthopedic surgeons the question of transfer from the unit later today. I have provided 35 minutes of critical care time today. I've seen the patient and have reviewed the history and physical and laboratory assessment and plan with the critical care team on rounds. Please see the resident's note for further details.</p>
	<p>Critical Care Attending KSA:jb    D:1/13/01    T:1/16/01</p>

ARKANSAS CHILDREN'S HOSPITAL  
 LITTLE ROCK, ARKANSAS  
**PROGRESS NOTES**

FORM NO. 1F  
 PAGE: 10 OF 58

Date	Notes Should Be Signed By Physician		
1/13/01	PICU Resident Progress Note	HD# 2	Attending: _____ Fellow: _____
SUBJECTIVE/Interim History:			
Stable			
OBJECTIVE/ Course by system			
RESPIRATORY: RR 11-20's POX 97-99 FiO2 30%			
Vent settings: Mode VM Rate - PEEP - Vt -			
Blood Gas: $\phi$			
Exam: CTA (B)			
CXR:			
CARDIOVASCULAR: HR 115-130 BP 100/40 SBP range - MAP - CVP 8			
DBP range			
Pressors: $\phi$			
Exam: RRRPM pulses 2 = (B)			
FEN/GI/RENAL			
Weight today: 53.7 Weight yesterday Change			
I/O 2573 / 2061 UOP 1.1+ cc/kg/hr $\phi$ Stool g/kg/d			
IVF: D5 1/2 NS + 20KCL 125cc/o Drain 590cc			
Feeds: Ice chips			
Exam: - soft ND (B) BS			
Lab:			

PROGRESS NOTE  
 51058C

ARKANSAS CHILDREN'S HOSPITAL  
LITTLE ROCK, ARKANSAS  
PROGRESS NOTES

EXHIBIT NO. 1F  
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Date	Notes Should Be Signed By Physician
1/13/2009 0910	<p><u>Pain Mgmt</u></p> <p>Currently, " " is complaining of 5/10 pain in back. Has made 62 dem/38 del. of PCA usage in past 20<sup>o</sup>. Nurse reports " " is frequently asleep, &amp; appears comfortable - he has fallen back asleep during my time &amp; while here in PICU. No ALS on PCA at this time - anticipate stop of background morphine tomorrow.</p>
1/14/2009 0915	<p><u>Pain Mgmt</u></p> <p>" " is currently sleeping - man believes he is using his PCA more for anxiety than pain. He has had 50 dem/31 del past 22 hrs, will stop background morphine now, please see scheduled ahead of codeine x 24<sup>o</sup> (then pmil), unless only PCA to continue.</p>

EXHIBIT NO. 1F  
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**ARKANSAS CHILDREN'S HOSPITAL**  
LITTLE ROCK, ARKANSAS  
**PROGRESS NOTES**

Date	Notes Should Be Signed By Physician
1/14/01	PT note Orders received and appreciated. Pt already sitting in W/C at bedside. Parents instructed in exercises and transfers. Pt unwilling to move back to bed or perform any exercises at this time. Will continue tomorrow. Evaluation placed in PT/OT section
1/15/01	Ortho POD # 0600 c/o back pain (+) 505 HR ~ 100 AF (+) strong bowel sounds NV $\bar{i}$ $\Delta$ Hct (c/14) 27.4
	Encourage OOB to ambulation Advance diet
1/15/01	PT Note: Pt ambulated ~ 80' c mod (A) under 0725 elbows c mild % dizziness. Will cont. to progress (+) + Pd endurance c gait. Pt remained sitting in bed p TX.

EXHIBIT NO. 1F  
 OF 58  
**ARKANSAS CHILDREN'S HOSPITAL**  
 LITTLE ROCK, ARKANSAS  
**PROGRESS NOTES**

Date	Notes Should Be Signed By Physician
1/16	<p><u>Ortho</u>                      3 clb. ready for Dlc                      USS AP                      wound clb                      NU F Δ                      p trans itat 30.8</p>
	<p>Dory. w/M                      Dlc name <span style="float: right;">67247</span></p>
1/16/01 1520	<p><u>P.T. Note:</u> Pt. transferred supine → sit + sit → stand                      ± SB(A) following spinal precautions. Pt.                      ambulated around 3 Blue + 3 Orange units ±                      SB(A) ± 1'd speed relative to AM TX. Pt. is                      Ⓢ bed exercises. Pt. returned to bed                      p TX.</p>

# ARKANSAS CHILDREN'S HOSPITAL

# PHYSICIAN'S ORDER

EXHIBIT NO. 1F  
PAGE 22 OF 58

### COMPONENTS OF A COMPLETE ORDER

1. Date and time
2. Medication identified - full drug name and concentration
3. Route of administration
4. Dose to be administered
5. Frequency to be administered
6. Physician signature
7. Print name of physician, level and contact number

Drug Allergies \_\_\_\_\_ PL Weight \_\_\_\_\_ kg

Another brand of drug identical in form and content may be dispensed unless checked

PHYSICIAN  
01737701

DATE	TIME	ORDER	DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS → 1	Nurse's Initials
4/15/01	1220	Type and Cross for Transfusion - Dr. Quinn / C. Smith husband		
			PHYSICIAN SIGNATURE C. Smith	
			DATE 4/16/01	TIME 1200
4/15/01	1445	FP chart - [unclear]		
4/16/01	0628	Chart - [unclear]		
4/16/01	0755	chart ✓ verified Beely Lamb		
4/16/01		Dis home p PT decrease		
4/16/01	1530	Wilson / S 4/16/01 1500 verified Beely Lamb		

PLEASE! USE BALL POINT PEN ONLY

PHYSICIAN'S

ARKANSAS CHILDREN'S HOSPITAL

PHYSICIAN'S ORDERS

COMPONENTS OF A COMPLETE ORDER

1. Date and time
2. Medication identified - full drug name and concentration
3. Route of administration
4. Dose to be administered
5. Frequency to be administered
6. Physician signature
7. Print name of physician, level and contact number

NAME
ROOM N (ADDRESS)
HOSP. N
PHYSICIAN

Drug Allergies \_\_\_\_\_ Pt. Weight \_\_\_\_\_ kg

Another brand of drug identical in form and content may be dispensed unless checked

DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS → Nurse's Initials

DATE	TIME	ORDER	Nurse's Initials
1/15/01	0600	D/c O <sub>2</sub> done	
		D/c Ancef done	
		D/c PCA	
		D/c Tylenol + codeine	
		Oxycodone 5-10 mg po q 4 PRN	
		Adv. diet as tolerated	
		OOB to chair in minimum QED	
		Verified by: _____ 1/15/01 0740	

1/15/01	0930	D/C CPAP T.O.	
		(CP)	
		PHYSICIAN SIGNATURE	
		1/15/01	
		DATE	TIME

1/15/01		Wilson's 1/15/01 0950 verified by C. Swanson 1/15/01 1045	
		Transfere to PRBC now in 3"	
		- CBC in port	
		- QD Dry Dsg, please instruct family to give supplies	

PLEASE USE BALL POINT PEN ONLY

Wilson's 1/15/01 1220 verified by C. Swanson 1/15/01 1540

# PATIENT CONTROLLED ANALGESIA

EXHIBIT NO. 1F  
58

**ARKANSAS CHILDREN'S HOSPITAL**  
**Pediatric Pain Management**

Name  
Rc  
(A  
Ho  
Ph

## Drug Allergies

Date	Another brand of drug identical in form and content may be dispensed unless checked <input type="checkbox"/>	Nurse's Initials
1/12/01	1. Drug: <input checked="" type="checkbox"/> Morphine	
11:30	<input type="checkbox"/> Other _____ 2. Pole mount, please 3. Continuous Infusion: mg/hr <u>.8/hr</u> 4. Incremental Dose: mg <u>.8 mg</u> 5. Lockout Interval: Minutes <u>10</u> 6. Four hour maximum: mg _____ 7. If pain is not controlled after 1 hour, page Pain Service (405-6079) 8. NO SYSTEMIC NARCOTICS OR SEDATIVES TO BE GIVEN EXCEPT BY ORDER OF PAIN SERVICE 9. Monitoring: Upon initiation of PCA - HR, RR, BP, and Pain Scale every 30 minutes X2 hours, then every 4 hours 10. Documentation: PCA usage to be recorded on MAR every 4 hours 11. Treatment of side effects: a) Naloxone 0.4 ampule available in Emergency Drug Box b) Respiratory depression: naloxone <u>.2</u> mg (0.004 mg/kg or 0.01 ml/kg of 0.4 mg/ml naloxone) STAT for respiratory rate < 9/minute and call Pain Service STAT May repeat naloxone x 1 (max of 0.4 mg total dose) c) Nausea and vomiting: metoclopramide <u>10</u> mg (0.25 mg/kg; max 10 mg) IV q6h prn nausea and vomiting If metoclopramide not effective in 30 min, may give ondansetron <u>4</u> mg (0.05 mg/kg; max 4 mg) IV q6h prn d) Pruritus: naloxone <u>.05</u> mg (0.001 mg/kg) IV prn pruritus, may repeat q 10 min x 2 diphenhydramine <u>50</u> mg (0.5 - 1.0 mg/kg) IV q6h pruritus 12. For inadequate analgesia or other problems related to PCA, call Pediatric Pain Management Service 405-6079, if no answer, call faculty on call for Pediatric Pain Management Service.	

ARKANSAS CHILDREN'S HOSPITAL

PHYSICIAN'S ORDERS

COMPONENTS OF A COMPLETE ORDER

1. Date and time
2. Medication identified - full drug name and concentration
3. Route of administration
4. Dose to be administered
5. Frequency to be administered
6. Physician signature
7. Print name of physician, level and contact number

NAME  
C  
ROOM  
(ADP)  
HOSF  
PHYS

Drug Allergies Pt. Weight kg

Another brand of drug identical in form and content may be dispensed unless checked

DO NOT USE THIS UNLESS A RED NUMBER SHOWS

Nurse's Initials

DATE	TIME	ORDER	Nurse's Initials
11/12/01	1143A	Anesthesia Recovery orders (1) MSO4 2-10 mg IV q 1 <sup>o</sup> prn pain until PCA commenced. (2) Zofran 4mg IV x 1 prn nausea. <del>(3)</del>	
01/11/01	1150	Noted quicken 1/18/2001 09/10/01	
1/12/01	1 <sup>15</sup>	Valium 3mg IV x 1 dose	
1/11/01	1150	Noted quicken	
1-12-01	19.25	12 <sup>o</sup> chest check A. Van Ue... R	
1/12/01	2330	12 <sup>o</sup> chest check rds q. clare R	gc
1/13/01	0145	T10 D <sub>12</sub> Sparks / q. clare R may give 3mg Valium IV x 1 q. clare R	
1/13/01	0800	12 <sup>o</sup> chest check Pldgr Ar	

ARKANSAS CHILDREN'S HOSPITAL  
CONSULTATION RECORD

SERVICE TO BE CONSULTED: PCA

REQUESTED BY: Ortho - Bl/2111

ATTENDING FOR CONSULTATION: \_\_\_\_\_

REASON: PCA

REQUIREMENTS FOR A CONSULTATION INCLUDE THE FOLLOWING:

- 1. Must be timely
- 2. Contain independent History and Physical relevant to Consultation
- 3. Consultant recommendations must be relevant to clinical indications for Consultation
- 4. Follow-up of consultant's recommendations must be noted by the Attending Physician

FINDINGS AND RECOMMENDATIONS: 14 yr w/M 5/p post spinal fusion

PHCA NKA 53kg ⊖ PMH

Leg postop pain

Flow - PCA requested

ms. 8/8/10

PATIENT CARE INQUIRY \*LIVE\*  
RCS Therapy Flowsheet

EXHIBIT NO. 1F  
PAGE: 28 OF 58

Age/Sex: 14 M

Arkansas Children's Hospital

Inpatient LOS:

from Jan 12, 01 0000 to Jan 16, 01 2359

Date: 01/13/01

1600

Section Therapy  
 Procedure  
 Tx Missed  
 Reason  
 Therapy IS SETUP  
 Therapy  
 Therapy  
 Updft Nebulizer  
 Med-1  
 Dose-1  
 Meds-2  
 Dose-2  
 Meds-3  
 Dose-3  
 Dose-3  
 FiO2  
 Tx Flow  
 Neb Volume  
 Pos Press Setng  
 Neg Press Setng  
 Pk Insp. Pres. 1000  
 Exhaled Vol. Equal  
 Insp. Capacity N  
 BS Equality None  
 BS Crackles N  
 BS Wheezes Y  
 BS Stridor Dry  
 Improved BS Absent  
 Pre Br Score  
 Post Br Score  
 User

User Name

RCS.ALK



# ARKANSAS CHILDREN'S HOSPITAL

800 MARSHALL L, LITTLE ROCK, ARKANSAS 72202-3591

EXHIBIT NO. 1F  
PAGE: 29 OF 58

## LABORATORY

RUN DATE: 01/17/01

RUN TIME: 01:30

ARKANSAS CHILDREN'S HOSPITAL  
ACH LABORATORY DISCHARGE SUMMARY FINAL

PAGE 1

PATIENT: [REDACTED] ACCT: [REDACTED]  
AGE/SX: 1A/M Loc: 30R U: [REDACTED]  
STATUS: DIS IN ROOM: 3277 REG: 01/12/01  
BED: 1 DIS: 01/16/01

### General Hematology Studies HEMATOLOGY DEPARTMENT

Time	JAN 15 0800	JAN 15 0740	JAN 13 0740	Reference	Units
WBC	11.1	11.1	11.1	4.5-11	K/uL
RBCC	4.8	4.8	4.8	4.5-11	M/uL
HGB	12.9	12.9	12.9	12.0-16	g/dL
HCT	34.6	34.6	34.6	37.0-49	FL
MCV	72.2	72.2	72.2	79-109	fL
MCHC	100	100	100	32-35	pg
RDW	12.9	12.9	12.9	11.5-14.5	g/dL
PLT	100	100	100	111-400	K/uL
MPV	8.8	8.8	8.8	9-11	FL

Time	JAN 12 1210	JAN 11 1015	Reference	Units
WBC	11.1	11.1	4.5-11	K/uL
RBCC	4.8	4.8	4.5-11	M/uL
HGB	12.9	12.9	12.0-16	g/dL
HCT	34.6	34.6	37.0-49	FL
MCV	72.2	72.2	79-109	fL
MCHC	100	100	32-35	pg
RDW	12.9	12.9	11.5-14.5	g/dL
PLT	100	100	111-400	K/uL
MPV	8.8	8.8	9-11	FL

MANUAL DIFFERENTIAL: [REDACTED]  
 (1) MANUAL DIFFERENTIAL: [REDACTED]  
 (2) MANUAL DIFFERENTIAL: [REDACTED]  
 (3) MANUAL DIFFERENTIAL: [REDACTED]  
 (4) MANUAL DIFFERENTIAL: [REDACTED]  
 (5) MANUAL DIFFERENTIAL: [REDACTED]  
 (6) MANUAL DIFFERENTIAL: [REDACTED]  
 (7) MANUAL DIFFERENTIAL: [REDACTED]  
 (8) MANUAL DIFFERENTIAL: [REDACTED]  
 (9) MANUAL DIFFERENTIAL: [REDACTED]  
 (10) MANUAL DIFFERENTIAL: [REDACTED]  
 (11) MANUAL DIFFERENTIAL: [REDACTED]  
 (12) MANUAL DIFFERENTIAL: [REDACTED]  
 (13) MANUAL DIFFERENTIAL: [REDACTED]  
 (14) MANUAL DIFFERENTIAL: [REDACTED]  
 (15) MANUAL DIFFERENTIAL: [REDACTED]  
 (16) MANUAL DIFFERENTIAL: [REDACTED]  
 (17) MANUAL DIFFERENTIAL: [REDACTED]  
 (18) MANUAL DIFFERENTIAL: [REDACTED]  
 (19) MANUAL DIFFERENTIAL: [REDACTED]  
 (20) MANUAL DIFFERENTIAL: [REDACTED]  
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ARKANSAS CHILDREN'S HOSPITAL  
DEPARTMENT OF REHABILITATION  
PHYSICAL THERAPY  
INPATIENT  
SPINAL FUSION

Date: 1/14/01

Diagnosis: Scoliosis                      Precautions:

PMH: Ø

Rehabilitation Request: posterior spinal fusion protocol--non-brace

Requesting Physician: \_\_\_\_\_

Assessment and Treatment Plan

Subjective and history:

Patient is 14 year old referred to physical therapy for intervention per posterior spinal fusion protocol. Patient has history of scoliosis and is now status post posterior spinal fusion on 1/12/01.  
Patient/family expectations: \_\_\_\_\_

O: Patient presents in bed. Posterior spinal fusion protocol initiated. Therapeutic activities included the following:

- active exercise:  quadriceps sets,  ankle pumps,  heel slides,  supine hip abduction/adduction,  gluteal sets
  - log rolling
  - sitting on side of bed
  - standing at bedside
- not performed*

Parents/caregivers instructed in log rolling and exercises to be performed by patient:  parents/caregivers verbalized understanding of instruction  
 further education required

A: Patient tolerance for therapeutic activities: None  
Patient will benefit from continued physical therapy per protocol to promote optimal return to independent mobility.

P: Physical therapy for therapeutic activities per posterior spinal fusion protocol.

Short term goals: (6-8 treatment sessions)

1. Patient will perform protocol exercises x 10 with verbal cues
2. Patient will get to sitting on side of bed with minimum assistance
3. Patient will transfer bed to and from standing with minimum to contact-guard assist
4. Patient will ambulate 350+ feet with contact-guard to stand-by assist -
5. Patient will ascend/descend 4 steps with contact-guard assist to stand-by assist using one hand rail or one hand held assist

Long term goals: (post hospital discharge)

Patient will return to pre-surgical activity level within limits as set by physician

Therapist's Signature: \_\_\_\_\_

May '99

ARKANSAS CHILDREN'S HOSPITAL  
DEPARTMENT OF REHABILITATION

- INPATIENT      - OUTPATIENT

DOB: *00B*

PHYSICAL THERAPY	ME588	ME588	97110	97530	97112	97116	97001	97001	97002	99111	97113	97022	97604	97032	97033	97140	97016	97520	97029	94550	97035	97042	29356	29425	E0187											
	Tracking/Lengthy Phone Consult	Tracking Team Conference - 15m	Therapeutic Procedure - 15 min	Therapeutic Activity - 15 min	Neuromuscular Re-ed - 15 min	Gait Training - 15 min	PT Evaluation	PT Evaluation, Brief Mod 52	PT Re-Evaluation	Developmental Eval/Testing	Pool Therapy - 15 min	Whirlpool	Orthotics Ftr/Training - 15 min	EMS Attended - 15 min	Int'l Physicals - 15 min	Manual Technique - 15 min	Palpation Bath	Prosthetic Training (e) - 15 min	Pubed Lavage - 15 min	Tens Instruction/Application	Ultrasound - 15 min	Wheelchair Mgmt/Prop Training - 15 min	Cast - Long Leg (walker)	Cast - Short Leg (Walker)	Crank Cuscion/grips 1 pr.	Swimwear, Boys	Swimwear, Girls	Tub/grip C/E	Wobble Board	PT Supplies - Misc	Hold					
DATE	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM				
1-15-01																																				
PROGRESS NOTE																									Please see note in pt's chart.										THERAPIST	
1-16-01																																				
PROGRESS NOTE																									Please see notes in pt's chart. Pt. did p cleaning P.T. & safe ambulation + transfers.										THERAPIST	
1-17-01																																				
PROGRESS NOTE																									THERAPIST											
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ORIGINAL - MEDICAL RECORDS     COPY - REHABILITATION

REHABILITATION - PHYSICAL THERAPY - DAILY RECORD

ARKANSAS CHILDREN'S HOSPITAL  
DEPARTMENT OF REHABILITATION

- INPATIENT

- OUTPATIENT

PHYSICAL THERAPY	M689	M685	97110	97130	97113	97110	97001	97001	97002	96111	97113	97022	97004	97032	97033	97140	97018	97020	97039	94530	97035	97042	29353	29428	E0157					
	Talking Language Phone Consult	Talking Team Conference - 15m	Therapeutic Procedure - 15 min	Therapeutic Activity - 15 min	Neuromuscular Re-ed - 15 min	Gait Training - 15 min	PT Evaluation	PT Evaluation, Brief Mod E3	PT Re-Evaluation	Developmental Eval/Teaching	Pool Therapy - 15 min	Whirlpool	Orthoses Fitting - 15 min	EMS Assessment - 15 min	Iontophoresis - 15 min	Manual Technique - 15 min	Paraffin Bath	Postural Training (le) - 15 min	Pulsed Lavage - 15 min	Tens Instruction/Application	Ultrasound - 15 min	Wheelchair Mgmt/Prop Training - 15	Cast - Long Leg (walker)	Cast - Short Leg (Walker)	Crotch Cushion/grips 1pr.	Swimwear, Boys	Swimwear, Gits	Tubgrip C/E	Wobble Board	PT Supplies - Misc.
PHONE	T C	EX	ACT	MR	GATT	EV	AB	EVA	DEVA	TPOOL	WP	OR	EMS	ION	MTT	PS	PTRN	PL	TENS	USS	WC	LLC	SJC	CG	SWB	SWG	TC	WB	MSUP	HOLD
DATE	AM	PM																												
1/4																														
PROGRESS NOTE																							THERAPIST							
Instructed family in exercises + transfers. pt already up in chair and given meds to ↓ agitation.																														
PROGRESS NOTE																							THERAPIST							
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ORIGINAL - MEDICAL RECORDS COPY - REHABILITATION

0005763

REHABILITATION - PHYSICAL THERAPY - DAILY RECORD

Arkansas Children's Hospital  
800 Marshall St., Little Rock, AR 72202  
Issue Date & Time: 01/15/01 1327 Issued By: LAB.KWU Spec #: 0115:B00019R

Unit Issue/Transfusion Record  
(Rev 11/93)

Pt Markers: .DD  
Donor-Directed PK CELLS  
Unit Markers:  
Unit Antigens:  
Spec Date/Time: 01/15/01 1230 XM By: LAB.KWU Compatible? Y  
Pt Location: 30R Messenger: 30R Unit Status: ISS

Pt Account#: \_\_\_\_\_  
Med Rec #: \_\_\_\_\_  
Wristband #: \_\_\_\_\_  
UBS #: \_\_\_\_\_  
Exp: 02/14/01 2359

[ CO POS ] Pt Age: 14  
[ CO POS ]

Comments: TV= 360 < c

Technologists: \_\_\_\_\_ Messenger: \_\_\_\_\_  
By our SIGNATURES ABOVE, we verify that the information on the unit CARD, the unit LABEL, this FORM, and the product REQUISITION are IDENTICAL. Tech above inspected unit IMMEDIATELY prior to issue and found it ACCEPTABLE.

\*\*\*\*\* Do you have CONSENT to transfuse? Yes  No  \*\*\*\*\*

By our SIGNATURES BELOW, we certify that before starting this transfusion, we have verified that:

- 1) The NAME & MEDICAL RECORD NUMBER on the unit CARD & this FORM are the same as the recipient's ARMBAND;
- 2) The UNIT NUMBERS & UNIT BLOOD TYPE on the unit CARD & this FORM are the same as those on the UNIT LABEL;
- 3) This blood product was administered under our supervision.

Nurse/Physician: \_\_\_\_\_ (legible signature)  
Date: 1/15/01 Time: 1412 Ordering Physician: \GUIS  
Time Transfusion Began: \_\_\_\_\_ Time Ended: \_\_\_\_\_ Volume Given: \_\_\_\_\_

Reaction/Comments:  
If TRANSFUSION REACTION is SUSPECTED, STOP TRANSFUSION IMMEDIATELY; keep I.V. patent with saline; NOTIFY PHYSICIAN & BLOOD BANK IMMEDIATELY; order 'TRX' in order category 'BB' or 'BBNED'; fill out TRX FORM with pertinent data and SUBMIT appropriate SPECIMENS & FORM as well as UNIT BAG and SET to BLOOD BANK.

- SIGNS & SYMPTOMS of Transfusion Reactions:
- a) HEMOLYTIC: Chills, fever, shock, dyspnea, pain, headache, abnormal bleeding
  - b) FEBRILE: Chills, fever
  - c) ALLERGIC: Local erythema, hives, itching, flushing, nausea, vomiting, diarrhea, anaphylaxis
  - d) CIRCULATORY OVERLOAD: Coughing, cyanosis, dyspnea

OTHER REACTIONS MAY OCCUR & MAY NOT BE APPARENT UNTIL MUCH LATER (i.e. jaundice unexplained drop in hematocrit). REPORT ANY SUSPECTED REACTION TO BLOOD BANK.  
#####  
##### CHART COPY #####  
#####



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

DIAGNOSTIC RADIOLOGY

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ e: 14 Sex: \_\_\_\_\_  
MFN: \_\_\_\_\_  
Adm #: \_\_\_\_\_ Financial Class: INS  
Room: 3277 Loc: DIS Adm Date: 01/12/2001

Diagnosis: SCOLIOSIS  
Pertinent History/Reason For Procedure? POST. SPINAL FUSION

Could Patient Be Pregnant? N - NO

Date/Time Exam Taken: 01/12/2001 1425  
Ordering MD: \_\_\_\_\_  
Attending MD: \_\_\_\_\_

Exams: 1. PORT CHEST, 2 VW/IP/SDC/OBS/ER 00042949  
2. L-S SPINE, COMPLETE W/OBLQ 000429491

PORTABLE AP X2 CHEST IN OR, #5

01/12/01

Films labeled #5A and #5B on 01/12/01. Film labeled #5A was taken preoperatively. It shows an ET tube with tip in the mid trachea and a right jugular central line with its tip in the SVC. The feeding tube tip is just below the EG junction with its last side hole in the distal esophagus. There is moderate scoliosis. Heart size is normal. The lungs are clear.

IMPRESSION: Tube and line position as described above. No acute cardiopulmonary disease.

Film labeled #5B was taken following rod placement. The proximal end of two spinal fixation rods projects from the upper thoracic region through the lower thoracic region. Heart size remains normal. The lungs remain clear. ET tube tip is in the mid trachea.

IMPRESSION: Stable chest following scoliosis rod placement. No complications noted.

PORTABLE PA/AP/LAT LUMBAR SPINE IN OR, #5

01/12/01

Lumbar spine films labeled #5B were taken in the Operating Room and show rod placement. Rods extend from the upper thoracic region through L4-5. No complications are noted.

737.30

D: 01/22/01 T: 01/24/01

Trans By: REC.LAK

Printed: 01/24/2001 (2301)

Batch #: \_\_\_\_\_

DIAGNOSTIC RADIOLOGY

Chart Copy

164



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

DIAGNOSTIC RADIOLOGY

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ 14 Sex: C-M  
MFN: \_\_\_\_\_  
Adm #: \_\_\_\_\_ Financial Class: INS  
Room: 3277 Loc: DIS Adm Date: 01/12/2001

EXHIBIT NO. 1F  
PAGE 03 OF 58

Diagnosis: SCOLIOSIS  
Pertinent History/Reason For Procedure? SCOLIOSIS  
:  
Could Patient Be Pregnant?

Date/Time Exam Taken: 01/12/2001 0625  
Ordering MD: \_\_\_\_\_  
Attending MD: \_\_\_\_\_

- Exams: 1. SPINE 3 FEET - LATERAL VIEW 000429149
- 2. SPINE 3 FEET - LATERAL VIEW 000429151

3 FT AP/LATERAL SPINE: 1/12/01 #4

Views of the spine shows a left upper thoracic scoliosis of 45 degrees, and a right thoracolumbar of 50 degrees, and a left lumbar of 34 degrees. No vertebral body anomalies are seen.

737.30  
D: 1/16/01 - T: 1/19/01

Trans By: RAD.JMP  
Printed: 01/19/2001 (1254) Batch #:

EXHIBIT NO. 1F  
PAGE: 38 OF 58  
306947

Name: [Redacted]  
DOB: [Redacted] Age: 14 Sex: C-M  
MFN: [Redacted]  
Adm #: [Redacted] Financial Class: INS  
Room: 3277 Loc: DIS Adm Date: 01/12/2001

NEUROPHYSIOLOGY LAB

Diagnosis: SCOLIOSIS  
Reason for test? SZ  
Pertinent history? SCOLIOSIS

Date/Time Exam Taken: 01/12/2001 1539  
Ordering MD: [Redacted]  
Attending MD: [Redacted]

Exams: 1. Intraoperative SER 000429153

INTRAOPERATIVE MONITORING TEMPLATE

NAME: [Redacted]  
DOB: [Redacted]  
ACH: [Redacted]  
DATE: 1/12/01  
PROCEDURE: Posterior Spinal Fusion

INTRODUCTION:

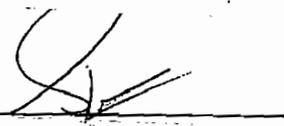
Intraoperative monitoring was performed on a 14 year old male during a posterior spinal fusion.

DESCRIPTION:

Tibial somatosensory evoked potentials (SEPs) were used to monitor lower limb function during surgery. Neurogenic motor evoked potentials (NMEPs) for spinal cord stimulation were used to monitor motor tract function. Responses were elicited at the aforementioned sites and recorded peripherally, cervically and over the somatosensory cortex. Standard elicitation and recording parameters were used. Symmetric latencies and amplitudes characterized baseline data for lower limb SEPs bilaterally. NMEP data was obtained with direct spinal cord stimulation, and data was well formed and reliable. The surgeon was informed of the status of all baseline responses.

CONCLUSION:

SEP and NMEP data remained consistent with baseline values during the procedure. It was not necessary to warn the surgeon of critically degraded data.



Trans By: ACH.SLY  
Printed: 03/13/2001 (1638)



ARKANSAS CHILDREN'S HOSPITAL  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

LABORATORY

EXHIBIT NO. 1F  
PAGE: 37 OF 58

TEST DATE: 01/17/01 ARKANSAS CHILDREN'S HOSPITAL PAGE 2  
TEST TIME: 0130 ACH LABORATORY DISCHARGE SUMMARY FINAL

Patient Information		Hematology Department		Units
[Redacted]		[Redacted]		
[Redacted]		[Redacted]		
Date	01/17/01	Time	10:30	Reference
WBC (K)	12.1			K/uL
EOS (ABS)	0.07			K/uL
EOS (%)	0.6			%
BASOS (ABS)	0.08			K/uL
BASOS (%)	0.7			%
RBC MORPHOLOGY	NORMAL			
PLATELETS	115			K/uL
PLATELET EST	115			K/uL
PLATELET FL	115			fl
MPV VALUE	115			fl



ARKANSAS CHILDREN'S HOSPITAL  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

LABORATORY

EXHIBIT NO. 1F  
PAGE: 38 OF 58

RUN DATE: 01/17/01 ARKANSAS CHILDREN'S HOSPITAL PAGE 3  
RUN TIME: 01:30 ACM LABORATORY DISCHARGE SUMMARY FINAL

Coagulation Studies		Reference	Units
PATIENT INR	1.11	0.8 - 1.2	SEC
PATIENT INR	1.11	0.8 - 1.2	SEC

NOTES: (h) New Reference Ranges established effective December 21, 2000.

Call Lab for Reference Intervals prior to 1 week of age. The INR is recommended for monitoring patients on stable long term coumadin therapy. It may be misleading or unreliable during coumadin induction and/or switchover from heparin to coumadin. The generally accepted therapeutic range of INR is 2.0-3.5, although for most conditions low intensity anticoagulation with an INR of 2.0-3.0 is recommended.

Disregard INR unless patient is on coumadin therapy. Compare PT result with reference range to aid in detection of factor deficiencies.

New Reference Ranges established with change in anticoagulant concentration effective October 5, 2000.

For most therapeutic applications of patients on therapy with unfractionated heparin, a therapeutic range of 1.5 to 2.5 times the mean normal APTT is appropriate. In house mean normal APTT is 25.7 sec.

Call Lab for Reference Intervals prior to 1 week of age.



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

**LABORATORY**

RUN DATE: 01/17/01 ARKANSAS CHILDREN'S HOSPITAL PAGE 4  
RUN TIME: 0130 ACH LABORATORY DISCHARGE SUMMARY FINAL

Patient		(Continued)	
CHEMISTRY DEPARTMENT			
Routine Urinalysis			
Date	Time	Reference	Units
JAN 17 2001	0600		
UR CLARITY	CLEAR	(1-504-3025)	
UR SG GRAVITY	1.025	(15-0-8-5)	
UR PH	7.0		
UR PROTEIN	NEGATIVE	(NEGATIVE)	MG/DL
UR GLUCOSE	NEGATIVE	(NEGATIVE)	MG/DL
UR KETONES	NEGATIVE	(NEGATIVE)	MG/DL
UR BILIRUBIN	NEGATIVE	(NEGATIVE)	
UR BLOOD	NEGATIVE	(NEGATIVE)	
UR NITRITE	NEGATIVE	(NEGATIVE)	
UR LEUKOCYTES	NEGATIVE	(NEGATIVE)	
UR UROBILINOGEN	NEGATIVE	(0-2-8-0)	E.U.
UR REDUCING SUB	NEGATIVE	(NEGATIVE)	/HPP
MUCUS	SMALL		



ARKANSAS CHILDREN'S HOSPITAL  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

LABORATORY

EXHIBIT NO. 1F  
PAGE: 40 OF 58

RUN DATE: 01/17/01 ARKANSAS CHILDREN'S HOSPITAL PAGE 5  
RUN TIME: 0130 ACH LABORATORY DISCHARGE SUMMARY FINAL

Patient: [REDACTED] (Continued)		
RESPIRATORY CARE SERVICES DEPARTMENT		
Blood Gases		
DATE	JAN 17 2001	Units
TIME	09:58	Reference
SAMPLE ID	226042	
PATIENT ID	[REDACTED]	
TEST DATE	01/17/01	
TIME RECEIVED	10:59	
TIME REPORTED	09:46:00	
SAMPLE SOURCE	Arterial	
SAMPLE SITE	LINE	
ALIENS TEST	N/A	
pH (C)	7.43	(7.35-7.45)
PO2 (C)	83	(85-100) mmHg
PO2 (C)	83	(85-100) mmHg
PiCO2	21.4	(20-24) mmol/L
BASE DEFICIT	1.2	(2.36-2.0) mmol/L
CALCULATED SAT	95.5	(88-99) %
EDTA NO.	143	(13-16) g/dl
PT (MP)	17.0	(15-19) C
ANALYZER	855B	
COMMENT		
OPERATOR ID	[REDACTED]	
NOTES: (C) - BALTIMORE		
[REDACTED]		170



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

**LABORATORY**

RUN DATE: 01/17/01  
RUN TIME: 0130

ARKANSAS CHILDREN'S HOSPITAL  
ACH LABORATORY DISCHARGE SUMMARY FINAL

PAGE 6

Patient: [REDACTED] (Continued)

BLOOD BANK DEPARTMENT

Blood Bank Studies

Specimen: 0112-B00019R Collected: 01/15/01 1230 Status: COMP Reg#: 0195802  
 Received: 01/15/01 1507 Subm Dr: [REDACTED]

Ordered: PK CELLS TYPE AND CROSS CROSSMATCH  
 Comments: Reason for crossmatch: LOW Hct  
 # of units/volume: 1  
 Date and time to be given: 1/15/01 NOW  
 Comments: LOW Hct  
 BBK History: O POS

ABO: Rh: O POS  
 INDIRECT COOMBS: NEGATIVE (NEGATIVE)  
 CROSSMATCH: [REDACTED]  
 PK CELLS: 25165-866 PK CELLS O POS Compatible

Specimen: 0112-OR00001R Collected: 01/17/01 0738 Status: COMP Reg#: 0195696  
 Received: 01/17/01 0738 Subm Dr: [REDACTED]

Ordered: Auto Transfusion  
 Comments: BBK History: O POS

UNITAL PROCESSED: 4615  
 TOTAL RETURNED: 875

Specimen: 0111-B00002R Collected: 01/11/01 1015 Status: COMP Reg#: 01955601  
 Received: 01/11/01 1015 Subm Dr: [REDACTED]

Ordered: FRESH PLASMA 2/2 PK CELLS 1/1 TYPE AND CROSS CROSSMATCH  
 Comments: Comments: FOR OR  
 Reason for crossmatch: FINAL FUSION  
 # of units/volume: 1 UNITS PRBC 8/2 UNDEFERRED  
 Date and time to be given: 01/30/00 IN OR  
 Comments: AUTOLOGOUS/ DIRECTED/BANK  
 BBK History: NONE

ABO: Rh: O POS  
 INDIRECT COOMBS: NEGATIVE (NEGATIVE)  
 ABO: Rh: O POS

**ISSUED and TRANSFUSED PRODUCTS**

**PACKED RED CELLS**

Product	Quantity	Transfused	Date	Time Used
PK CELLS	390 CC	TRANSFUSED	01/15/01	390 CC
PK CELLS	875 CC	TRANSFUSED	01/12/01	875 CC

ARKANSAS CHILDREN'S HOSPITAL  
DEPARTMENT OF REHABILITATION  
PHYSICAL THERAPY  
INPATIENT  
SPINAL FUSION

Date: 1/14/01

Diagnosis: Scoliosis                      Precautions:

PMH: Ø

Rehabilitation Request: posterior spinal fusion protocol--non-brace

Requesting Physician: \_\_\_\_\_

Assessment and Treatment Plan

Subjective and history:

Patient is 14 year old referred to physical therapy for intervention per posterior spinal fusion protocol. Patient has history of scoliosis and is now status post posterior spinal fusion on 1/12/01.

Patient/family expectations: \_\_\_\_\_

O: Patient presents in bed. Posterior spinal fusion protocol initiated. Therapeutic activities included the following:

- active exercise: quadriceps sets, ankle pumps, heel slides, supine hip abduction/adduction, gluteal sets
- log rolling *not performed*
- sitting on side of bed
- standing at bedside

Parents/caregivers instructed in log rolling and exercises to be performed by patient:  parents/caregivers verbalized understanding of instruction  
 further education required

A: Patient tolerance for therapeutic activities: none

Patient will benefit from continued physical therapy per protocol to promote optimal return to independent mobility.

P: Physical therapy for therapeutic activities per posterior spinal fusion protocol.

Short term goals: (6-8 treatment sessions)

1. Patient will perform protocol exercises x 10 with verbal cues
2. Patient will get to sitting on side of bed with minimum assistance
3. Patient will transfer bed to and from standing with minimum to contact-guard assist
4. Patient will ambulate 350+ feet with contact-guard to stand-by assist -
5. Patient will ascend/descend 4 steps with contact-guard assist to stand-by assist using one hand rail or one hand held assist

Long term goals: (post hospital discharge)

Patient will return to pre-surgical activity level within limits as set by physician

Therapist's Signature: \_\_\_\_\_

May '99

EXHIBIT NO. 17  
PAGE: 43 OF 68  
3000115

ARKANSAS CHILDREN'S HOSPITAL  
DEPARTMENT OF REHABILITATION

- INPATIENT  - OUTPATIENT

PHYSICAL THERAPY			PHONE	TC	EX	ACT	HAIR	GAIT	EV	AB	EVA	DEVA	TYOOL	WP	OR	EMS	ICW	MTT	PB	PTRN	PL	TENS	USS	WC	LLG	SIC	CG	SWB	SWG	TC	WB	MSUP					
1-15-01	AM																																				
PROGRESS NOTE																	Please see note in pt's chart.												THERAPIST								
1-16-01	AM																																				
PROGRESS NOTE																	Please see notes in pt's chart. H. D/C'd p clearing P.T. w/ safe ambulation + transfers.												THERAPIST								
1-20-01	AM																																				
PROGRESS NOTE																													THERAPIST								
	AM																																				
PROGRESS NOTE																													THERAPIST								
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PROGRESS NOTE																													THERAPIST								

30R

ARKANSAS CHILDREN'S HOSPITAL  
DEPARTMENT OF REHABILITATION

- INPATIENT

- OUTPATIENT

PHYSICAL THERAPY	MESS	MESS	97110	97130	97112	97116	97001	97001	97002	90111	97113	97022	97504	97032	97033	97140	97019	97520	97039	94550	97035	97042	20366	20425	ED157							
	PHONE	TC	EX	ACT	NMR	GAITT	EV	AS	EVA	DEVA	TPOOL	WP	CR	EMS	ION	MTT	PS	PTRN	PL	TEMS	US5	WC	LLC	SLC	CG	SNB	SWG	TG	WB	MSUP	Hold	
	"Trcking" Lengthy Phone Consult	"Trcking" Team Conference - 15m	Therapeutic Procedures - 15 min	Therapeutic Activity - 15 min	Neuromuscular Re-od - 15 min	Gait Training - 15 min	PT Evaluation	PT Evaluation, Bilat Mod 52	PT Re-Evaluation	Developmental Eval/Testing	Pool Therapy - 15 min	Whitpool	Orthotics FRT/Tring - 15 min	EMS Attended - 15 min	Integritness - 15 min	Manual Technique - 15 min	Parent's Bath	Prosthetic Training (e) - 15 min	Pulse Lavage - 15 min	Tens Instruction/Application	Ultrasound - 15 min	Wheelchair Mngmt/Prop Tring -15	Cast - Long Leg (walker)	Cast - Short Leg (Walker)	Crutch Cues/Tring 1pr.	Swimwear, Boys	Swimwear, Girls	Tubigrip CE	Wobble Board	PT Supplies - Misc	Hold	
DATE	AM	PM																														
PROGRESS NOTE <i>Instructed family in exercises + transfers. pt already up in chair and given meds to D. agitation.</i>																									THERAPIST							
DATE	AM	PM																														
PROGRESS NOTE 																									THERAPIST							
DATE	AM	PM																														
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DATE	AM	PM																														
PROGRESS NOTE 																									THERAPIST							

Arkansas Children's Hospital  
 800 Marshall St., Little Rock, AR 72202  
 Issue Date & Time: 01/15/01 1327

Unit Issue/Transfusion Record  
 (Rev 11/93)  
 Issued By: LAB.KWU Spec #: 0115:800019R

Reaction/Comments:

If TRANSFUSION REACTION is SUSPECTED, STOP TRANSFUSION IMMEDIATELY; keep I.V. patent with saline; NOTIFY PHYSICIAN & BLOOD BANK IMMEDIATELY; order 'TRX' in order category 'BB' or 'BBNED'; fill out TRX FORM with pertinent data and SUBMIT appropriate SPECIMENS & FORM as well as UNIT BAG and SET to BLOOD BANK.

SIGNS & SYMPTOMS of Transfusion Reactions:

- a) HEMOLYTIC: Chills, fever, shock, dyspnea, pain, headache, abnormal bleeding
- b) FEBRILE: Chills, fever
- c) ALLERGIC: Local erythema, hives, itching, flushing, nausea, vomiting, diarrhea, anaphylaxis
- d) CIRCULATORY OVERLOAD: Coughing, cyanosis, dyspnea

OTHER REACTIONS MAY OCCUR & MAY NOT BE APPARENT UNTIL MUCH LATER (i.e. jaundice, unexplained drop in hematocrit). REPORT ANY SUSPECTED REACTION TO BLOOD BANK.

#####  
 ##### CHART COPY ##### 175 #####  
 #####



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

DIAGNOSTIC RADIOLOGY

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: 14 Sex: C-M  
MFN: \_\_\_\_\_  
Adm #: \_\_\_\_\_ Financial Class: INS  
Room: 3277 Loc: DIS Adm Date: 01/12/2001

Diagnosis: SCOLIOSIS

Pertinent History/Reason For Procedure? POST. SPINAL FUSION

Could Patient Be Pregnant? N - NO

Date/Time Exam Taken: 01/12/2001 1425

Ordering MD: \_\_\_\_\_

Attending MD: \_\_\_\_\_

Exams: 1. PORT CHEST, 2 VW/IP/SDC/OBS/ER 00042949  
2. L-S SPINE, COMPLETE W/OBLQ 000429491

PORTABLE AP X2 CHEST IN OR, #5

01/12/01

Films labeled #5A and #5B on 01/12/01. Film labeled #5A was taken preoperatively. It shows an ET tube with tip in the mid trachea and a right jugular central line with its tip in the SVC. The feeding tube tip is just below the EG junction with its last side hole in the distal esophagus. There is moderate scoliosis. Heart size is normal. The lungs are clear.

IMPRESSION: Tube and line position as described above. No acute cardiopulmonary disease.

Film labeled #5B was taken following rod placement. The proximal end of two spinal fixation rods projects from the upper thoracic region through the lower thoracic region. Heart size remains normal. The lungs remain clear. ET tube tip is in the mid trachea.

IMPRESSION: Stable chest following scoliosis rod placement. No complications noted.

PORTABLE PA/AP/LAT LUMBAR SPINE IN OR, #5

01/12/01

Lumbar spine films labeled #5B were taken in the Operating Room and show rod placement. Rods extend from the upper thoracic region through L4-5. No complications are noted.

737.30

D: 01/22/01 T: 01/24/01

Trans By: REC.LAK

Printed: 01/24/2001 (2301) Batch 17635



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

DIAGNOSTIC RADIOLOGY

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: 14 Sex: C-M  
MFN: \_\_\_\_\_  
Adm #: \_\_\_\_\_ Financial Class: INS  
Room: 3277 Loc: DIS Adm Date: 01/12/2001

Diagnosis: SCOLIOSIS  
Pertinent History/Reason For Procedure? SCOLIOSIS  
:  
Could Patient Be Pregnant?

Date/Time Exam Taken: 01/12/2001 0625  
Ordering MD: \_\_\_\_\_  
Attending MD: \_\_\_\_\_

Exams: 1. SPINE 3 FEET - LATERAL VIEW 000429149  
2. SPINE 3 FEET - LATERAL VIEW 000429151

3 FT AP/LATERAL SPINE: 1/12/01 #4

Views of the spine shows a left upper thoracic scoliosis of 45 degrees,  
and a right thoracolumbar of 50 degrees, and a left lumbar of 34  
degrees. No vertebral body anomalies are seen.

737.30  
D: 1/16/01 - T: 1/19/01

Trans By: RAD.JMP  
Printed: 01/19/2001 (1254) Batch #17733

NEUROPHYSIOLOGY LAB

Name: [unclear]  
DOB: [unclear] Age: 14 Sex: C-M  
MFN: [unclear]  
Adm #: [unclear] Financial Class: INS  
Room: 3277 Loc: DIS Adm Date: 01/12/2001

Diagnosis: SCOLIOSIS  
Reason for test? SZ  
Pertinent history? SCOLIOSIS

Date/Time Exam Taken: 01/12/2001 1539  
Ordering MD: [unclear]  
Attending MF: [unclear]  
Exams: 1. Intraoperative SER 000429153

INTRAOPERATIVE MONITORING TEMPLATE

NAME: [unclear]  
DOB: [unclear]  
ACH: [unclear]  
DATE: 1/12/01  
PROCEDURE: Posterior Spinal Fusion

INTRODUCTION:

Intraoperative monitoring was performed on a 14 year old male during a posterior spinal fusion.

DESCRIPTION:

Tibial somatosensory evoked potentials (SEPs) were used to monitor lower limb function during surgery. Neurogenic motor evoked potentials (NMEPs) for spinal cord stimulation were used to monitor motor tract function. Responses were elicited at the aforementioned sites and recorded peripherally, cervically and over the somatosensory cortex. Standard elicitation and recording parameters were used. Symmetric latencies and amplitudes characterized baseline data for lower limb SEPs bilaterally. NMEP data was obtained with direct spinal cord stimulation, and data was well formed and reliable. The surgeon was informed of the status of all baseline responses.

CONCLUSION:

SEP and NMEP data remained consistent with baseline values during the procedure. It was not necessary to warn the surgeon of critically degraded data.



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

DIAGNOSTIC RADIOLOGY

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: 13 Sex: C-M  
MFN: \_\_\_\_\_  
Adm #: \_\_\_\_\_ Financial Class: INS  
Room: \_\_\_\_\_ Loc: ORTCL Adm Date: 08/21/2000

Diagnosis: SCOLIOSIS  
Pertinent History/Reason For Procedure? SCOLIOSIS

Could Patient Be Pregnant?

Date/Time Exam Taken: 08/21/2000 0837  
Ordering MD: \_\_\_\_\_  
Attending MD: \_\_\_\_\_

Exams: 1. BEND TILT 000382489

BEND TILT, #3

08/21/00

Patient has a left thoracic curve which almost completely corrects on bending to the left.

D: 08/21/00 T: 08/22/00

Trans By: REC.LAK  
Printed: 08/22/2000 (2243) Batch #17958

**ARKANSAS CHILDREN'S HOSPITAL  
SEDATION RECORD**

Procedure MRI Date 8-11-00  
Start Time 0900 Procedure End Time 1000  
Performed by \_\_\_\_\_ Where RAD  
Attending M.D. \_\_\_\_\_  
Arrived:  Amb  Wheelchair  Stretcher

Check the level of sedation planned:

Light Sedation  Deep Sedation

**PRE-PROCEDURE ASSESSMENT**  
(for deep sedation)

NPO	Age	WT	BP	Temp	Pulse	RR	SpO <sub>2</sub>
—	13y10m	105	—	—	—	—	—

Signature: \_\_\_\_\_  
General: Good  
Respiratory Status: BBB Clear lungs  
Mental Status: Alert - Dev. Delay

Other: 47.7kg (9.5m) @ 4/10 run over by car  
Allergies: N.K. M.A.  
Current Meds: Adir PRN

This patient is a candidate for deep sedation. M.D. \_\_\_\_\_

**CONSENT FOR SEDATION** (Complete when the test, procedure, or exam being performed does not require consent, but deep sedation is to be administered)

I understand that my child will be given sedation under the supervision of Dr. \_\_\_\_\_ I understand that the administration of sedation may involve side effects and risks including drowsiness, dizziness, and forgetfulness. I am aware that possible rare risks of sedation include breathing and heart rate problems or loss of life. I have been informed appropriate monitoring equipment and medication will be available to immediately diagnose and manage these complications should they occur. I acknowledge that I have read and understand the above and have had my questions answered.

Parent/Guardian: \_\_\_\_\_ Witness: \_\_\_\_\_ M.D. \_\_\_\_\_ Date: \_\_\_\_\_

Check if consent for deep sedation is in the medical record with procedure consent.

**PROCEDURE AND RECOVERY RECORD** (Documentation for sedation includes med and time given. If deep sedation is given, monitor per Sedation Policy I 17)

Time	Medication	Route	EKG	BP	Temp	P	RR	SpO <sub>2</sub>	LOC*	Comments	Signature
8:50	<u>Valium</u>	<u>P.O.</u>	/	/	/	/	/	/	1	<u>Spontaneous</u>	<u>[Signature]</u>
	<u>10mg</u>	<u>-</u>	/	/	/	/	/	/		<u>Documented</u>	<u>[Signature]</u>

Fluids: Type \_\_\_\_\_  
Infused \_\_\_\_\_

O<sub>2</sub>: [ ] yes [ ] no \_\_\_\_\_ L/min Start: \_\_\_\_\_  
via \_\_\_\_\_ Stop: \_\_\_\_\_  
N<sub>2</sub>O: [ ] yes [ ] no \_\_\_\_\_ L/min Start: \_\_\_\_\_  
via \_\_\_\_\_ Stop: \_\_\_\_\_

alert - 1 rouses easily - 4  
\*LOC drowsy - 2 sleeping - 5  
slurred - 3 does not respond to stimuli - 6

**CHARGE EVALUATION:** Patient returned to pre-sedation status. [ ] Yes [ ] No Time: \_\_\_\_\_

Comments: Alert. NAD. D/C id home @ clinic 180  
Signature: \_\_\_\_\_

Transferred/Discharged to: Home Time: 1000 Via: amb. Post Sedation Instructions Given:  Yes [ ] No To: Mom  
Home, clinic, nursing unit (specify)



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

MAGNETIC RESONANCE IMAGING

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: 13 Sex: C-M  
MFN: \_\_\_\_\_  
Adm: \_\_\_\_\_ Financial Class: INS  
Room: \_\_\_\_\_ Loc: RADSV Adm Date: 08/11/2000

Diagnosis: SPINE/MVA/BACK PAIN  
Pertinent History/Reason For Procedure? BACK PAIN, SCOLIOSIS

Could Patient Be Pregnant? N - NO

Date/Time Exam Taken: 08/11/2000 1616  
Ordering MD: \_\_\_\_\_  
Attending MD: \_\_\_\_\_

- Exams: 1. CERVICAL SPINE 000379995
- 2. THORACIC SPINE 000379996
- 3. LUMBAR SPINE 000379997

MRI OF THE CERVICAL SPINE: 8/11/00

HISTORY: 13-year-old with history of scoliosis. Patient now has back pain.

TECHNIQUE: Sagittal T1 weighted scans, axial T1 weighted scans and axial T2\* gradient echo scans were made through the cervical spine. Sagittal fast-spin echo T2 images were also done.

FINDINGS: The craniocervical junction, cervical vertebral bodies, subarachnoid space and cervical spinal cord appear unremarkable. Scoliosis is noted.

IMPRESSION: Normal MRI of the cervical spine.

MRI OF THORACIC SPINE:

TECHNIQUE: Sagittal and axial T1 weighted scans and axial T2\* gradient echo scans were made through the thoracic spine. Sagittal fast-spin echo T2 images were also done.

FINDINGS: The thoracic vertebral bodies, thoracic subarachnoid space and thoracic spinal cord all appear unremarkable. Scoliosis is noted.

IMPRESSION: Normal MRI of the thoracic spine.

MRI OF LUMBAR SPINE:

TECHNIQUE: Sagittal and axial T1 weighted scans and axial T2\* gradient echo scans were made through the lumbar spine. Sagittal fast-spin echo T2 images were also done.

FINDINGS: The conus medullaris ends normally at L1. No intraspinal masses are seen. The lumbar vertebral bodies and lumbar subarachnoid space appears unremarkable. Scoliosis is noted.

IMPRESSION: Normal MRI of the lumbar spine.



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

MAGNETIC RESONANCE IMAGING

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: 13 Sex: C-M  
MFN: \_\_\_\_\_  
Adm #: \_\_\_\_\_ Financial Class: INS  
Room: \_\_\_\_\_ Loc: RADSV Adm Date: 08/11/2000

Diagnosis: SPINE/MVA/BACK PAIN  
Pertinent History/Reason For Procedure? BACK PAIN, SCOLIOSIS

Could Patient Be Pregnant? N - NO

Date/Time Exam Taken: 08/11/2000 1616  
Ordering MD: \_\_\_\_\_  
Attending MD: \_\_\_\_\_

Exams: 1. CERVICAL SPINE 000379995  
2. THORACIC SPINE 000379996  
3. LUMBAR SPINE 000379997  
(CONTINUATION)

\_\_\_\_\_, Resident D: 8/11/00 - T: 8/11/00  
Dr. \_\_\_\_\_ was present and personally reviewed this examination, and  
this report reflects his interpretation of the findings.

*W*

Trans By: RAD.JMP  
Printed: 08/11/2000 (2300) Batch # 18242



ARKANSAS CHILDREN'S HOSPITAL  
800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

EXHIBIT NO. 1F  
PAGE: 53 OF 58

ORTHOPAEDIC CLINIC NOTE

NAME:  
ACCOUNT#:  
MR #:

DATE: 08/21/2000

HISTORY OF PRESENT ILLNESS: This patient is a 13+11-year-old that is following up for painful scoliosis. The patient had an MRI in the interim which was read as normal MRI of the cervical, thoracic, and lumbar spine. The patient reports decrease in pain in his back overall. However, he has a new complaint of bilateral knee and left shoulder pain. The parents feel that this is due to the fact that he went innertubing yesterday all day at the lake. The patient states that when he does have back pain, his pain is in his low back.

PHYSICAL EXAMINATION: The patient has a large right rib hump and left shoulder blade prominence. He has a normal gait, and the rest of his physical exam is unchanged. X-rays today bending AP were done which shows a curve that appears to be flexible.

PLAN: We discussed the risks and benefits of surgery with the patient including the option of no surgery and a prognosis for his curve. We feel that his curve will continue to worsen over time, and that surgery is his best option. The parents agreed to consider any questions that they have about surgery, and we will write those down and ask when calls to set up surgery that we have scheduled for him. He will need a posterior spinal fusion for this curvature, and we will call the patient for scheduling in the future.

dict: 08/21/2000  
WG/MDQ34

tran: 08/21/2000

job id: 53441



ARKANSAS CHILDREN'S HOSPITAL  
LITTLE ROCK, ARKANSAS  
OUTPATIENT CLINIC RECORD

CLINIC: ORTHOPAEDICS 5 ALLERGIES:

DATE: 08/21/00 HEIGHT: WEIGHT: BP: HC: IMMUNIZATIONS:

Nursing Assessment  
Referring Physician:

History: P/L PAINFUL SCIASS

HAI MRI DUE TO

PAIN - NORMAL

News of knee & shoulder, TENDERNESS MILD PAIN IN  
LOW BACK & PAIN IN BACK OVERALL

Physical: (A) RIB HUMP & (L) SHOULDER BLADE PROMINENCE  
SLIGHT PATELLAR TENDON TENDERNESS (B)

- S: DIC CURVE
- O: MME AC
- A: SCUTE SCOLY
- P: SCHAUF ASI-

X-ray: BENDING X-RAYS AP - Flexible

Assessment: Discussed Risks and Benefits of Surgery. Reluctant

Opten of No Surgery & prognosis of his Curves

Plan: Will call for scheduling

Patient Instructions:

PHYSICIAN SIGNATURE: /

SE'S SIGNATURE:



**ARKANSAS CHILDREN'S HOSPITAL**  
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

DIAGNOSTIC RADIOLOGY

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: 13 Sex: C-M  
MFN: \_\_\_\_\_  
Adm #: \_\_\_\_\_ Financial Class: INS  
Room: \_\_\_\_\_ Loc: ORTCL Adm Date: 07/31/2000

Diagnosis: SCOLIOSIS  
Pertinent History/Reason For Procedure? SCOLIOSIS  
:  
Could Patient Be Pregnant?

Date/Time Exam Taken: 07/31/2000 0859  
Ordering MD: \_\_\_\_\_  
Attending MD: \_\_\_\_\_

Exams: 1. SPINE 3 FEET - AP VIEW 000376992  
2. SPINE 3 FEET - LATERAL VIEW 000376993

STANDING 3 FT AP & LATERAL SPINE: 7/31/00 #1

There is a 35 degree thoracic scoliosis convex to the right measured from T8 to L1. There is a 30 degree curve convex to the left measured from L1 through L4.

IMPRESSION: Scoliosis as described above. No vertebral anomalies noted.

D: 7/31/00 - T: 7/31/00

Trans By: RAD.JMP  
Printed: 07/31/2000 (2349) Batch #: 1855



ARKANSAS CHILDREN'S HOSPITAL  
800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

EXHIBIT NO. 1F  
PAGE: 56 OF 58

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ORTHOPAEDIC CLINIC NOTE

NAME:

DATE: 07/31/2000

ACCOUNT#:

MR #:

HISTORY OF PRESENT ILLNESS: [redacted] is 13 years old, and is seen today regarding scoliosis. He had a positive school screening in 05/00, went to see Dr. [redacted], and was referred here for further evaluation. He complains of back pain with activity, sometimes back pain at night. He sleeps on the floor, takes Motrin for the pain. He is not active in sports. He feels he cannot participate in sports because of his back pain. FAMILY HISTORY: Positive, mother may have had scoliosis. PAST MEDICAL HISTORY: Negative. He did have a previous run over injury as a child and had a fracture of the head, and he also had a fracture of the pelvis. REVIEW OF SYSTEMS: Otherwise negative. ALLERGIES: No allergies. No ongoing medicines other than the occasional Advil.

PHYSICAL EXAMINATION: He has a normal gait. He can walk on his heels, walk on his toes, perform a deep knee bend. The pelvis is level on forebending. He does have a rib hump and a lumbar prominence. Deep tendon reflexes are within normal limits. Straight leg raising is negative. There is no wasting and no leg length discrepancy.

X-rays taken today show a curvature from T8-T12 of 48 degrees, and from T12-L4 of 36 degrees. He is Risser 0.

IMPRESSION: Severe back pain with scoliosis.

PLAN: I explained to mother that I thought his curvature was large enough that it was likely to require surgery, but I was concerned about the fact he was having so much pain. I thought he would need a preoperative evaluation of his spine to consist of an MRI to make sure he does not have some intrinsic lesion of the spine causing this pain. We will go ahead and schedule this for the near future.



ARKANSAS CHILDREN'S HOSPITAL  
800 Marshall Street  
Little Rock, Arkansas 72202-3501  
(501) 320-1100

EXHIBIT NO. 1F  
PAGE: 57 OF 58

ORTHOPAEDIC CLINIC NOTE

NAME:

ACCOUNT#:

MR#:

CONTINUED...

We will see him back after that, and if there is no spinal cord abnormality we will consider scheduling him for surgery.

Attending Physician

cc: DR.

PCP:

Referring Physician:

dict: 07/31/2000  
RDB/MDQ34

tran: 07/31/2000

job id: 51405



ARKANSAS CHILDREN'S HOSPITAL  
LITTLE ROCK, ARKANSAS  
OUTPATIENT CLINIC RECORD

PATIENT: [redacted]  
UNIT #: [redacted] ACCT# [redacted] EXHIBIT NO. 1F 58  
D.O.B: [redacted]

CLINIC: ORTHOPAEDICS DR [redacted] ALLERGIES: [redacted]

DATE: 07/31/00 HEIGHT: [redacted] WEIGHT: [redacted] BP: [redacted] HC: [redacted] IMMUNIZATIONS: [redacted]

Nursing Assessment: 13 yr old WM here for eval of scoliosis - ID  
Referring Physician: CENAC, JOSEPH W.

History: 13 + 10 y/o WM referred by school screening (8/00).

PMH: mother referred by Dr. Cenac.  
PMA: ♀ c/o back pain with Pet activity, sleep on floor  
PSH: "head fix" mild scoliosis, avoid help.

Physical: All: ♀ P/B / normal / weakness  
Medi: ♀  
Scoliosis ↑ (R) thorax 9°  
↑ (L) lumbar 8°  
T8/T9 45°

X-ray: T12/L1 36°  
L5/S1 0°  
2<sup>nd</sup> DYN's

Assessment: (C) torticollis / down  
① 5/5 MS U/SI.  
S: SEVERE BACK PAIN + SCOLIOSIS  
Plan: symmetrical distinct reflex  
L: LACK CURVATURE  
X-rays  
NO LOCALIZING FINDINGS  
MNI SPIT

Patient Instructions:  
A: PAINFUL SCOLIOSIS  
P: MNI, WILL U/SI

PHYSICIAN SIGNATURE: [redacted] SIGNATURE: [redacted]

EXHIBIT NO. 2F  
PAGE: 1 OF 22**REPORT OF EDUCATIONAL EVALUATION**  
**Lake Hamilton School District, Percy, Arkansas**

<b>NAME:</b> _____	<b>AGE:</b> 1
<b>DATE OF BIRTH:</b> _____	<b>SEX:</b> male
<b>ASSESSMENT:</b> 1-11-2003	<b>GRADE:</b> 9
<b>EXAMINER:</b> _____	<b>SCHOOL:</b> Lake Hamilton
<b>VISION SCREENING:</b> Passed 9-25-02	<b>DOMINANT HAND:</b> Right
<b>HEARING SCREENING:</b> Passed 9-25-02	<b>REEVAL CONF BY:</b> 1-11-06
<b>REFERRED BY:</b> Reevaluation	<b>LEARNING STYLE:</b> Visual

**REASON FOR REFERRAL:**

\_\_\_\_\_ was referred for his three year reevaluation. Reestablishment of eligibility is not necessary due to the nature of \_\_\_\_\_ disability. This battery will be used as a tool by the evaluation committee for programming purposes. \_\_\_\_\_ is currently receiving special services in self contained classroom.

**EDUCATIONAL HISTORY**

\_\_\_\_\_ repeated second grade and he has changed schools at least 5 times. School attendance is reportedly satisfactory.

\_\_\_\_\_ had educational and speech language evaluations done by Lake Hamilton School in 1997 and 2000. The results of those evaluations may be found in his due process file.

Results of those evaluations reflect ability level in the borderline range as measured by the WISCIII with scores as Verbal 63, Performance 82 and Full Scale 70.

**BACKGROUND INFORMATION and  
DEVELOPMENTAL/SOCIAL HISTORY**

\_\_\_\_\_ family consists of his mother and younger brother. The Home/Health Form was completed by his mother. Birth history was reportedly complicated by Caesarian section delivery. Developmental problems considered significant a skull fracture due to being dropped and a delay in developmental milestones. Speech therapy was provided to the \_\_\_\_\_ when he was enrolled in Lake Hamilton School.

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**CURRENT EVALUATION INSTRUMENTS****Assessment Tools**

Curriculum Based Assessments  
 Observations  
 Teacher Present Levels of Functioning  
 Review of School Records: Attendance, Test Results, Grades, Conduct  
 Physician Statement  
 Behavior Evaluation Scale-2

**RESULTS OF CURRENT EVALUATION INSTRUMENTS****Curriculum/Classroom Assessment Information**

Curriculum/Classroom-based assessments indicate weaknesses in the areas of reading comprehension.

Curriculum/Classroom based assessments indicate strengths in the areas of spelling.

**Classroom Observation**

\_\_\_\_\_ was observed in his Math class. He was actively working on the appropriate task. He appeared organized and to be following directions. He interacted with peers, but was not easily distracted.

\_\_\_\_\_ is quiet, studious and usually on task. He is polite and waited to ask questions.

**Adaptive Behavior**

On the Behavior Evaluation Scale--2, a teacher rated measurement, a score of 6 or below is considered significant. \_\_\_\_\_ was rated by his teacher in the following manner:

<u>Area</u>	<u>Standard Score</u>
Learning Problems	7
Interpersonal Difficulties	11
Inappropriate Behavior	10
Unhappiness/Depression	8
Physical Symptoms/Fears	9
Adaptive Behavior Quotient	93

## **SUMMARY OF CURRENT DATA**

An observation showed on task behaviors and lack of distractibility. His BES-2 indicated no deficit areas.

### **Suspected PHC with supporting evidence and committee clause Evidence of suspected handicapping condition**

Based on previous evaluations, observations, teacher reports, and current evaluation results, it is the recommendation of this examiner that \_\_\_\_\_ qualifies for special services under the disabling condition **Specific Learning Disability**

### **Curriculum and Programming Recommendations**

\_\_\_\_\_ best learning style appears to be visual. This is based on indicators from appropriate evaluation tools. Recommendations based on \_\_\_\_\_ evaluation are as follows:

1. Provide \_\_\_\_\_ with preferential seating at or near the front of the classroom.
2. Review with \_\_\_\_\_ class more often than you might for another class.
3. Use praise and positive reinforcement as often as possible and appropriate.
4. When giving directions in a large group setting, an attempt should be made to include visual aids such as gestures, charts, pictures, and various symbols.

Educational Examiner

EXHIBIT NO. 2F  
PAGE: 4 OF 22**REPORT OF EDUCATIONAL EVALUATION**  
**Lake Hamilton School District**  
**Pearcy, Arkansas**

**NAME:** ..  
**DATE OF BIRTH:**  
**AGE:**  
**SEX:** Male  
**GRADE:** 12 - Graduation 5/2006  
**SCHOOL:** Lake Hamilton High School  
**VISION SCREENING:** Passed 2/24/06  
**HEARING SCREENING:** Passed 2/24/06  
**REFERRED BY:** Review of Existing Data Committee

**REASON FOR REFERRAL:**

was referred for his three year Review of Existing Data in accordance with the Individuals with Disabilities Education Act (IDEA). Reestablishment of eligibility is not necessary due to the nature of 's disability. All existing data, teacher reports, social history and curriculum connection will be utilized to establish 's strengths and weaknesses and for providing data for his review committee.. Upon his graduation in May 2006 ' will be dismissed from the school aged special services program.

**HISTORY/BACKGROUND**

Transfer student from Glenwood to Lake Hamilton as a 2<sup>nd</sup> grader.  
Frequent moves prior to enrollment at Lake Hamilton.  
History of special education placement and services to include speech/language.  
Records indicated that ' repeated 4<sup>th</sup> grade.  
His family consists of his mother and one younger brother.  
Surgery at age six for curvature of the spine additional medical history is unremarkable.  
He is to wear glasses for driving.  
School attendance is currently good.  
Attendance in the morning at Rehab  
At semester his grades were: 2 A's and 1 B.

**DATA REVIEWED**

Social History  
Review of School Records: Attendance, Test Results, Grades, Conduct  
The Curriculum Connection  
Observations  
Teacher Present Levels of Functioning  
Behavior Evaluation Scale-2  
Vision/Hearing Screening

**RESULTS**

**Curriculum/Classroom Assessment Information**

Curriculum Connections is a classroom based assessment that identifies grade based content area knowledge and skills. (see attached)

Curriculum/Connection based assessments indicate weaknesses in the areas of capitalization, punctuation, word usage and literature. Skills in these areas were not present but emerging.

**Teacher Present Levels of Functioning**

Finance instructor reported a positive attitude, good class preparation, work completion, attention and following directions. Classroom modifications were the use of a peer tutor.

**Classroom Observation**

as observed in his English classroom. was serious about his assignments and motivated to do his best. He was focused and on task.

**Adaptive Behavior**

The Behavior Evaluation Scale provides a measure of adaptive skills which is relevant and meaningful to educational assessment and the educational environment. On the teacher rated measurement, a score of 10 is considered average. as rated by his resource room teacher M

Area	Standard Score
Communication	4
Self-Care	11
Home Living	3
Social	9
Community Use	7
Self-Direction	7
Health & Safety	3
Functional Academics	5
Leisure	1
Work	7
<b>Adaptive Behavior Quotient</b>	<b>78</b>

**Summary**

Based on \_\_\_\_\_'s previous evaluation (see in due process file), observations, teacher reports and current data, \_\_\_\_\_ continues to meet state criteria for Specific Learning Disability.

\_\_\_\_\_  
Educational Examiner

**REPORT OF TEST RESULTS**

STUDENT: \_\_\_\_\_ TEST DATE: \_\_\_\_\_

GRADE: \_\_\_\_\_ AGE: \_\_\_\_\_ SCHOOL: Lake Hamilton  
Int

**WECHSLER INTELLIGENCE SCALE FOR CHILDREN - III**

(AVE. RANGE 90-110)

VERBAL SCORE 63

PERFORMANCE SCORE 82

FULL SCALE SCORE 70

**WECHSLER INDIVIDUAL ACHIEVEMENT TEST**

(AVE. RANGE 90-110)

Basic Reading 74

VMI 92 (AVE. RANGE 90-110)

Mathematics Reasoning 73

DTLA-3 (AVE. RANGE 8-12)  
Subtest III 1

Spelling 82

Reading Comprehension 72

Subtest IX 4

Numerical Operations 77

Written Expression —

**Language Screener**

**COMPOSITES**

Speech Pathologist  
Language Eval.

Reading 71

Mathematics 71

Writing \_\_\_\_\_

**REPORT OF ACHIEVEMENT TESTING**

**STUDENT** \_\_\_\_\_ **STATE** \_\_\_\_\_  
**SCHOOL** \_\_\_\_\_ **AGE** \_\_\_\_\_

**WOODCOCK READING MASTERY TEST-REVISED (FORM G) FORM H**  
(Average Range 90-110)

AREA	STANDARD SCORE
Word Identification	64
Word Attack	63
Word Comprehension	66
Passage Comprehension	62
BASIC SKILLS CLUSTER	63
READING COMPREHENSION CLUSTER	61
TOTAL READING CLUSTER	61

**KEY MATH - REVISED** FORM A **FORM B**  
(Average Range 90-110)

AREA	STANDARD SCORE
Basic Concepts	72
Operations	84
Applications	71
TEST TOTAL	73

**TEST OF WRITTEN LANGUAGE 3**

SUBTEST	SCALED SCORE
Vocabulary	5
Spelling	5
Style	6
Logical Sentences	2
Sentence Completion	7

**WRITTEN LANGUAGE**  
**QUOTIENT (Contrived**  
**Section)** \_\_\_\_\_ 66

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**LAKE HAMILTON PUBLIC SCHOOL**  
**SPEECH/LANGUAGE EVALUATION REPORT**

NAME:  
DATE OF BIRTH: \_\_\_\_\_  
AGE:  
SCHOOL: Lake Hamilton Middle School  
EVALUATION DATE: December 10, 1999

**HISTORY/PRESENTING COMPLAINTS**

Age 13 years, 2 months, was seen for a speech and language reevaluation. He has been receiving speech therapy services here at Lake Hamilton for a speech and language disorder.

This speech/language evaluation was conducted to help determine his communication strengths and weaknesses as well as his current level of speech and language functioning.

Medical and developmental history reports as well as the results of his Psychoeducational Evaluation can be obtained from his due process folder.

**GENERAL OBSERVATIONS**

\_\_\_\_\_ came willingly to the testing situation and was very cooperative. He interacted well with the examiner and was very pleasant and communicative. His response time to the individual testing tasks appeared to be appropriate. This evaluation is believed to be a valid assessment of \_\_\_\_\_ speech and language skills at the time of testing.

**TESTS ADMINISTERED**

CLINICAL EVALUATION OF LANGUAGE FUNDAMENTALS-THIRD EDITION  
COMPREHENSIVE RECEPTIVE AND EXPRESSIVE VOCABULARY TEST  
ARIZONA ARTICULATION PROFICIENCY SCALE  
GOLDMAN-FRISTOE TEST OF ARTICULATION  
ORAL PERIPHERAL EVALUATION  
INFORMAL ASSESSMENT

**SPEECH/LANGUAGE EVALUATION**

The *COMPREHENSIVE RECEPTIVE AND EXPRESSIVE VOCABULARY TEST* assesses oral vocabulary and identifies any discrepancies between receptive and expressive oral vocabulary skills. [redacted] receptive language standard score of 72 and expressive language standard score of 59, yielded a general vocabulary standard score of 59. Standard scores between 110 and 90 are considered to be within the normal range.

The *CLINICAL EVALUATION OF LANGUAGE FUNDAMENTALS-THIRD EDITION* is an individually administered clinical tool for the identification, diagnosis, and follow-up evaluation of language skill deficits in school-age children, adolescents, and young adults. The results of each subtest are as follows:

SUBTEST	RAW SCORE	STANDARD SCORE
Concepts and Directions	11	3
Word Classes	22	6
Semantic Relationships	8	3
Receptive Language Score:		53
Formulated Sentences	13	3
Recalling Sentences	21	3
Sentence Assembly	15	8
Expressive Language Score:		61
Total Language Score:		54

The higher language score of 61, minus the lower language score of 53, reveals a difference of 8. This difference is considered to be statistically significant.

Standard language scores between 85 and 115 are considered to be in the average range.

The concepts and directions subtest assesses the ability to interpret, recall, and execute oral commands of increasing length and complexity that contain concepts requiring logical operations.

The formulated sentences subtest assesses the formulation of simple, compound, and complex sentences.

The word classes subtest assesses the ability to perceive relationships between words that are categorized by part-whole and semantic class features and synonyms and

antonyms.

The recalling sentences subtest assesses the recall and reproduction of sentence surface structure as a function of syntactic complexity.

The sentence assembly subtest assesses the ability to assemble syntactic structures into grammatically acceptable and semantically meaningful sentences.

The semantic relationships subtest assesses interpretation of semantic relationships in sentences.

The *ARIZONA ARTICULATION PROFICIENCY SCALE-R* was administered to assess consonant and vowel production in words. \_\_\_\_\_ achieved a total score of 97, a percentile rank of 1, and a standard score of 27, based on a standard score distribution of a mean of 50 and a standard deviation of 10. These scores indicate a moderate disorder when compared to his chronological age. The following errors were noted: vowelization of /ʃ/ and /ʒ/, /gw/ for /gr/.

The *GOLDMAN-FRISTOE TEST OF ARTICULATION* is designed to assess the production of consonants in words and in sentence form. The following is an interpretation of the results: /w/ for initial /r/, /f/ for initial /θ/, /f/ for initial /ʒ/, /d/ for medial /ʒ/, /bw/ for /br/, and /dw/ for /dr/. These results indicated a percentile rank of 8 when compared to other children of his chronological age.

An *ORAL PERIPHERAL EXAMINATION* was conducted to assess the structure and function of the lips, tongue, and the hard and soft palate. There were no observable deviations in structure or function noted that would adversely affect speech.

An informal assessment of vocal skills revealed characteristics to be within normal limits.

During an informal assessment, fluency skills were judged to be within normal limits.

## **VISION/HEARING EVALUATION**

Audiometric screening at 20 dB indicated normal hearing acuity bilaterally.

Vision screening done by the school nurse was passed and recorded.

## **DIAGNOSTIC IMPRESSIONS AND CONCLUSIONS**

Based on the results of this evaluation and the *ARKANSAS GUIDELINES AND*

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**SEVERITY RATINGS FOR SPEECH/LANGUAGE IMPAIRMENT, \_\_\_\_\_ exhibits a moderate articulation disorder and a moderate-severe language disorder. It is recommended that \_\_\_\_\_ continue to receive speech and language services at this time.**

VISION/HEARING SCREENING

STUDENT \_\_\_\_\_ GRADE 12

DATE EXAMINED 2/24/06

EXAMINER (S) \_\_\_\_\_

EYE EXAMINATION:

RESULTS ACCEPTABLE  RESULTS UNACCEPTABLE \_\_\_\_\_

COMMENTS: \_\_\_\_\_

Letter sent to parents requesting examination by specialist:

yes \_\_\_\_\_ no \_\_\_\_\_

HEARING SCREENING:

RESULTS ACCEPTABLE  RESULTS UNACCEPTABLE \_\_\_\_\_

COMMENTS: \_\_\_\_\_

Letter sent to parents requesting examination by specialist:

yes \_\_\_\_\_ no \_\_\_\_\_

1-5  
6+7

Lake Hamilton

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Anytown Public Schools  
INDIVIDUALIZED EDUCATION PROGRAM (IEP)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
(M/D/Y)

Age: 18 School/Site: Lake Hamilton High School Date Developed: 04/07/05  
(M/D/Y)

Duration of Service(s) from 04/07/05 to 04/07/06  
(M/D/Y) (M/D/Y)

(Excluding summer months and school holidays unless otherwise indicated):

Grade: 12 Semester: 1 Grade: 12 Semester: 2

PROPOSED SCHEDULE OF SERVICES

Course/Activity	Gen Ed.	Sp. Ed.	Course Grade, If Applicable, Determined By			Course/Activity	Gen Ed.	Sp. Ed.	Course Grade, If Applicable, Determined By		
			Gen Ed.	Sp. Ed.	Joint				Gen Ed.	Sp. Ed.	Joint
ACTI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	ACTT	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ACTI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	↓	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
ACTI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SH	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
SH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Amount of Time (weekly): Gen. Ed. _____ Sp. Ed. _____			Total Amount of Time (weekly): Gen. Ed. _____ Sp. Ed. _____								

SCHEDULE OF SPEECH LANGUAGE PATHOLOGY SERVICES

Semester: 12-1

AND

Semester: 12-2

None Needed

SCHEDULE OF RELATED SERVICES

None Needed

Related Services	Location	Frequency	Amount	Related Services	Location	Frequency	Amount
------------------	----------	-----------	--------	------------------	----------	-----------	--------

I (check one)  give  deny permission for \_\_\_\_\_ to bill my private insurance for the above services.  
(agency name)

Name \_\_\_\_\_ Date 04/07/05 Page EXHIBIT NO. 2F  
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**STATEMENT OF PARENTAL PARTICIPATION AND CONCERNS**

\_\_\_\_\_ are invited and attended the conference.

Both had input into \_\_\_\_\_ programming. \_\_\_\_\_ is supportive of \_\_\_\_\_ placement and programming

**SUMMARY OF PRESENT LEVELS OF EDUCATIONAL PERFORMANCE**

*[Based on most recent evaluation/assessments which may include: the results of any State or district-wide assessment (not applicable to preschool), academics, behavioral, medical, functional, developmental, vocational, social]*

**I. Describe strengths relative to general curriculum/appropriate activities:**

(5 - 21 years) (3 - 5 years)

\_\_\_\_\_ is a visual learner. His strengths relative to general curriculum are in the area of math application and computation. \_\_\_\_\_ seems to be a good worker and has level headed social interaction with teachers and peers

**II. Describe how the disability affects involvement and progress in general curriculum/appropriate activities:**

(5 - 21 years) (3 - 5 years)

\_\_\_\_\_ weaknesses are in the area of reading decoding, spelling and reading comprehension

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Name \_\_\_\_\_ Date \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_

**CONSIDERATION OF SPECIAL FACTORS**

Is this a student who demonstrates need for any of the following:

- |  |                          |                                     |
|--|--------------------------|-------------------------------------|
|  | Yes                      | No                                  |
| 1. Positive behavioral interventions, and supports, and other strategies to address behavior that impedes his/her learning or that of others?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If yes, explain _____  |                          |                                     |
| 2. Accommodations for the student's limited English proficiency, including alternative language services and/or instruction in a language other than English?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If yes, explain _____  |                          |                                     |
| 3. Instruction in Braille and the use of Braille in reading and writing skills and appropriate reading and writing media, in the case of the student who is blind or visually impaired?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If yes, explain _____  |                          |                                     |
| 4. Special communication consideration? (including, but not limited to, students with hearing or visual impairments)   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If yes, explain _____  |                          |                                     |
| 5. Language and special communication consideration, direct communication with peers and professional personnel in the student's language and communication mode, consideration of academic level, direct instruction in his/her language and communication mode, for the student who is deaf or hearing impaired? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If yes, explain _____  |                          |                                     |
| 6. Assistive technology devices and services as required for the student to benefit from special education and related services? (The IEP Team determines if AT devices will be used in the home or other settings, in order for the child to receive FAPE.)   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If yes, explain _____  |                          |                                     |

Additionally

	Yes	No		Yes	No
7. Can the student follow regular discipline policies?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Attendance policies?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
If no, explain _____					

8. Can the student participate in standard administration of state-wide and district-wide required assessments? (Not applicable to pre-school)

List accommodations needed (if any) consistent with IEP and test administration guidelines.

*- small group*                      *- extended time*  
*- reader*

Will the student participate in the Arkansas Alternative Assessment Program?       

If yes, provide a statement of why the child cannot participate in the regular assessment.

If yes, provide a statement of why the alternate assessment selected is appropriate for the child.

9. Are there other factors which need consideration?       

If yes, explain \_\_\_\_\_

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Name \_\_\_\_\_

Date 04/07/05

Page \_\_\_\_\_

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### INSTRUCTIONAL MODIFICATIONS, SUPPLEMENTAL AIDS, AND SUPPORTS (cont.)

Modifications are supplementary aids and supports to the regular education program. Only those modifications that are required to ensure the student's participation in the regular education program should be considered.

#### FREQUENCY CODES

- C Classwork
- H Homework
- T Test
- A All

#### TEACHER'S INITIALS

#### SUBJECT AREAS

MANAGE BEHAVIOR BY PROVIDING :  None Needed

ACCESS TO EQUIPMENT/SUPPORTS:  None Needed

SUPPORTS FOR PRESCHOOL/SCHOOL PERSONNEL:  None Needed

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Name \_\_\_\_\_ Date 04/07/05 Page \_\_\_\_\_ of EXHIBIT NO. 2F  
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**CRITERIA FOR DETERMINING LEAST RESTRICTIVE ENVIRONMENT (LRE)**

The following criteria shall be used by the individualized education program (IEP) Team as a basis for determining the educational placement of a student with disabilities in the least restrictive environment and to ensure that such placement is based on the student's IEP. (✓) indicates that criteria have been reviewed.

- 1.  To the maximum extent appropriate, students with disabilities, including students in public or private institutions or other care facilities, are educated with students who do not have disabilities
- 2.  Special classes, separate schooling or other removal of students with disabilities from regular education environment occurs only when the nature or severity of the disability is such that education in regular classes/appropriate preschool environment with the use of supplementary aids and services cannot be achieved satisfactorily
- 3.  A continuum of alternative placements is available to the extent necessary to implement the IEP for each student with a disability, including instruction in regular classes, special classes, special schools, home instruction, and instruction in hospitals and institutions
- 4.  Provisions have also been made for supplementary services and supports (such as resource room or itinerant instruction) to be provided in conjunction with regular class placement/ appropriate preschool environment
- 5.  Educational placement is determined at least annually
- 6.  Educational placement is being made based on the student's IEP
- 7.  Educational placement is as close as possible to the student's home
  - (a) Unless the IEP of a student with a disability requires some other arrangement, the student is educated in the school which he or she would attend if not disabled
  - (b) Consideration is given to any potential harmful effect on the student or on the quality of services he or she needs
- 8.  Each student with a disability participates with students who do not have a disability in nonacademic and extracurricular services and activities, including meals, recess periods, etc., to the maximum extent appropriate to the needs of that student
- 9.  To the maximum extent appropriate, students with disabilities placed in residential settings are also to be provided opportunities for participation with other students
- 10.  For preschool students with a disability, consideration is given to the setting where the student is presently spending most of his/her day or where the student could be spending time if the student were not disabled

**JUSTIFICATION FOR EDUCATIONAL PLACEMENT SELECTION**

The following statements of student needs will be reviewed by the IEP Team for each identified student with a disability. This should be used as a guide to assist the committee in determining the appropriateness of the student's educational placement as it relates to the LRE. This list is not inclusive of all the unique student needs which the IEP Team may wish to consider. The committee should review each of the following statements of need and add any additional statements to the list in determining which of the statements apply to the student in question.

**YES NO**

- 1.   Student's acquisition of academic/developmental skills as addressed on the IEP can be met through modification/adaptation of the general curriculum
- 2.   Small group instruction is necessary for this student to acquire skills specified in IEP
- 3.   Behavior management techniques established in student's IEP require a degree of structure which cannot be implemented in a large group setting
- 4.   The student's needs as addressed in IEP goals and objectives cannot be satisfactorily achieved in the general educational/preschool environment even with the provision of supplemental aids and supports
- 5.   Student's behavior significantly impairs his/her ability to learn in a large group setting, as well as impairing the learning of other students in a large group setting
- 6.   Based upon individual needs, goals and objectives in student's IEP, the general curriculum/appropriate preschool activities would need to be completely restructured
- 7.   Based upon individual needs and goals and objectives in the student's IEP, additional individualized instruction is required to facilitate his/her learning
- 8.   Based upon individual needs and goals and objectives in the student's IEP, an intensive behavior management program is required
- 9.   Greater opportunity is needed for interaction with peers who are not disabled
- 10.   Participation in regular nonacademic classes/appropriate preschool activities is needed to implement goals and objectives stated in the student's IEP
- 11.   A more structured environment is needed than can be provided in the current educational/developmental placement
- 12.   Based upon the items reviewed above, a more flexible approach to program delivery is required. If Yes, explain.

13. Other statements of this student's needs: \_\_\_\_\_ **207**

Name \_\_\_\_\_ Date \_\_\_\_\_ Page \_\_\_\_\_ EXHIBIT NO. 2F  
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**LEAST RESTRICTIVE ENVIRONMENT (LRE)**

**CONTINUUM OF ALTERNATIVE PLACEMENT OPTIONS FOR SCHOOL AGE STUDENTS**

Circle the placement (service setting) which is least restrictive for this student based upon data obtained during his/her evaluation, IEP development, and review of criteria and justification for LRE.

Regular Class	Regular Class	Regular Class	Some/or no Instruction in Regular Class	Some/or no Instruction in Regular Class	No Instruction in Regular Class			
Indirect Service	Some Direct Instruction Less than 21% of time out of the classroom for Special Education	21% to 60% of the Instructional Day in Resource Services	Minimum of 60% of Instructional Day in Special Class	School-Based Day Treatment	Special Day School Facility Greater than 50% of time at the facility	Residential School	Hospital Program	Homebound Instruction
1	2	3	4	5	6	7	8	9

**ALTERNATIVE PLACEMENT OPTIONS FOR PRESCHOOL STUDENTS**

Check the placement (service setting) which is least restrictive for this student based upon data obtained during his/her evaluation and the IEP.

**SPECIAL EDUCATION AND RELATED SERVICES DELIVERED IN:**

- A  EARLY CHILDHOOD SETTING (Regular preschool designed primarily for children without disabilities)
- B  EARLY CHILDHOOD SPECIAL EDUCATION SETTING (Classroom designed primarily for children with disabilities)
- C  HOME (Services delivered in the principal residence)
- D  PART-TIME EARLY CHILDHOOD / PART-TIME EARLY CHILDHOOD SPECIAL EDUCATION SETTING (Combine definitions A and B)
- E  RESIDENTIAL
- F  SEPARATE SCHOOL (Public or private day schools for children with disabilities)
- G  ITINERANT (Services outside the home up to 3 hours weekly)
- H  REVERSE MAINSTREAM (Classroom designed for children with disabilities but 50% + without disabilities)

List lesser restrictive placement option which the program developers considered and the reason(s) why that option was rejected.

OPTION # 3

REASON(S)

needs more one on one instruction

The section pertaining to Transition Services is not applicable below age 16 unless determined otherwise by the IEP Team. If not applicable, proceed to the signature page.

Name \_\_\_\_\_ Date \_\_\_\_\_ Page \_\_\_\_\_ EXHIBIT NO. 2F  
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**Transition Plan**

Must be included not later than the first IEP to be in effect when the child is 16 and updated annually thereafter.

DATE	UPDATE(S) NEEDED
INITIAL DATE: 02/22/00	
DATE REVIEWED: 02/27/01	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
DATE REVIEWED: 02/27/02	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
DATE REVIEWED: 02/27/03	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
DATE REVIEWED: 4/28/04	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
DATE REVIEWED: 4/5/08	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
DATE REVIEWED: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
DATE REVIEWED: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Post School Outcomes - Based on age appropriate transition assessments.**

Training: continued training in culinary arts  
 Education: \_\_\_\_\_  
 Employment: employability skills  
 Independent Living Skills: cook meals take care of clothing

**TRANSFER OF RIGHTS**

I have been informed that the rights and procedural safeguards afforded to parents under part B of the Individual with Disabilities Education Act, will transfer from my parents to me when I turn eighteen, except that my parents retain the right to receive any notices required under part B.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Transition Activities**

	Transition Activities	Responsible Party	Semester(s)	Status *
Training	Classes in Culinary Arts	ACTI	11-1, 11-2 12-1, 12-2	2
Education	_____	_____	_____	_____
Employment	Basic skills review social skills	ACTI	11-2 12-1, 12-2	1
Independent Living Skills	Plan meal: shopping list	10-1 9-2, 10-1	FCS school.	3

\* 1 = New, 2 = Continued, 3 = Completed

**Student's Courses of Study - List courses of study to be taken each year that focuses on the student's anticipated post-school outcomes.**

8th Grade School Year: _____ Credits: _____	9th Grade School Year: _____ Credits: _____	10th Grade School Year: 03-04 Credits: _____	11th Grade School Year: 04-05 Credits: _____	12th Grade School Year: 05-06 Credits: _____
0 Agri	2 PE	3 Health Agri	3 ACT I FCS Agri	3 ACT I Agri

209

Name \_\_\_\_\_

Date \_\_\_\_\_

Page \_\_\_\_\_

EXHIBIT NO. 2F  
PAGE 22 OF 22

**Individual Education Program (IEP) Team** – means a group of individuals composed of the parents of a student with a disability; not less than one regular education teacher of such student (if the student is, or may be, participating in the regular education environment); not less than one special education teacher, or where appropriate, not less than one special education provider of such student; a representative of the local education agency who is qualified to provide, or supervise the provision of, specially designed instruction to meet the unique needs of students with disabilities, is knowledgeable about the general curriculum, and is knowledgeable about the availability of resources of the local educational agency; an individual who can interpret the instructional implications of evaluation results, who may already be a member of the team; at the discretion of the parent or the agency, other individuals who have knowledge or special expertise regarding the student, including related services personnel as appropriate; and whenever appropriate, the student with a disability. The public agency shall invite a student with a disability of any age if a purpose of the meeting will be the consideration of the statement of transition services. The public agency also shall invite a representative of any other agency that is likely to be responsible for providing or paying for transition services.

**SIGNATURES OF COMMITTEE MEMBERS**

	POSITION
	parent
	teacher
	geometry

Parent received a copy of the IEP on \_\_\_\_\_ date



H S R C CLIENT FACT/ENROLLMENT SHEET

EXHIBIT NO. 3F  
PAGE: 2 OF 43

NAME

060882060000550

SS#

ISRC#

REIMBURSEMENT SOURCES

\*- CHAMPUS ONLY

RANK  
REIMBUR SOURCE CODE  
GROUP #  
POLICY/CONTRACT #  
\*STATUS (A, R, D)  
\*BRANCH  
SUBSCRIBER  
SEX  
DOB 0/00/00  
RELATION

RANK  
REIMBUR SOURCE CODE  
GROUP #  
POLICY/CONTRACT #  
\*STATUS (A, R, D)  
\*BRANCH  
SUBSCRIBER  
SEX  
DOB 0/00/00  
RELATION

RANK  
REIMBUR SOURCE CODE  
GROUP #  
POLICY/CONTRACT #  
\*STATUS (A, R, D)  
\*BRANCH  
SUBSCRIBER  
SEX  
DOB 0/00/00  
RELATION

HOT SPRINGS REHABILITATION CENTER/HOSPITAL  
CONSENT FOR TREATMENT/PAYMENT/HEALTH CARE OPERATIONS

EXHIBIT NO. 3F  
PAGE: 3 OF 43

060802060000530

Consent must be signed by the patient/student or by the next of kin, legal guardian, or authorized representative in the case of a minor.

Date 08/27/06

Time 5pm

I, \_\_\_\_\_, consent to my attending physician or his/her associates and the Hot Springs Rehabilitation Center Hospital to perform such tests, to administer such medications, and to render such treatments which in the judgement of my physician or his/her associates may be necessary or advisable.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees as to result of treatments in the Hot Springs Rehabilitation Center Hospital have been made to me.

I consent to the release of my medical information and records (1) to physicians or their representatives and other health care providers for the purpose of diagnosis and/or treatment and (2) as may be otherwise required by law. I consent to the release of medical information to my primary care physician, and entities that are providing services to me. I further consent to the release of the necessary medical information and records to my insurance companies, managed care organizations, government agencies, outside reviewers, and for research, education, quality and /or peer review, or patient satisfaction assessment.

I consent to the payment of hospital and physician's benefits directly to the Hot Springs Rehabilitation Hospital. Benefits will not exceed the hospital's regular charges. I understand that I am financially responsible to the Hot Springs Rehabilitation Center Hospital for charges not covered by this assignment. (This does not apply to Rehabilitation Clients).

I understand that the Hot Springs Rehabilitation Center and Hospital cannot be responsible for the loss of or damage to any articles of personal property (including spectacles and dentures) kept by me in my room. I also understand articles having monetary value, unless placed by me in safekeeping in the facilities provided by the Hot Springs Rehabilitation Center and Hospital, shall remain my responsibility.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that these images will become part of my medical record and become subject to the same storage and confidentiality policies and practice.

The above has been fully explained to me, and I certify that I understand.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient is unable to sign because \_\_\_\_\_

\_\_\_\_\_  
Signature Relationship Witness

(If no one available to sign consent-complete lower portion page 2)

Consent for Treatment/Payment/Health Care Operations  
Page 2

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Inpatient Hospital Use:

My signature below acknowledges my receipt of information pertaining to a person's right for making advance health care decisions under the law.

I presently have such a document:

- copy attached
- copy available at this location \_\_\_\_\_  
(copy will be provided by me)

\_\_\_\_\_  
Signature

If no one is available to sign consent, obtain telephone authorization and have it witnessed by two people.

_____ Name of person giving authorization	_____ Relationship
_____ Witness	_____ Witness

8/8/02

ACKNOWLEDGMENT OF NOTICE

I have been provided a copy of the Notice Regarding Medical Information with an effective date of 7/1/03 and have been given an opportunity to read it and ask questions.

Signature: \_\_\_\_\_

Date: 8/1

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

Social Security Number: \_\_\_\_\_

060802060000530

DISCHARGE NOTICE

D 4

NAME	HSRC#	DATE OF DISCHARGE	6/13/06
SS#	DATE OF ENROLLMENT	DATE OF LAST CENTER SERVICE	5/03/06

MEDICAL SERVICE

INSTRUCTIONAL SERVICES CAFETERIA TRAINING PROGRAM INCOMPLETE

REASON FOR DISCHARGE 20 PROGRAM INCOMPLETE  
VOLITIONAL DROP OUT

FORWARDING ADDRESS

DORM ROOM BED

COUNSELOR #

000

DATE PRINTED 6/14/06

060802060000530  
H S R C CLIENT FACT/ENROLLMENT SHEET

EXHIBIT NO. 3F  
PAGE: 7 OF 43

SPONSOR WEP REHAB Y/N Y SOURCE OF SUPPORT SELF  
FUNDING CODE 95 FISCAL CODE \_\_\_\_\_  
EMPLOYMENT STATUS 3-NOT EMPLOYED  
FOR WHOM P-PATIENT EMPLOYMENT INFORMATION  
EMPLOYER NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, ST \_\_\_\_\_  
ZIP CODE 00000 PHONE \_\_\_\_\_

050802060000530  
H S R C CLIENT FACT/ENROLLMENT SHEET

EXHIBIT NO. 3F  
PAGE: 8 OF 43

NAME \_\_\_\_\_ SS# \_\_\_\_\_ HSRC# \_\_\_\_\_

REIMBURSEMENT SOURCES

\*-CHAMPUS ONLY

RANK  
REIMBUR SOURCE CODE  
GROUP #  
POLICY/CONTRACT #  
\*STATUS(A,R,D)  
\*BRANCH  
SUBSCRIBER  
SEX  
DOB 0/00/00  
RELATION

RANK  
REIMBUR SOURCE CODE  
GROUP #  
POLICY/CONTRACT #  
\*STATUS(A,R,D)  
\*BRANCH  
SUBSCRIBER  
SEX  
DOB 0/00/00  
RELATION

RANK  
REIMBUR SOURCE CODE  
GROUP #  
POLICY/CONTRACT #  
\*STATUS(A,R,D)  
\*BRANCH  
SUBSCRIBER  
SEX  
DOB 0/00/00  
RELATION

HOT SPRINGS REHABILITATION CENTER/HOSPITAL  
CONSENT FOR TREATMENT/PAYMENT/HEALTH CARE OPERATIONS

Consent must be signed by the patient/student or by the next of kin, legal guardian, or authorized representative in the case of a minor.

Date 1/24/05

Time 8 AM

I, T. J. S SS# \_\_\_\_\_ consent to my attending physician or his/her associates and the Hot Springs Rehabilitation Center Hospital to perform such tests, to administer such medications, and to render such treatments which in the judgement of my physician or his/her associates may be necessary or advisable.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees as to result of treatments in the Hot Springs Rehabilitation Center Hospital have been made to me.

I consent to the release of my medical information and records (1) to physicians or their representatives and other health care providers for the purpose of diagnosis and/or treatment and (2) as may be otherwise required by law. I consent to the release of medical information to my primary care physician, and entities that are providing services to me. I further consent to the release of the necessary medical information and records to my insurance companies, managed care organizations, government agencies, outside reviewers, and for research, education, quality and /or peer review, or patient satisfaction assessment.

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The above has been fully explained to me, and I certify that I understand.

✓  
✓  
✓

Patient is unable to sign because \_\_\_\_\_

\_\_\_\_\_  
Signature Relationship Witness

Consent for Treatment/Payment/Health Care Operations  
Page 2

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

**Inpatient Hospital Use:**

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- copy attached
- copy available at this location \_\_\_\_\_  
(copy will be provided by me)

\_\_\_\_\_  
Signature

If no one is available to sign consent, obtain telephone authorization and have it witnessed by two people.

_____ Name of person giving authorization	_____ Relationship
_____ Witness	_____ Witness

8/8/02

ACKNOWLEDGMENT OF NOTICE

I have been provided a copy of the Notice Regarding Medical Information with an effective date of 7/1/03 and have been given an opportunity to read it and ask questions.

Signature: [Handwritten Signature]

Date: 7/2

Printed Name: [Handwritten Name]

Social Security Number [Handwritten Number]

060802060000530

PHYSICIAN'S ORDERS

DATE 8-1-07	TIME 1715	NAME	SS#
dial soap scrub per protocol for sm lac on (L) thumb			
g / W, lu			
TIME 1715	PHYSICIAN		

DATE 4/10/07	TIME 1045	NAME	SS
1. Nungalax Soaks bid on the floor x 2 weeks			
2. Nystatin powder p soaks			
TIME 1100	PHYSICIAN B 4/10/07		

DATE 4/10/07	TIME	NAME	SS
9:25 AM (1) RTC 2 weeks.			
TIME 1000	PHYSICIAN B		

DATE 4/3/07	TIME 715 am	NAME	SS#
(1) Nungalax soaks bid on the floor x one week.			
(2) Keep feet dry and use clean white socks qd			
(3) Nystatin powder p soaks.			
(4) RTC one week. 4/10/07 0915			
NURSE	TIME 0700	PHYSICIAN B	

DATE 2/27/07	TIME 1045 AM	NAME	SS#
(1) 3 pak one as directed NR			
(2) 4 fluids			
(3) Robitussin 8m qd Po q 4H pain cough & 3 in NR			
(4) up schedule			
(5) RTC DRN.			
NURSE	TIME 1100	PHYSICIAN B 222	

DATE 2/26/07	TIME 0830	NAME:	SS#
Acetaminophen 325mg # - take po q 4hr PRN X 3 doses protocol Chlorpheniramine 4mg po q 4hr PRN X 3 doses protocol Copaxone #6 - dissolved + in mouth PRN protocol Vimegan #1 bottle - single QID PRN protocol by B 2/26/07			
NURSE	TIME 0830	PHYSICIAN	B

DATE 11/2/06	TIME 810am	NAME:	SS#
(1) DC dressings (2) DC silvadene to wound (3) Leave open to air (4) Multamin E Cream Apply bid X One month NR (5) RTC, DRI			
NURSE	TIME 0855	PHYSICIAN	B

DATE 10/26/06	TIME 0920	NAME:	SS#
(1) DC Neosporin ung (2) Silvadene dressing (Telfa) - change daily - keep dry (3) OX 1 wk -			
NURSE	TIME 0945	PHYSICIAN	B

DATE 10/16/06	TIME 085am	NAME:	SS#
(1) Continue present wound care. (2) Flu c Aug. Lang on 10/29/06 in skin rounds.			
NURSE	TIME 0900	PHYSICIAN	B

DATE 10/13/06	TIME 1030am	NAME:	SS#
(1) H <sub>2</sub> O <sub>2</sub> followed by Neosporin ointment bid X one week. (2) Keep dry. (3) RTC 10/16/06 (4) dual 1. can bid v one week			
NURSE	TIME 1130	PHYSICIAN	B

PHYSICIAN'S ORDERS

DATE	TIME	NAME	SS#
9/28/06			
7:30 am ① Motrin 100 q 6hr c-food per headache # 10 PRN.			
② RTC PRN			
NURSE	TIME 0745	PHYSICIAN B	

DATE	TIME	NAME	SS#
9/11/06			
8 am ① Amoxic 500 tid c-food x 10 days.			
② 4 fluids			
③ salt H <sub>2</sub> O grade PRN.			
④ Tylenol 325 q 6hr q pain fever # 20 NR			
NURSE	TIME 0820	PHYSICIAN B	

DATE	TIME	NAME	SS#
⑤ CBC			
mono spot			
throat c/s			
⑥ off schedule until recheck Wednesday am.			
NURSE	TIME 0810	PHYSICIAN B	

DATE	TIME	NAME	SS#
9/10/06	1345		
① Cepacol Lozenges # 6 + PRN sore throat.			
② Chlorbrymetol + PG q 4hrs. PRN 3 times only			
protocol			
NURSE	TIME	PHYSICIAN B	9/10/06

DATE	TIME	NAME	SS#
8/31/06	1575		
Acetaminophen 325 mg # 2 tabs po q 4hr PRN x 3 days protocol			
De-pacel 100 min on q hr PRN protocol			
NURSE	TIME 1575	PHYSICIAN	224

**PHYSICIAN'S ORDERS**

DATE	TIME	NAME	SS#

NURSE	TIME	PHYSICIAN

DATE	TIME	NAME	SS#

NURSE	TIME	PHYSICIAN

DATE	TIME	NAME	SS#

NURSE	TIME	PHYSICIAN

DATE	TIME	NAME	SS#
1/29/05	0940		
1. Cleanse laceration to (L) thumb to MS apply triple ant and oc. Pressure dog.			

NURSE	TIME	PHYSICIAN
	0945	

DATE	TIME	NAME	SS#
1/26/05	1430		
v/o Dr. Lang / Omnesseff Eye Consult & treat - decreased visual acuity			

NURSE	TIME	PHYSICIAN	SS#
	1500		225
			1/27/05

# TREATMENT RECORD

(See instructions on reverse.)

DATE	TREATMENT ORDER	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
START 7/3	Vinegar soaks BIO x 1 wt. Dystatin powder	1100 1900																																
STOP																																		
START	p soaks Keep feet dry & use Clean white socks QD		New Order 4-10-07 OT																															
STOP																																		
START																																		
STOP																																		
START 4-10	1 foot R- Vinegar soak BIO Dystatin p soaks x 2 wks	1100 1900																																
STOP 4-24																																		
START																																		
STOP																																		
START																																		
STOP																																		
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STOP																																		

Diagnosis: *Seclusis mesopis Jena H/A*

Admission Date	5/7/78	DOB	9-12-86	Allergies	NK OA	Diet	Reg	Current Mo/Yr	4-07	Page No.	
NAME-Last	8-28-86	First		Middle		Attending Physician		Record No.		Room/Bed	

**INSTRUCTIONS:** Initial appropriate box when treatment is given. Circle initials when treatment is refused or held and state reason below. For each PRN treatment, state reason and result. State progress or decline of condition for which treatment is administered as often as facility policy specifies.

**NURSE'S TREATMENT NOTES**

DATE		TIME	TREATMENT	REASON HELD/REASON GIVEN	RESULT / PROGRESS	INIT.
INITIALS	NURSE'S SIGNATURE		INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE
	<i>Tina Jordan L. O'Connell, R.N.</i>			<i>P. Miller, R.N.</i>		

TREATMENT RECORD/NOTES

060802060000530

EXHIBIT NO. 3F  
PAGE: 18 OF 43 MD-87

### MEDICATION RECORD

NAME \_\_\_\_\_ CC

Hot Springs Rehabilitation Center

	#1	#2	#3	#4	#5

060802060000530

EXHIBIT NO. 3F  
PAGE: 19 OF 43  
MD-87

MEDICATION RECORD

NAMI

D.

(MEDICATION  
RECORDS)




# CLINIC NOTES

cc

Date: April 10, 2007 9:26 AM

Client:

He is here in follow up of ongoing medical care of his tenia pedis. He denies any complaints at this time.

Physical Examination is significantly improved from the previous visit. No erythema, etc.

Data: -None-

### Assessment/Plan:

1. Tenia Pedis--

- a. Clinically stable and responding to treatment without complications.
- b. Continue present treatment.
- c. Return to clinic in two weeks.

2. All other medical problems addressed in the future

*B*

8-1-07 @ 1715 presented to med call requesting band-aid, upon assessment was noted to have superficial laceration to (L) thumb, cleansed & dial soap scrub per protocol + triple antibiotic applied + covered & band aid instructed to keep area clean + RTC for F/U. if S/S of infection become present, acknowledged understanding



## CLINIC NOTES

Date: April 3, 2007 7:43 AM

Client:

Complaint: The patient presents complaining of painful left foot with a rash that he states is athlete's foot for the past two months. Has tried various OTC medications without improvement. Denies any drainage. Nothing will exacerbate it nor alleviate it.

## Physical Examination

The patient's vital signs are stable. He is afebrile.

Extremities: Symmetrical without edema. He does exhibit an erythematous based rash about the toes on the left foot as well as some flaking on the ball of the foot consistent with Tenia-Pedis.

Data: None.

## Assessment/Plan:

## 1. Tenia Pedis--

- a. I discussed this particular etiology, diagnosis, and treatment options.
- b. Will use vinegar soaks followed by Nystatin powder BID for one week.
- c. Dry clean and white socks daily.
- d. Keep feet dry.
- e. Return to schedule.
- f. See Orders.
- g. Return to Clinic in one week.
- h.

## 2. All other medical problems addressed in the future

B

4/9/07 1100 Treatment in progress. Fungal areas on plantar area plus fungal areas and broken skin at base of toes @ foot. Student reports treatment per self while on care 4/6/07 - 4/8/07. Appt c. Tuesday 4/10/07



# PROGRESS NOTES

N:

Date: Tuesday, February 27, 2007

Clinic:

Complaint: The patient presents complaining of intermittent purulent tinged cough with congestion without shortness of breath for the past few days. Has tried OTC-meds without results.

Other symptoms does include:  chest pain.  fever.  headache.  sore throat.  malaise.  wheeze.  Other-

### Physical Examination

HEENT: TM's are unremarkable. Pharynx mildly injected with significant postnasal drip.

Neck is supple without any significant adenopathy.

Heart: The rhythm is regular without murmur.

Lungs: Clear to auscultation. Negative respiratory distress.

Data: None.

### Assessment/Plan:

1. URI--
  - a. I discussed this particular etiology, diagnosis, and treatment options.
  - b. Placed on antibiotics.
  - c. Increase fluids.
  - d. Off schedule.
  - e. Return to clinic if no improvement.
  - f. See Orders.
  - g.
2.
  - a.
3. All other medical problems will be addressed in the near future.



NOTES

2/26/07 0830 % eye throat, cough & green expectorates -  
since yesterday. ~~collected~~ <sup>collected</sup> ~~throat~~ <sup>throat</sup> noted. T 98° -  
P106 SpO2 97% R20 BP 125/71. Tx per protocols. Cxpt -  
C.D. 2/27/07 at 1045. Admined RTC in ~~supp~~  
worsen

2/27/07 - Here to do sinus compression / sore throat.  
1040 Using protocol, needs that has not been  
effective. Vs. 976, 915, 20, 119/59. 95%.



# PROGRESS NOTES

Name / SS#

Date: Monday, October 16, 2006

Client:

Complaint: The patient presents in follow up his burn. He denies any significant amount of pain, fever, etc.

Physical Examination

The patient's vital signs are stable and afebrile.

Extremities: Symmetrical without edema. The wound is significantly improved with no erythema around the wound, except for the localized irritation associated with healing on the peripheral edge. No exudates.

Data: None.

Assessment/Plan:

- 1. Secondary burn with cellulitis—
  - a. Resolving.
  - b. The cellulitis appears resolved.
  - c. Clinically responding to the current wound care regime.
  - d. Continue present treatment.
  - e. Follow up with Dr. [signature] during skin rounds on October 24<sup>th</sup>.

[Handwritten signature/initials]

10/17/06 (0810) Ix to Rt forearm per Pt - no edema noted - cont of present treatment in home

10/26/06 (0900) At clinic for FU on <sup>Dress</sup> forearm - <sup>Dressing</sup>  
 O - Wound left forearm 8cm x 1cm - very red.  
 A - Burn left forearm  
 P. P.C. Neosporin - use Silvadene  
 OK 1 wk

10/27/06 (0825) <sup>Dressing</sup> forearm dressing A. Area appears closed - drain. Silvadene applied. 3 boxes <sup>Dressing</sup>

10/29/06 (0920) - <sup>Dressing</sup> forearm dressing changed. Silvadene dressing (Jelfa) applied. Skin intact. No drainage present. Reminded of need to change dressing daily. Instructed to return to clinic as needed.

11/2/06 (0800) At clinic for FU visit to MD for <sup>Dressing</sup> forearm burn

no pain, etc.  
 vs. stable <sup>Dressing</sup> forearm burn well healed & residual <sup>Dressing</sup> resolved.  
 A/P <sup>Dressing</sup> forearm burn & cellulitis - Vitamin E for <sup>Dressing</sup>



# GRESS NOTES

Ni

Date: Friday, October 13, 2006

Client: I

Complaint: The patient presents complaining of a burn to the left medial forearm. He states that 2 days ago while working in food service that he bumped up against a hot pan. There was no significant treatment at the time, except some type of ointment applied. He is here complaining of pain, etc. Denies any fever.

**Physical Examination**

The patient's vital signs are stable and afebrile.

Extremities: Symmetrical without edema. However, there is a 1 cm by 10 cm second degree burn to the medial mid left forearm with a band of erythema measuring 4 cm about the burn consistent with cellulitis.

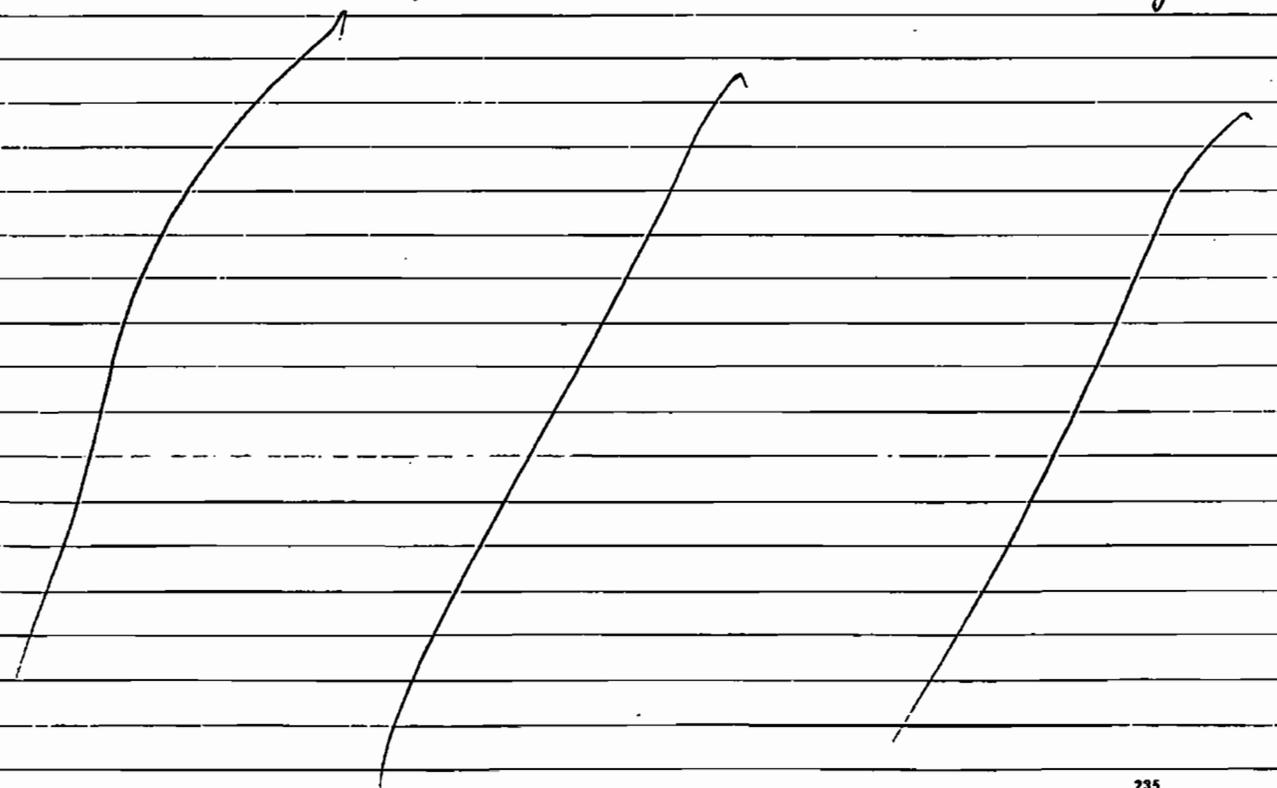
Date: -None-

**Assessment/Plan:**

1. Second degree burn with associated cellulitis to the left forearm—
  - a. I discussed this particular etiology, diagnosis, and treatment options.
  - b. Wound care discussed.
  - c. Place on PO antibiotics.
  - d. RTC on Monday.

MD *B*  
@1100GE

10-15-06 - Presented to clinic for assistance & wound care treatment. Cleansed w/ H<sub>2</sub>O<sub>2</sub> followed by applying neosporin ointment and covered w/ telfa non-adherent pad. Confirmed appointment 10/16/06. Instructed to return to clinic as necessary. No further needs at this time.





CLINIC NOTES

CI

9/11/06 - Here to see throat. Back of throat  
0740 noted to be swollen & white spots on uvula.  
vs 9/7/06. 9/20/06. 9/20/06. Spoke with [unclear] re [unclear]  
aft. sore throat.

\* see H/P \*

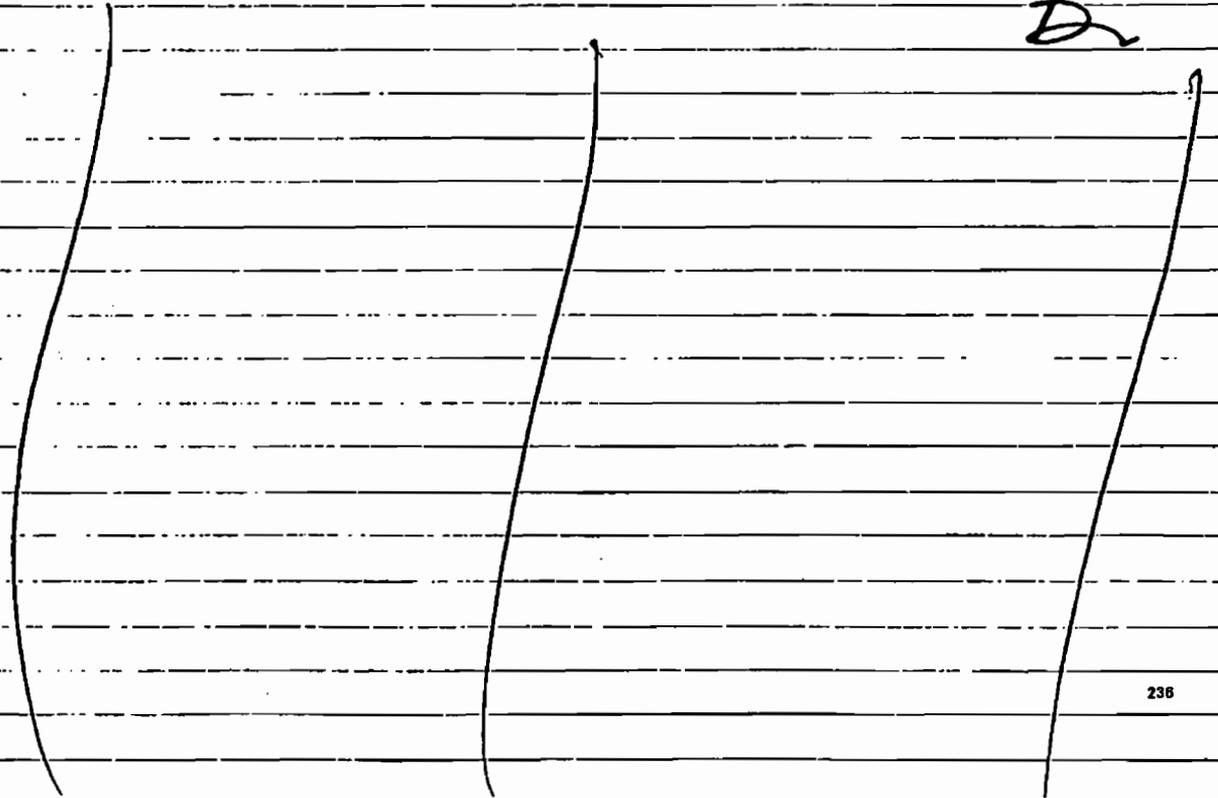
B

9/28/06 (0715) Student at clinic, request for Ibuprofen Rx.  
He states that Tylenol doesn't "take care of" his H/A's.

↳ takes "ibuprofen" for tension headaches and  
requests refill.  
vs - 07/06

PE - φ  
H/P ① tension headaches - discussed in patient.  
- see orders.

B



## PROGRESS NOTES

(Family Name) \_\_\_\_\_

(no) \_\_\_\_\_

1/24/05 (1020) 12/65, 78, 18, 96.5, 98% 5'7" 170lbs Admitted to HSRC 18/6 w/ dx diagnosis of LD, scoliosis & surgical correction, limited bending of back, moderate myopia, tension H/A/S. Student's only med is OK H/A medication. NKDA OB 2/10/05 2/6/05 2/30/05. Has glasses for driving. Wt lift 55 lbs 11/11/05 Skills WNL. PPD (B) value \_\_\_\_\_

11/29/05 98.2, 98, 18, 125/70, 95%. Down from dietary  
0940 & cut to tip of (L) thumb - was cutting a tomato at cut thumb. Pressure was applied to stop bleeding & being cleaned. Description circular in shape & 1cm. TPA applied. No return to clinic if bleeding continues. \_\_\_\_\_

8/21/06 1515 C/O knee pain - reports banging on side of refrigerator in Food Service approx 2 hrs ago. Pain upon palpation medial and lateral aspects of knee and edema. Edema +/0 knee as well - but no pain upon palpation. Acetaminophen and ice pack per protocol. Advised dressing and application times. Update med clinic in AM. \_\_\_\_\_

9/1/06 0715 To MC - steady gait. No C/O pain. \_\_\_\_\_

9/10/06 - 1345 - Returned from pass & mother reporting sore throat & congestion. + 96.3  
P 196 R 80 SpO2 = 93% BP = 94/3/75.  
Lungs clear bilaterally. No C/O cough.  
Cepacol lozenges # 6 per protocol &  
chlortrimeton 4mg TPO per protocol.  
Instructed to return in 4 hrs per  
Report to clinic at 0715 in AM if  
needed. \_\_\_\_\_

### St Springs Rehabilitation Center History & Physical

Number	Sex	Age	Marital Status
--------	-----	-----	----------------

m  f  19 s  m  w  d  sp

CC & history of present illness: *10 day throat. onset 24 hrs ago. (-) fever (+) fatigue.*

Past Medical History	Past Surgical History	Social History	Family History
Arthritis	NONE	Smokes Yes No <input type="checkbox"/> <input checked="" type="checkbox"/>	Member Alive Died Age Reason
Asthma	Amputation	Alcohol <input type="checkbox"/> <input checked="" type="checkbox"/>	Father <input checked="" type="checkbox"/> <input type="checkbox"/> ?
Cancer	Angioplasty	Drugs Cocaine Meth THC Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	Health Hx Mother <input checked="" type="checkbox"/> <input type="checkbox"/> 40
Depression/Anxiety	Appendectomy	Education Grade High School College <input checked="" type="checkbox"/> <input type="checkbox"/>	Health Hx Brother Sister Children
Diabetes	CABG	Employment <i>None</i>	
Heart Disease	Cholecystectomy	Accessibility	
Hypertension	C-section		
Obesity	Hernia		
SCI	Hysterectomy		
Seizures	Joint Replacement		
Stroke	Lithotomy <i>7/10</i>		
TBI	ORIP		
Thyroid Disease	Other		
LD			
Other	<i>Scabies requiring surgery</i>		

Allergies *NKA*

ROS Checkmark reviewed and negative, unless otherwise stated.

General <input type="checkbox"/> <i>As Above</i>	Respiratory <input checked="" type="checkbox"/>	MS <input type="checkbox"/> <i>See ache/pain</i>
HEENT <input checked="" type="checkbox"/> <i>As Above</i>	GI <input checked="" type="checkbox"/>	Neuro <input checked="" type="checkbox"/>
Neck <input checked="" type="checkbox"/>	GU <input checked="" type="checkbox"/>	Skin <input checked="" type="checkbox"/>
Heart <input checked="" type="checkbox"/>	Gyn <input type="checkbox"/> <i>N/A</i>	Psych <input checked="" type="checkbox"/>

Physical Examination  
 Vitals HT *67"* WT *187* BP *130/79* P *91* R *20* O<sub>2</sub> Saturation *99%* BMI *27*

- Checkmark indicates examined with findings as written, unless otherwise stated.
- Skin  warm and dry without unusual rashes--
  - Head  normocephalic--
  - Ears  EAC's patent. TM clear--
  - Eyes  EOMI. PERRLA--
  - Nose  Septum midline without drainage--
  - Mouth  no oral lesions. Dentation unremarkable. Pharynx clear *marked injection & edema*
  - Neck  no JVD or adenopathy or thyromegaly--
  - Breasts  normal appearing breasts--
  - Heart  regular, rate, & rhythm without murmurs or ectopy--
  - Lungs  clear to auscultation--
  - Abdomen  soft, nontender, no masses--
  - Extremities  symmetrical without edema--
  - Neurologic  no focal or lateralizing signs--
  - Spine  essential full range of motion. No tenderness noted--

Other *Asp @ pharyngitis - R/o strep R/o mono*

Diagnosis *- 4 fluids*

Plan-- *- on antibiotics, etc.*  
*- see orders.*

*B 9/11/06*

WORK EVALUATION - MEDICAL

EXHIBIT NO. 3F  
PAGE: 29 OF 43

Name \_\_\_\_\_ SS \_\_\_\_\_

Date 11/24/05

Please check the appropriate answer

Physical Function	Improvement		Expected	Not Likely
	No Problem	Problem		
Upper Extremity				
Lifting (up to 85 lbs)		✓		
Pushing		✓		
Pulling		✓		
Reaching (including above shoulders)	✓			
Range of motion	✓			
2 good hands	✓			
Steady hands	✓			
Good use of hands	✓			
Good use of arms	✓			
Good hand/eye coordination	✓			
Handwriting	✓			
Coordination, fine	✓			
Coordination, gross	✓			
Reach above shoulders	✓			
Speed of function	✓			
Lower Extremity				
Standing	✓			
Walking	✓			
Stooping		✓		
ROM		✓		
Twisting		✓		
Bending		✓		
Crawling		✓		
Climbing		✓		
Able to stand 8 hrs	✓			
Speed of function	✓			
Sensory				
Vision		✓		
Color perception	✓			
Good hand/eye coordination	✓			
Hearing	✓			
Speech	✓			
Smell	✓			
Speed of function	✓			

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WORK EVALUATION - MEDICAL

Please check the appropriate answer

Physical Function	No Problem	Problem	Improvement	
			Expected	Not Likely
Miscellaneous				
Balance	✓			
Sitting	✓			
Sensation	✓			
Speed of function				
Environmental				
Work inside	✓			
Work outside	✓			
Extreme cold	✓			
Extreme heat	✓			
Wet and/or humid	✓			
Noise and/or vibrations	✓			
Hazards	✓			
Atmospheric change	✓			
Illness				
Cardiac	✓			
Respiratory	✓			
Seizures	✓			
Allergies - Inhalation/Contactant	✓			
Pacemaker	✓			

- 1) Scoliosis with surgical correction
- 2) Limited bending of back
- 3) Moderate Myopia
- 4) Tension H/A'S

Avoid: strenuous labor/exercise

Based on general medical  
assessment dated 1/10/87

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ARKANSAS REHABILITATION SERVICES  
GENERAL MEDICAL ASSESSMENT

Counselor Name \_\_\_\_\_ Location \_\_\_\_\_

To Be Completed by Counselor

Client's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Primary Physician \_\_\_\_\_  
Name \_\_\_\_\_ Location \_\_\_\_\_

CLIENT DESCRIPTION OF DISABILITY (The scoliosis is bad) and a  
learning disability

COUNSELOR OBSERVATIONS Cooperative - interested in training

TO BE COMPLETED BY PHYSICIAN (FRONT AND BACK)

PRIMARY DISABLING CONDITION Scoliosis & Surgical Correction

CHARACTERISTICS OF DISABLING CONDITION (Check as indicated)

Permanent  Temporary \_\_\_\_\_ Stable \_\_\_\_\_ Improving \_\_\_\_\_  
Slowly Progressive \_\_\_\_\_ Rapidly Progressive \_\_\_\_\_

MAJOR DISABLING CONDITION CAN BE:

Removed by treatment: Yes \_\_\_\_\_ No \_\_\_\_\_

Substantially reduced by treatment: Yes  No \_\_\_\_\_

SECONDARY (AND OTHER) DISABLING CONDITIONS: 1) Limited Bending of Back  
2) Atypia (Medicate) 4) Trauma H/A

PHYSICAL CAPACITIES: (USE SYMBOLS (X) LIMITATIONS (O) TO BE AVOIDED AS APPROPRIATE UNDER "PHYSICAL ACTIVITIES" AND "WORKING CONDITIONS")

PHYSICAL ACTIVITIES: Walking \_\_\_\_\_ Standing \_\_\_\_\_ Stooping X Bending X  
Kneeling \_\_\_\_\_ Lifting X Reaching \_\_\_\_\_ Pushing X Pulling X  
Other (specify) strenuous labor, uneven

WORKING CONDITIONS:

Outside \_\_\_\_\_ Inside \_\_\_\_\_ Humid \_\_\_\_\_ Dry \_\_\_\_\_ Dusty \_\_\_\_\_ Temperature Extremes \_\_\_\_\_  
Other (specify) \_\_\_\_\_

DEFICITS IN FUNCTIONAL CAPACITY AREAS: (Check appropriate term-- term description on back)

Mobility \_\_\_\_\_ Communication \_\_\_\_\_ Self-care \_\_\_\_\_ Self-direction \_\_\_\_\_  
Interpersonal Skills \_\_\_\_\_ Work Tolerance \_\_\_\_\_ Work Skills \_\_\_\_\_

RECOMMENDATIONS: (Indicate as Appropriate)

SPECIALIST EXAMINATION ADVISABLE FOR COMPLETENESS OF DIAGNOSIS OR PROGNOSIS (SPECIFY TYPE) \_\_\_\_\_

TREATMENT (SPECIFY TYPE AND APPROXIMATE DURATION) \_\_\_\_\_

OTHER \_\_\_\_\_

REMARKS: (over) Psychological report - Robert Shannon 241

11-20-95

Costing?

*Aug 14, 2014*  
*Dr. [Signature]*

*Allegria KDA*

*Accid: Sprain/Ankle*  
*Very hard on*  
*(not by ETC)*

**HISTORY AND PHYSICAL**

**HEIGHT** *H 5' 8" 168 lb* **PROBLEM INDICATED** *Since: 6* **DESCRIPTION OF PROBLEM**  
No  Yes  *Disin H/A*

**VISION** *Wears glasses* **PROBLEM INDICATED** *L 20/60 R 20/100* **DESCRIPTION OF PROBLEM**  
No  Yes  *Myopia (Med)*

**HEARING** **PROBLEM INDICATED**  
No  Yes

**LUNGS** **PROBLEM INDICATED**  
No  Yes  *R, L = clear*

**HEART (BP 112/50)** **PROBLEM INDICATED**  
No  Yes  *ECG, 72%*

**ORTHOPEDIC** **PROBLEM INDICATED**  
No  Yes  *Scoliosis & Arthritis*

**NEUROLOGICAL/MENTAL STATUS** **PROBLEM INDICATED**  
No  Yes  *L7 R S1*  
*Right arm. w/ walk = limp 45° hump* *Limited Bending*

**OTHER** **PROBLEM INDICATED**  
No  Yes

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **DATE** *11/8/14*  
*[Signature]*

**DEFINITION OF FUNCTIONAL CAPACITY AREAS**

- MOBILITY** - Capability of moving efficiently from place to place.
- COMMUNICATION** - Accurate and efficient transmission and/or reception of either verbal or non-verbal information.
- SELF-CARE** - Ability to fulfill basic needs such as those related to health, safety, food preparation and nutrition, grooming, transportation, housing, homemaking, and money management.
- SELF-DIRECTION** - Capacity to organize, structure, and manage activities in a manner which best served the objectives of the individual.
- INTERPERSONAL SKILLS** - Ability of the individual to interact in a socially acceptable and mature manner with co-workers, supervisors, and others to facilitate the normal flow of work activities.
- WORK TOLERANCE** - Ability to carry out required physical and cognitive work tasks in an efficient and effective manner over a sustained period of time.
- WORK SKILLS** - Those specific skills required to carry out work functions as well as the capacity for an individual to benefit from training in those work functions.

*CI-20.25*

**REHABILITATION INITIAL DIAGNOSIS AND ASSESSMENT FOR CLIENTS**  
**4601 WEST MARKHAM LITTLE ROCK, ARKANSAS 72205**

**PSYCHOLOGICAL SCREENING EVALUATION**

This confidential report is generated for Arkansas Rehabilitation Services use only for the purpose of determining eligibility and program planning. It is not to be utilized as a stand-alone document for treatment purposes, and is the property of Arkansas Rehabilitation Services. It is not to be released to any third party.

**NAME:**  
**SOCIAL SECURITY:**  
**BIRTH DATE:**  
**DATE EVALUATED:** 11-08-04  
**REFERRED BY:**

**PURPOSE:** Intellectual and academic evaluation relative to training.

**TESTS ADMINISTERED**

**OHIO LITERACY TEST**  
**WRAT-3**  
**SHIPLEY ABSTRACTION**  
**FULL RANGE PICTURE VOCABULARY TEST**  
**BETA III**

**GENERAL OBSERVATIONS:**

reports that he is in the 11<sup>th</sup> grade this year. He thinks he does his best work in history but has difficulty in a family and consumers class. He has been in a resource class grades 5 through 11. He has no work experience. He reports scoliosis as a medical condition. He has an interest in learning how to cook. He was cooperative during the evaluation and displayed no unusual behavior except for a noticeable difficulty with any testing which requires speed.

**TESTS RESULTS:**

On the Ohio Literacy Test scored in the marginal range of literacy. He can make out only a few short and simple sentences. He is severely handicapped for work or training requiring anywhere near average reading comprehension. He could not handle textbooks or manuals. He would require that instructors or supervisors interpret almost all written verbal material for him. He could not validly take a written test.

JAN 20 2005

WRAT-3 results are as follows:

Reading Standard Score 63 Grade 2

Spelling Standard Score 68 Grade 3

Arithmetic Standard Score 78 Grade

5

WRAT-3 Reading results are extremely low and are very similar to the Ohio Literacy Test results. The indication is that he is not really functionally literate. WRAT-3 Spelling results are far below average and indicate that [redacted] has no academically or vocationally useful spelling ability. WRAT-3 Arithmetic results are in the borderline range and indicate that [redacted] would be extremely handicapped for work or training requiring anywhere near average computation and measurement ability.

Surprisingly, his performance on the Shipley Abstraction places [redacted] at the 88 IQ standard score level. This indicates close to average abstract reasoning ability. He is able to discriminate and understand at least lower level series, patterns connections or relationships. Since only a small amount of reading individual words is required, perhaps [redacted] could better handle the task and demonstrate at least some area of near average cognitive ability.

In order to obtain another measure of verbal intelligence not requiring reading, the Full Range Picture Vocabulary Test was administered. On his test [redacted] scored at the 82 IQ level. This indicates low average verbal receptive intelligence. Although the [redacted] has some severe learning disorders, his vocabulary is fairly close in size to the average individual and he should be able to understand oral instructions associated with lower level work or training.

[redacted] had a great deal of difficulty with the Beta III, probably because it is such a closely timed test and requires very quick work. He scored only at the 70 IQ level. While this would suggest barely borderline nonverbal intellectual functioning, his score was obtained in a not typical manner. For example, he was able to score in the average range on a subtest having to do with nonverbal problem solving, while scoring extremely low on a subtest having to do with quick processing of information.

#### SUMMARY:

It seems very likely that learning disorder symptoms, especially very slow processing, interfered with current test taking ability. [redacted] may have somewhat more ability than he was able to demonstrate. Based only on current test results [redacted] is barely literate, has very poor spelling ability, has borderline numerical ability, has close to average abstract reasoning ability, low average verbal receptive intelligence and borderline nonverbal intellectual functions. Based on school history of resource classes and current test results [redacted] will be diagnosed 315.00 Reading Disorder and 315.1 Mathematics Disorder. These learning disorders have resulted in numerous areas

of functional impairment, especially for any academic, training or vocational task requiring anywhere close to average reading and mathematics ability.

---

**RECOMMENDATIONS:**

---

1. Despite his handicaps [redacted] appears to have potential for rehabilitation.
2. Intellectual and academic test results suggest, as well as [redacted] learning disorders suggest that formal classroom training would not be a good training method. He would probably do better in some type of on-the-job training. He appears to have enough cognitive ability to learn by being shown and told how to do something. Based on his test taking ability, he should not be expected to perform tasks requiring quick processing and a high rate of production. He would do better on work which requires that one do something more slowly, carefully, and correctly rather than very quickly.
3. Services indicated which should aid in the rehabilitation process include supportive counseling, vocational guidance, academic counseling, referral for appropriate training, possible on-the-job training, job seeking, job retention and follow up services as indicated. If [redacted] takes advantage of these services there is a possibility that he can complete training and enter competitive employment.

---

Psychologist [redacted]

RT: hs

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EXHIBIT NO. 3F  
 For use with  
 1135A and 1136A  
 VS-II Screeners

# Keystone VS-II Record Form (Standard Targets)

Name \_\_\_\_\_ Date 1/24/05

Occupation STUDENT Age 18

Glasses/Contacts: Yes  No  Always  Sometimes  Distance Only  Reading  Multifocals

1. Have you ever been examined by a vision specialist?  No  Yes How long since last exam? unknown

2. Do you have any difficulty with your eyes?  No  Yes (If yes) What kind of difficulties? \_\_\_\_\_

### FAR VISION TESTS — Switch to "FAR" on control

TEST DESCRIPTION AND KEY (Corresponds to Remote Control Key)	UNACCEPTABLE	RETEST	ACCEPTABLE See Standards Guide (1)
<b>RIGHT EYE: ACUITY</b> A B C 1. 20 = 547638 25 = 428576 30 = 943852 2. 40 = 795823 50 = 357248 60 = 7236 3. 70 = 9574 100 = 92 200 = 5	20/200 = 6 20/100 = 92 20/70 = 8574 20/50 = 7236 20/40 = 257248	(One Miss Allowed Per Line) 20/40 = 795823	20/30 = 943852 20/25 = 428576 20/20 = 547638
<b>LEFT EYE: ACUITY</b> A B C 1. 20 = 745932 25 = 578236 30 = 346752 2. 40 = 534268 50 = 752386 60 = 6254 3. 70 = 8453 100 = 85 200 = 3	20/200 = 3 20/100 = 85 20/70 = 8453 20/50 = 752386 20/40 = 534268	(One Miss Allowed Per Line) 20/40 = 534268	20/30 = 346752 20/25 = 578238 20/20 = 745932
<b>BOTH EYES: ACUITY</b> A B C 1. 20 = 857432 25 = 674235 30 = 382457 2. 40 = 563472 50 = 859423 60 = 8927 3. 70 = 2978 100 = 43 200 = 9	20/200 = 9 20/100 = 43 20/70 = 2978 20/50 = 859423 20/40 = 563472	(One Miss Allowed Per Line) 20/40 = 563472	20/30 = 382457 20/25 = 674235 20/20 = 857432

### NIGHT VISION TEST — Hold Down "Nite" Switch

TEST DESCRIPTION AND KEY (Corresponds to Remote Control Key)	UNACCEPTABLE	RETEST	ACCEPTABLE See Standards Guide (1)
<b>BOTH EYES: ACUITY</b> A B C 1. 20 = 857432 25 = 674235 30 = 382457 2. 40 = 563472 50 = 859423 60 = 8927 3. 70 = 2978 100 = 43 200 = 9	20/200 = 9 20/100 = 43 20/70 = 2978 20/50 = 859423 20/40 = 563472	(One Miss Allowed Per Line) 20/40 = 563472	20/30 = 382457 20/25 = 674235 20/20 = 857432

### INTERMEDIATE DISTANCE TEST (V.D. SCREEN) — Insert special lens plunger (2)

TEST DESCRIPTION AND KEY (Corresponds to Remote Control Key)	UNACCEPTABLE	RETEST	ACCEPTABLE See Standards Guide (1)
<b>BOTH EYES: ACUITY</b> A B C 1. 20 = 857432 25 = 674235 30 = 382457 2. 40 = 563472 50 = 859423 60 = 8927 3. 70 = 2978 100 = 43 200 = 9	20/200 = 9 20/100 = 43 20/70 = 2978 20/50 = 859423 20/40 = 563472	(One Miss Allowed Per Line) 20/40 = 563472	20/30 = 382457 20/25 = 674235 20/20 = 857432

### FAR VISION TESTS Continued — Release special lens plunger

F-4	<b>PHORIA (EYE CO-ORDINATION)</b> Red - Lateral Green - Vertical	ISO 0 1 2 3 4 5 6 7 8 9 EXO RIGHT H. 0 1 2 3 4 5 6 7 8 9 LEFT H. ORTHO		
F-5	<b>FUSION</b>	Four Balls	Four then Three	Three Balls
F-6	<b>STEREOPSIS (Depth Perception)</b>	Box Heart Cross	Star	Cross
F-7	<b>COLOUR</b> Severe (Red/Green) 79 23	None Correct	One Correct	Two Correct
F-8	<b>COLOUR</b> Mild (Blue/Violet) 92 56	None Correct	One Correct	Two Correct
	<b>HORIZONTAL FIELD TESTS (3)</b>	<input type="checkbox"/> 85° <input type="checkbox"/> 70° <input type="checkbox"/> 55°	<input type="checkbox"/> NASAL <input type="checkbox"/> NASAL <input type="checkbox"/> 55° <input type="checkbox"/> 70° <input type="checkbox"/> 85°	

Use reverse side for Near Vision Tests





**ST. JOSEPH'S MERCY**  
300 Werner Street, PO Box 29001  
Hot Springs, AR 71813-8937  
(501) 6221092

DOB/Sex:  
Med Rec:  
Account #:  
Ordered by:  
Atten Phys: E  
Admitted: 9/11/06  
Location: JOP Laboratory /

**Outpatient Laboratory Services**

**M i c r o b i o l o g y**

**PROCEDURE:** Culture, Throat  
**SOURCE:** THROAT  
**BODY SITE:** Throat

**COLLECTED:** 09/11/2006 08:00  
**STARTED:** 09/11/2006 12:22  
**ACCESSION:**

**Final**

**Final Report**  
Verified: 09/13/2006 07:21  
Abundant Normal Flora after 2 days.  
No Group A Strep isolated.

**Order Comments**  
(1) hsrc

B

As of: 09/13/06 12:32 PM  
Admitted: 9/11/06

H: High L: Low A: Abnormal  
C: Critical \*: Corrected  
Room/Bed: /

Discharged: 9/11/06  
Page 1 of 1  
Interim-Any



**ST. JOSEPH'S MERCY**

300 Werner Street, PO Box 28001

Hot Springs, AR 71913-9937

(501) 6221092

DOB/Sex:  
Med Rec:  
Account #:  
Ordered by:  
Atten Phys:  
Admitted: 9/11/06  
Location: J OP Laboratory /

**Outpatient Laboratory Services**

**Serology**

Date 9/11/06

Time 8:15:00

Test	Expected	Units
Mononucleosis	[Negative]	Negative

9/11/06 8:15:00 MONO:  
hsrc

*B*

As of: 09/11/06 1:28 PM  
Admitted: 9/11/06

H: High L: Low A: Abnormal  
C: Critical \*: Corrected  
Room/Bed: /

Discharged:

Page 1 of 1

N/A

HOT SPRINGS REHAB CENTER  
105 RESERVE AVENUE  
HOT SPRINGS, AR 71902  
501-624-4411 EXT 313

EXHIBIT NO. 3F  
PAGE: 40 OF 43

CD1800 SPECIMEN DATA REPORT

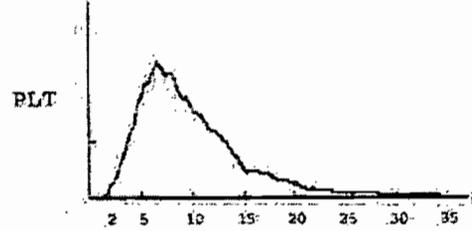
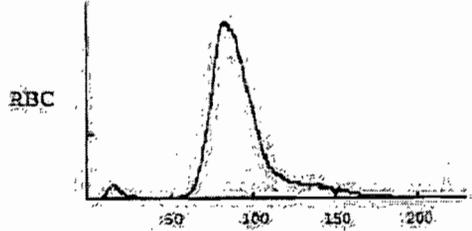
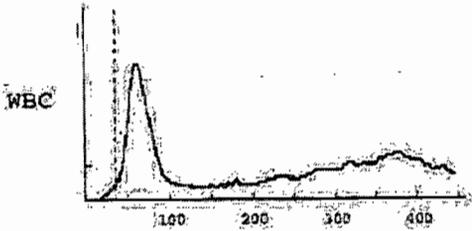
Specimen ID: \_\_\_\_\_  
Patient: \_\_\_\_\_  
Sex: M DOB: \_\_\_\_\_  
Physician: \_\_\_\_\_  
Comments: MC SW

Analyzed: 09/11/06 09:27  
Operator I.D.: 02  
Sequence #: 6107  
Mode: Open  
Collected: 09/11 08:15

TEST	RESULT	FLAG	LIMIT	REFERENCE RANGE (LIMIT 2)
WBC	7.4 K/uL	[ * ]	[ * ]	4.5 - 11.1 K/uL
LYM	2.1 28.9 %L	[ * ]	[ * ]	0.6 - 4.1 10.0 - 58.5 %L
*MID	0.4 5.6 %M	[ * ]	[ * ]	0.0 - 1.8 0.1 - 24.0 %M
GRAN	4.8 65.5 %G	[ * ]	[ * ]	2.0 - 7.8 37.0 - 92.0 %G
RBC	5.44 M/uL	[ * ]	[ * ]	4.60 - 6.20 M/uL
HGB	15.9 g/dL	[ * ]	[ * ]	13.5 - 18.1 g/dL
HCT	46.2 %	[ * ]	[ * ]	40.0 - 54.0 %
MCV	84.9 fL	[ * ]	[ * ]	80.0 - 96.0 fL
MCH	29.2 pg	[ * ]	[ * ]	27.0 - 31.0 pg
MCHC	34.4 g/dL	[ * ]	[ * ]	32.0 - 40.0 g/dL
RDW	12.0 %	[ * ]	[ * ]	11.6 - 14.6 %
PLT	240 K/uL	[ * ]	[ * ]	140 - 440 K/uL
MPV	9.5 fL	[ * ]	[ * ]	6.0 - 10.0 fL

*B*

\* MID cells may include less frequently occurring and rare cells correlating to monocytes, eosinophils, basophils, blasts and other precursor white cells.



MANUAL DIFFERENTIAL , MORPHOLOGY 1 2 3 4

SEG _____ %	POLYCHROM	[ ]	[ ]	[ ]	[ ]
BAND _____ %	HYPOCHROM	[ ]	[ ]	[ ]	[ ]
LYMP _____ %	POIK	[ ]	[ ]	[ ]	[ ]
MONO _____ %	TARGET	[ ]	[ ]	[ ]	[ ]
EOSIN _____ %	SPHERO	[ ]	[ ]	[ ]	[ ]
BASO _____ %	ANISO	[ ]	[ ]	[ ]	[ ]
VAR LYM _____ %	MICRO	[ ]	[ ]	[ ]	[ ]
META _____ %	MACRO	[ ]	[ ]	[ ]	[ ]
MYELO _____ %	BASO STIP	[ ]	[ ]	[ ]	[ ]
PRO MYELO _____ %	VACUOLES	[ ]	[ ]	[ ]	[ ]
BLAST _____ %	TOXIC GRAN	[ ]	[ ]	[ ]	[ ]

PLT EST \_\_\_\_\_  
PLT MORPH \_\_\_\_\_

COMMENTS \_\_\_\_\_

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EXHIBIT NO. 3F  
PAGE: 41 OF 43

### TD TESTING

Name \_\_\_\_\_ Age 21

Social Security No. \_\_\_\_\_ Room No. \_\_\_\_\_

Counselor \_\_\_\_\_ Sex  M  F

Date of Birth \_\_\_\_\_ Adm. Date 1/24/09 Date of Hire \_\_\_\_\_

M.D. \_\_\_\_\_

PPD: Date done 3/12/07 Site (D) Nolan Nurse \_\_\_\_\_

Date read 3/16/07 Results DM Nurse \_\_\_\_\_

Known Positive Reactors

Interview:  Negative  Referred to Health Department for follow-up

HSRC HOSPITAL  
MD-116

MD-116

Date read 1/24/09

Known Positive Reactors

Interview:  Negative  Referred to Health Department for follow-up

HSRC HOSPITAL  
MD-116

060802060000530

### TB TESTING

Name \_\_\_\_\_ Age \_\_\_\_\_

Social Security No. \_\_\_\_\_ Room No. \_\_\_\_\_

Counselor \_\_\_\_\_ Sex  M  F

Date of Birth \_\_\_\_\_ Adm. Date \_\_\_\_\_ Date of Hire \_\_\_\_\_

M.D. \_\_\_\_\_

PPD: Date done 2/16/06 Site QUOLAR Nurse \_\_\_\_\_

Date read 2/18/06 Results MM Nurse \_\_\_\_\_

Known Positive Reactors

Interview:  Negative  Referred to Health Department for follow-up

HSRC HOSPITAL  
MD-116

Date read 1/24/06

Known Positive Reactors

Interview:  Negative  Referred to Health Department for follow-up

HSRC HOSPITAL  
MD-116


### TB TESTING

Name

Social

Couns

Date o

M.D. \_

PPD:

Known

Interview:     Negative     Referred to health Department for follow-up

EXHIBIT NO. 4F  
PAGE: 1 OF 2PATIENT NAME:

DATE OF EXAMINATION: 10/31/2007

CLINICAL INFORMATION: SCOLIOSIS

X-RAY #:

DATE OF BIRTH:

LUMBAR SPINE:

AP and lateral views show a moderately severe scoliosis in the lumbar region which I believe is compensatory to a thoracic scoliosis. There has been previous scoliosis surgery with a very long Harrington rod extending from L4 up to about the T4 level. The lateral alignment is actually normal and the disc spaces are well preserved. The SI joints are normal. There are no fractures or compression deformities or destructive changes or any significant spurring or degenerative changes seen.

IMPRESSION:

1. MODERATELY SEVERE THORACOLUMBAR SCOLIOSIS WITH CORRECTIVE FRONTAL ROD PRESENT EXTENDING FROM T4 TO L4.
2. OTHERWISE NEGATIVE LUMBAR SPINE WITHOUT FRACTURES, DEGENERATIVE CHANGES, OR ACUTE FINDINGS.

Signed by

A.D. 10/31/2007

15:54

RF/VS

dict.: 10/31/2007

trans.: 10/31/2007

#000027037

cc: Disability Determination

Outpatient

MEDICAL IMAGING

NATIONAL PARK MEDICAL CENTER

HOT SPRINGS, ARKANSAS 71901

10/31/2007 RA

Disability Determination

ORIGINAL

254

EXHIBIT NO. 4F  
PAGE: 2 OF 2

PATIENT NAME: .....

DATE OF EXAMINATION: 10/31/2007

CLINICAL INFORMATION: SCOLIOSIS

X-RAY #:

DATE OF BIRTH: .....

**CERVICAL SPINE:**

AP and lateral views show straightening of the usual lordotic curvature. Alignment might be considered within normal limits. The disc spaces are preserved. The patient has a severe thoracolumbar scoliosis and this does not involve the cervical area but the T1 vertebra is slightly tilted and C7 seems to be a little tilted as well. The facet joints are normal and the disc spaces are well preserved.

**IMPRESSION:**

1. MILD STRAIGHTENING OF THE CERVICAL LORDOSIS.
2. OTHERWISE NEGATIVE CERVICAL SPINE.

Signed by

M.D. 10/31/2007

15:54

, M.D.

RF/VS

dict.: 10/31/2007

trans.: 10/31/2007

#000027037

cc: Disability Determination

D.

Outpatient

MEDICAL IMAGING

NATIONAL PARK MEDICAL CENTER

HOT SPRINGS, ARKANSAS 71901

10/31/2007 RA

Disability Determination

ORIGINAL

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EXHIBIT NO. 5F  
PAGE: 1 OF 8

**PATIENT:**  
**DATE OF BIRTH:**  
**DATE OF VISIT:** 11/29/2007

This is a social security physical.

**SUBJECTIVE:**

Complaint #1: This man is applying for Social Security disability because "I cannot pick up anything over 50 pounds". He states that every time he applies for a job they never call him back and he thinks it is because he cannot pick up anything over 50 pounds. He says he cannot pick this up because he had scoliosis repair of his back in 2001 and had rods in his back. He can bend and lift but his back is weak and he cannot pick over 50 pounds without having pain. However, he has no problems standing. He can stand for 3-4 hours, he can walk without any limitation. He finished high school in the resource classes. He says "I am very slow learner." His reading is very poor. I gave him a paragraph to read which was on the first page of the physical which said "all procedures must be authorized by State agency examiner or physician. Called this office for authorization prior to performing any procedures not listed on the authorization. It took him five minutes to read this and then he did not really understand what he had read. Also, I asked him some simple multiplications and he could not do that. He could add and subtract satisfactorily. The only job he has ever had is cutting grass and that was only helping his stepfather. I really feel his major problem is mental retardness and not physical.

MNK/avn

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**State of Arkansas**  
**DISABILITY DETERMINATION FOR SOCIAL SECURITY ADMINISTRATION**

701 Pulaski Street – Little Rock, Arkansas 72201

EXHIBIT NO. 5F  
PAGE: 2 OF 8

GENERAL PHYSICAL EXAMINATION

APPLICANTS NAME	DOB	SSN / CASE #	DATE OF EXAM
		/ 0831108	November 14, 2007

**ALL PROCEDURES MUST BE AUTHORIZED BY A STATE AGENCY EXAMINER OR PHYSICIAN. Call this office for authorization prior to performing any procedure not listed on the authorization. Local: 682-3030 or Long Distance Toll Free: 1-800-482-9950.**

Please ask for BARBARA COBB.  
ALLEGED IMPAIRMENTS: scoliosis

**HISTORY:** (Please include onset of significant problems)

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Myocardial infarctions: NO

Previous stress testing or angiograms: NO

Surgical: rods in back for scoliosis

Present Medications: none

**REVIEW OF SYSTEMS** (Fill in if relevant)

HEENT: none

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RESPIRATORY:   No  

\_\_\_\_\_ If asthmatic, number of severe attacks  
requiring physician intervention during the past year: \_\_\_\_\_

EXHIBIT NO. 5F  
PAGE: 3 OF 8

**CARDIOVASCULAR:** \_\_\_\_\_

Amount of walking, carrying, lifting, etc. that produces exercise-limiting dyspnea  
\_\_\_\_\_  
\_\_\_\_\_

Chest Pain: \_\_\_\_\_ Yes   X   No

Please give a detailed current description of chest pain, if present:

Location and radiation: \_\_\_\_\_

Quality of Pain: (sharp, dull, tightness, etc.) If pain is "sharp", specify if this means a rhythmic pain,  
e.g., "stabbing", "jabbing", or "throbbing". \_\_\_\_\_  
\_\_\_\_\_

Precipitating Factors: Is the above pain predictably exertional? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, specify type and amount of exertion that produces pain, giving two examples.

TYPE \_\_\_\_\_ (1) \_\_\_\_\_ AMOUNT

\_\_\_\_\_ (2) \_\_\_\_\_

Is the above chest pain brought on by any of the following items? a) Deep breathing \_\_\_\_\_  
b) Eating \_\_\_\_\_ c) Twisting/Turning movements \_\_\_\_\_ d) Palpation of chest wall \_\_\_\_\_  
e) Other \_\_\_\_\_

Mode of Relief: Nitroglycerin \_\_\_\_\_ In minutes, duration until relief \_\_\_\_\_ Number of  
tablets in last month \_\_\_\_\_ Rest \_\_\_\_\_ In minutes, duration until relief \_\_\_\_\_  
Any unusual mode of relief such as antacid or belching? \_\_\_\_\_ Yes \_\_\_\_\_ No

Frequency of above chest pain (three times per day, or week, or month, etc.) \_\_\_\_\_

How long has above pain been present? \_\_\_\_\_

INTERMITTENT CLAUDICATION. (due to peripheral vascular disease) \_\_\_\_\_ If yes, how far can  
patient walk before symptoms start? \_\_\_\_\_  
\_\_\_\_\_

Quality of pain \_\_\_\_\_ Location of pain \_\_\_\_\_

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Pain Duration \_\_\_\_\_ Mode of relief \_\_\_\_\_

**HEMATOLOGICAL:** none

**GASTROINTESTINAL:** none

EXHIBIT NO. 5F  
PAGE: 4 OF 8

**ORTHOPEDIC:** see PF

**NEUROLOGICAL:** none

**PSYCHIATRIC:** (Is there a past history of hospitalization or outpatient treatment?)  
none

**PHYSICAL EXAMINATION**

**VITAL SIGNS:**

Height (without shoes) 5'7" Weight 197 Pulse 85 Blood Pressure 110/80 BM 131  
Q 98

**EYES:**

**FUNDI** (Check if present):

	Neovascularization	Hemorrhages	Exudates	Papilledema	Normal
O.D.	_____	_____	_____	_____	<u>X</u>
O.S.	_____	_____	_____	_____	<u>4</u>
Central Visual Acuity: Uncorrected -	O. D. _____		O. S. _____		
(Snellen) Corrected -	O. D. _____		O. S. _____		

**Confrontational Fields:**

O.D. Normal X O. S. Normal \_\_\_\_\_  
Decreased \_\_\_\_\_ Decreased \_\_\_\_\_

**EARS** OK

Can the patient hear normal conversation? \_\_\_\_\_

Estimate % auditory loss if noted: \_\_\_\_\_

**OROPHARYNX:** OK  
If speech is impaired, describe ability to carry on speech which can be understood and sustained: \_\_\_\_\_

**NECK** WNL  
 Neck Vein distention: \_\_\_\_\_ Adenopathy \_\_\_\_\_

EXHIBIT NO. 5F  
 PAGE: 5 OF 8

**LUNGS:** Normal breath sounds X Increased A.P. Diameter \_\_\_\_\_ Hyper-resonance \_\_\_\_\_  
 Prolonged expiration \_\_\_\_\_ Whczzing \_\_\_\_\_ Other \_\_\_\_\_

**HEART:** NR S m

**ABDOMEN:** LK S not palpable  
 Ascites: \_\_\_\_\_ Organomegaly: \_\_\_\_\_

**SKIN CHANGES:** surgical scars on Back from T<sub>2</sub> to Sacrum  
 Cyanosis \_\_\_\_\_ Clubbing \_\_\_\_\_ Jaundice \_\_\_\_\_

**ORTHOPEDIC:** (If joint motion is limited by more than 30%, please call for authorization to perform X-ray)

SPINE		Normal Motion	Range of Motion
Cervical Spine:	Flexion	0° - 50°	WNL
	Extension	0° - 60°	
	Rotation	0° - 80° R & L	60 40 R & L
Lumbar Spine:	Flexion	0° - 90°	0-45

Muscle Spasm: (If present, specify location) \_\_\_\_\_  
 Straight-Leg Raising: **NORMAL** X **ABNORMAL** \_\_\_\_\_

**EXTREMITIES:**

**PASSIVE** Range of Motion (In Degrees)

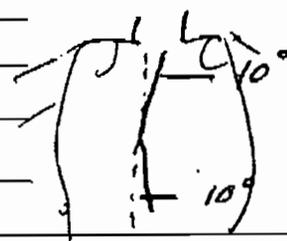
		RIGHT	NORMAL	LEFT	ACUTE SYNOVITIS (heat, swelling and tenderness)
Shoulders	Forward Elevation	WNL	150°	WNL	
Elbows:	Flexion		0° - 150°		
Wrists:	Dorsiflexion		0° - 60°		
	Palmar Flexion		0° - 60°		
Hands:	PIP		0° - 100°		
	MP		0° - 90°		
Hips:	Flexion		0° - 100°		
Knees:	Flexion		0° - 150°		
Ankies:	Dorsiflexion		0° - 20°		
	Plantar Flexion		0° - 40°		260

Describe any other joint abnormalities, deformities, instability, ankylosis, contractures, etc.:

**NEUROLOGICAL:**

	Right	Left
Reflexes:		
Biceps:	0	0
Triceps:	+	0
Patellar:	++	++
Achilles:	++	++

EXHIBIT NO. 5F  
PAGE: 6 of 24  
Rotation 5° of shoulder R/L  
Bending was



10° scoliosis in upper  
& 10° in lower  
Back  
Scar in from  
Sacrum to T2

Muscle Weakness: location and grade (0-5)

None

Muscle Atrophy: \_\_\_\_\_

If atrophy is present, measure extremity circumference: \_\_\_\_\_

Sensory Abnormalities: (if dermatomal, please describe): \_\_\_\_\_

Gait and Coordination: (indicate specific abnormal findings including posture)

Romberg: \_\_\_\_\_

Tremor: \_\_\_\_\_

Ataxia: \_\_\_\_\_

Cogwheel Rigidity: \_\_\_\_\_

Tandem Walk: \_\_\_\_\_

Bradykinesia: \_\_\_\_\_

Proprioception: \_\_\_\_\_

**LIMB FUNCTION:** Describe ability to:

- 1. Hold a pen and write: YES
- 2. Touch fingertips to palm: YES
- 3. Grip (estimate % of normal): OK
- 4. Oppose thumb to fingers: OK
- 5. Pick up a coin: YES
- 6. Stand and walk without assistive devices: YES
- 7. Walk on heel and toes: YES
- 8. Squat and arise from a squatting position: YES

**CIRCULATORY:**

EXHIBIT NO. 5F  
PAGE: 7 OF 8

Pulses: (Absent, decreased or normal)

	Right	Left
Dorsalis Pedis:	<u>2+</u>	<u>2+</u>
Posterior Tibial:	<u>2+</u>	<u>2+</u>

Edema: (If present, note location) \_\_\_\_\_

**VEINS:**

Varicose Veins: neg

Stasis Dermatitis: \_\_\_\_\_

Brawny Edema: Ankle \_\_\_\_\_ to mid-calf \_\_\_\_\_ to knee \_\_\_\_\_

Active Ulcers: \_\_\_\_\_

Scars from Healed Ulcers: \_\_\_\_\_

**MENTAL STATUS:**

Is the applicant oriented to time, person, place? yes

Any evidence of psychosis (such as hallucinations or delusions) or of serious mood disorder?

no

PLEASE ATTACH ANY RESULTS OF LAB STUDIES, X-RAY RESULTS, ETC:

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EXHIBIT NO. 5F  
PAGE: 8 OF 8

**DIAGNOSIS:**

- 1. Scoliosis of spine severe
- 2. Surgical repair of Scoliosis - Rods
- 3. Limitation of motion of twisting & bending due to (2)
- 4. mental retardation probable 80 IQ estimate

Based on your evaluation, are there any limitations in this claimant's ability to walk, stand, sit, lift, carry, handle, finger, see, hear or speak, etc. Please assess the severity of limitations (mild, moderate, severe).

moderate limit with <sup>physical</sup> labor - could lift 40-50 L  
 once per hour but not over 5 min  
 severe limited with comprehension of most jobs

REPORTING PHYSICIAN'S SIGNATURE, AND DATE

<b>Signature:</b> _____	<b>Date:</b> 11-29-07
-------------------------	-----------------------

**MENTAL DIAGNOSTIC EVALUATION**  
**AND**  
**INTELLECTUAL ASSESSMENT**

CLAIMANT NAME	DATE OF BIRTH	SSN	DATE OF EXAM
			12/03/2007

COLLATERAL INFORMATION:           None

Briefly list the medical information sent to you by this agency.

Did you review this information? Yes \_\_\_\_\_ No \_\_\_\_\_

**MENTAL ALLEGATIONS**

\_\_\_\_\_ was brought by his mother to the office. \_\_\_\_\_ said he is disabled because of some medical problems. His mother said he is speech impaired and stutters. "He doesn't move fast enough. His socialization skills are not good. He's slow to communicate. He is delayed in lots of ways. He doesn't handle stress well. For example, when he was at the vocational training center he called us and was crying. He was exaggerating the situation. He works himself up. I worry about him being out on his own. He's slow thinking and doesn't always think before he acts."

**HISTORY OF PSYCHIATRIC TREATMENT**

Claimant has not had any treatment for mental disorders and takes no medication.

**RELEVANT PERSONAL AND EMPLOYMENT HISTORY**

Claimant is single and has no children. He lives with his mother, stepfather and younger brother. He helps around the house by doing dishes and laundry. He can cook meals, drives a vehicle and goes shopping by himself. He attends church regularly and manages his own money.

He has friends and they hang out together. No girlfriend exists at this time.

He finished high school and took some resource classes. He has no military or legal history.

Claimant went to the voc-rehab school in 2005 and 2006 and trained in food service. He graduated and since then has interviewed and finds it hard to get a job. "I'm still looking." His plan is to eventually get a job. His mother commented "he's not a good interviewer because of his slow speech."

**SUBSTANCE ABUSE**

Claimant denied any substance abuse.

**MENTAL STATUS INFORMATION**

Appearance (attire, hygiene, pain indicators, etc.)

Claimant was an average size 21 year old male with short tousled hair and a slow crackly voice. He wore blue warm up pants and a blue shirt.

General Attitude/nature and degree of cooperativeness.

He seemed to be at ease throughout the evaluation. He spoke slowly and did not stutter at any time. This was commented on after the mother said that he had a bad stuttering problem and she said he usually does stutter. However, none was noted today, he was just slow with verbal expression.

**Mood** (predominant, sustained emotion – “depressed, anxious, irritable”, etc.)  
Mood was normal.

**Affect** (observable behavior-level of appropriateness, range of expression-expansive, normal, flat, etc.)  
Affect was appropriate.

**Speech** (fluency, rate, volume, etc.)  
Speech was slow.

**Thought processes** (degree to which speech is logical, relevant, associations are well connected and goal directed. Please describe in detail any observations of circumstantial, tangential or other peculiar thought processes.)  
Thought processes were logical, relevant and goal directed.

**Thought content** (any formal delusional material, thought withdrawal/insertion, overvalued ideas, bizarre obsessions or preoccupations suicidal/violent ideas).  
Thought content was appropriate.

**Perceptual Abnormalities** (auditory, visual or other types of hallucinatory experiences. If reported, obtain specific content details, frequency, age of onset, emotional and functional impact, controlled by medication? occur primarily during substance abuse?)  
Claimant denied any perceptual abnormalities.

### TEST RESULTS

Results from the **WAIS-III** are as follows:

Verbal IQ:	71		
Performance IQ:	85		
Full Scale IQ:	76		
Vocabulary	5	Picture Completion	8
Similarities	5	Digit Symbol	4
Arithmetic	5	Block Design	8
Digit Span	5	Matrix Reasoning	9
Information	5	Picture Arrangement	10
Comprehension	6		

According to the WAIS-III claimant is functioning within the Borderline range of intelligence.

### DIFFERENTIAL DIAGNOSTIC FORMULATION/CONCLUSIONS

Axis I            Adjustment Disorder with Mixed Emotional Features  
Axis II           None  
Axis V/GAF      60-70

### EFFECTS OF IDENTIFIED MENTAL/COGNITIVE IMPAIRMENTS ON ADAPTIVE FUNCTIONING.

How do mental impairments interfere with this person's day to day adaptive functioning? Capacity to communicate and interact in a socially adequate manner? Capacity to cope with the typical mental/cognitive demands of basic work-like tasks? Ability to attend and sustain concentration on basic tasks? Capacity to sustain persistence in completing tasks? Capacity to complete work-like tasks within an acceptable timeframe?

Mental impairments do not appear to significantly interfere with this person's day to day adaptive functioning. He can drive, shop independently and handle his own finances. He participates in social groups and can perform most ADL's autonomously.

He communicates and interacts in a socially adequate manner although not as finessed as most people would like. He speaks slowly as if he has difficulty getting the words out. To be comfortable in conversation with him one must resign himself to waiting for slow answers to questions. Nevertheless, he makes good eye contact and communicates effectively although somewhat slowly.

Claimant is able to cope with the cognitive demands of most work like tasks. He is able to sustain and attend concentration on basic tasks as well as persistence. He displayed good focus on tasks and did not give up easily. He was able to complete tasks within an acceptable timeframe with the possible exception of written expression which was slow.

**VALIDITY**

Did the claimant give adequate effort/cooperation? Yes

Are there indicators of symptom exaggeration? No

IS THE CLAIMANT ABLE TO MANAGE FUNDS WITHOUT ASSISTANCE?

Yes     No



Electronic Records Express Attestation: This document was electronically signed

Social Security Number:  
Request ID: L0000129AG000  
SiteID: S04  
Route: DMA

Sender Name: [REDACTED]  
Date: Mon Dec 17 19:46:26 EST 2007

The following affirmation was electronically signed:

I am certifying, under penalty of perjury, that I have been authorized or contracted by the Disability Determination Services to examine the claimant named in the attached, and produced a consultative examination report for that claimant. The report is accurate. By clicking on the "Agree" button below, I am certifying that I personally conducted, or personally participated in conducting, the consultative examination and have electronically signed the report contained within.

CASE ANALYSIS

SSN	
NAME	
STATE	AR
DATE	02/07/2008

I have reviewed all the evidence in file and the assessment of 12/1/7/07 is affirmed as written.

THESE FINDINGS COMPLETE THE MEDICAL PORTION OF THE DISABILITY DETERMINATION.

SIGNATURE <i>Bill F. Payne</i>	SPECIALTY 32	OFFICE
NAME (PRINTED OR TYPED) Bill F. Payne	PAGE <u>1</u> OF <u>1</u>	

**REQUEST FOR MEDICAL  
ADVICE**

Date Referred  
02/07/2008

Social Security **EXHIBIT NO. 7F**  
PAGE 2 OF 13

To: Review by specialist(s) in

**PHYSICAL**

From:

**WALDEN, REBECCA**

Examiner Name

Examiner Telephone Number

**WALDEN, REBECCA**

(501) 682-7714

Reviewer Name

Reviewer Telephone Number

( ) -

Claimant Name

Sex

Birth Date (mo, da, yr)

Application Date (mo, da, yr)

M  F

10/05/2007

Type of Claim

DIB

DAC

DWB

SSI ADULT

SSI CHILD

BLINDNESS

**Case History**

INITIAL

RECON

ALJ

DHO

TERI

Congressional or Controlled Inquiry

CDR Involved

Reopening of Prior Decision

CPD Date \_\_\_\_\_

Prior ALJ, AC, Court Decision

Cess. Date \_\_\_\_\_

Prior Disability Established \_\_\_\_\_ to \_\_\_\_\_

Age 18 Redetermination

Other

Date Last Insured or Prescribed Period

Alleged Onset

10/05/2007

Please Review the Medical Evidence and Respond to the following:

Please provide an assessment of the individual's current residual functional capacities.

Physical  Mental

SSI Childhood - Please prepare SSA-538

Please provide an assessment of whether there has been medical improvement (MI) in the individual's impairment(s) since CPD. If MI has occurred, a decision is needed as to whether MI is related to the individual's ability to work.

CPD was based on meeting/equaling listing \_\_\_\_\_

RFC Comparison Needed.

Specific problems or questions:

**Name:** \_\_\_\_\_ s **Age:** 21 **ED:** 12 SE **MPD:** <sed

**AOD/DOF:** 10/5/07 **DLI:** **Case Type:** 16

**Allegations:** Scoliosis / RC no change

**Pain/Date:** 10/22/07

**ADLs/Date:** 10/22/07

Continued on Attached Sheet

**Claimant:****SSN:**

Attachment to Form SSA-448 (5-2004)

Page 1 of 1

2/7/2008

**Initial MSS/ Date/ Source:** 11/29/07 MSS: mod limits. lift 40-50lbs once per hr, but not every 5min. Severe limits w/ comprehension of most jobs. (9) Dr. ---

**Recon MSS/ Date/ Source:** 11/8/04 MSS: limit stooping, bending, lifting, pushing, pulling. (34)Hot SpringsRehab

1/24/05 MSS: avoid strenuous labor/exercise. (33)Hot SpringsRehab

**Initial Rating (RFC)/ Date/ MC:** Light RFC by Dr. ' on 12/17/07

**Recon Orienting Paragraph:** 21yo alleges scoliosis. XR shows mod to severe TSpine scoliosis w/ rod in place. Decreased ROM spine

**PY Rating:** **MN Rating:**

**Types of Work:** None **Earnings Info:**

**Evidence In File:**

**Source: National Park Med Center**

10/31/07 XR LSpine: mod severe thoracolumbar scoliosis w/ corrective frontal rod extending T4 to L4.

(3) XR CSpine: mild straightening of the cervical lordosis. (4)

**Source: Dr. I**

11/29/07 GPCE: can't pick up anything over 50#. No problem standing. PE: BMI 31. CTA, RRR, LKS not palpable. CSpine rotation to 60, LSpine flex to 45. Rotation 5 of shoulder R and L. Bending wnl. 10 scoliosis in upper and 100 in lower back. Absent reflexes biceps, triceps. Gait nl, can H/T, S/A. Dx: severe scoilliosis of spine, surgical repair w/ rods, limitation of motion of twisting and bending. (2-9)

**Recon MER in File:**

**Source:Hot SpringsRehab**

10/16/06 OV: 2nd burn w/ cellulitis. (27)

**REQUEST FOR MEDICAL  
ADVICE**Date Referred  
12/05/2007Social Security Exhibit No. 7F  
PAGE 4 OF 13

To: Review by specialist(s) in

**PHYSICAL**

From:

**MOONEY, REBEKAH**

Examiner Name

Examiner Telephone Number

**MOONEY, REBEKAH**

(501) 682-6162

Reviewer Name

Reviewer Telephone Number

( ) -

Claimant Name

Sex

Birth Date (mo, da, yr)

Application Date (mo, da, yr)

 M  F

10/05/2007

Type of Claim

 DIB DAC DWB SSI ADULT SSI CHILD BLINDNESS**Case History** INITIAL RECON ALJ DHO TERI Congressional or Controlled Inquiry CDR Involved Reopening of Prior Decision

CPD Date \_\_\_\_\_

 Prior ALJ, AC, Court Decision

Cess. Date \_\_\_\_\_

 Prior Disability Established \_\_\_\_\_ to \_\_\_\_\_ Age 18 Redetermination Other

Date Last Insured or Prescribed Period

Alleged Onset

10/05/2007

Please Review the Medical Evidence and Respond to the following:

 Please provide an assessment of the individual's current residual functional capacities. Physical  Mental SSI Childhood - Please prepare SSA-538 Please provide an assessment of whether there has been medical improvement (MI) in the individual's impairment(s) since CPD.  
If MI has occurred, a decision is needed as to whether MI is related to the individual's ability to work. CPD was based on meeting/equaling listing \_\_\_\_\_ RFC Comparison Needed. Specific problems or questions:**Name** \_\_\_\_\_ **Age** 21 **ED** 12<sup>th</sup> w/ sp ed **MPD** <sed <unskill**AOD/DOF** 10/5/07 **DLI** N/A **Case Type** DI**Allegations** scoliosis**Pain/Date** 10/22/07 pain when moving head side to side, stand 2hrs, sit 2 hrs,**ADLs/Date** 10/22/07 problems sleeping b/c of headaches, problems w/ pc, makes simple meals, does light hw,  
drives, shops, walk 20mins, Continued on Attached Sheet**271**

<b>Claimant:</b>	<b>SSN:</b>
Attachment to Form SSA-448 (5-2004)	Page 1 of 1
	12/17/2007

**MSS/Source** 11/29/07 Moderate limitation w/ physical. could life 40-50lbs once per hr but not every 5 mins, severe limitation w/ comprehension of most jobs

**Orienting Paragraph** 21 yr old male alleging scoliosis. Says he is unable to lift 50lbs, has trouble turning head. Has hx of corrective rods in back.

**PY Rating** Pending **MN Rating** N/A

**Types of Work** Never worked **Earnings Info** N/A

**Evidence In File:**

10/31/07 X-ray L-spine - moderately severe thoracolumbar scoliosis w/ corrective frontal rod present T4-L4, o/w negative, w/o fx,

X-ray C-spine - mild straightening of cervical lordosis, o/w negative C-spine (National Park 3-4)

11/29/07 GPCE: c/o can't lift over 50 lbs, had rods in back, can stand 3-4 hrs, walk w/o limitations, PE 67" 197lbs BMI 31, LROM in spine, nml SLR, FROM all extremities, can squat & arise, can walk heel toes, pulses 2+,

Dx scoliosis of spine severe, surgical repair of scoliosis, limitation of motion of spine, MR Moderate limitation w/ physical, could life 40-50lbs once per hr but not every 5 mins, severe limitation w/ comprehension of most jobs (

**PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT**

CLAIMANT:		SOCIAL SECURITY NUMBER:	
NUMBERHOLDER (IF CDB CLAIM):			
PRIMARY DIAGNOSIS: Scoliosis	RFC ASSESSMENT IS FOR:		
SECONDARY DIAGNOSIS:	<input checked="" type="checkbox"/> Current Evaluation	<input type="checkbox"/> Date	12 Months After Onset:
OTHER ALLEGED IMPAIRMENTS:	<input type="checkbox"/> Date Last Insured: _____ (Date)	_____ (Date)	
	<input type="checkbox"/> Other (Specify): _____		

**PRIVACY ACT NOTICE:** The information requested on this form is authorized by Section 223 and Section 1633 of the Social Security Act. The information provided will be used in making a decision of this claim. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between Social Security and other agencies.

**PAPERWORK REDUCTION ACT:** This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

**I. LIMITATIONS:**

**For Each Section A - F**

- ➡ Base your conclusions on **all evidence** in file (clinical and laboratory findings; symptoms; observations, lay evidence; reports of daily activities; etc.).
- ➡ Check the blocks which reflect your **reasoned judgement**.
- ➡ Describe how the **evidence substantiates your conclusions** (Cite specific clinical and laboratory findings, observations, lay evidence, etc.).
- ➡ Ensure that you have:
  - Requested appropriate treating and examining source statements regarding the individual's capacities (DI 22505.000ff. and DI 22510.000ff.) and that you have given appropriate **weight to treating source conclusions** (See Section III.).
  - Considered and responded to **any alleged limitations imposed by symptoms** (pain, fatigue, etc.) attributable, in your judgement, to a medically determinable impairment. Discuss your assessment of symptom-related limitations in the explanation for your conclusions in A - F below (See also Section II.).
  - Responded to all allegations of physical limitations or factors which can cause physical limitations.
- ➡ **Frequently** means occurring one-third to two-thirds of an 8-hour workday (cumulative, not continuous). **Occasionally** means occurring from very little up to one-third of an 8-hour workday (cumulative, not continuous).

Continued on Page 2

## A. EXERTIONAL LIMITATIONS

None established. (Proceed to section B.)

1. **Occasionally lift and/or carry (including upward pulling)**

(maximum) - when less than one-third of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

less than 10 pounds

10 pounds

20 pounds

50 pounds

100 pounds or more

2. **Frequently lift and/or carry (including upward pulling)**

(maximum) - when less than two-thirds of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

less than 10 pounds

10 pounds

25 pounds

50 pounds or more

3. **Stand and/or walk (with normal breaks) for a total of -**

less than 2 hours in an 8-hour workday

at least 2 hours in an 8-hour workday

about 6 hours in an 8-hour workday

medically required hand-held assistive device is necessary for ambulation

4. **Sit (with normal breaks) for a total of -**

less than about 6 hours in an 8-hour workday

about 6 hours in an 8-hour workday

must periodically alternate sitting and standing to relieve pain or discomfort. (If checked, explain in 6.)

5. **Push and/or pull (including operation of hand and/or foot controls) -**

unlimited, other than as shown for lift and/or carry

limited in upper extremities (describe nature and degree)

limited in lower extremities (describe nature and degree)

6. **Explain how and why the evidence supports your conclusions in item 1 through 5.**

Cite the specific facts upon which your conclusions are based.

Continued on Page 3

6. Continue (NOTE: MAKE ADDITIONAL COMMENTS IN SECTION IV)

**B. POSTURAL LIMITATIONS**

None established. (Proceed to section C.)

	Frequently	Occasionally	Never
1. Climbing - ramp/stairs _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- ladder/rope/scaffolds _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Balancing _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Stooping _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Kneeling _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Crouching _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Crawling _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. When less than two-thirds of the time for frequently or less than one-third for occasionally, fully describe and explain. Also explain how and why the evidence supports your conclusions in items 1 through 6. Cite the specific facts upon which your conclusions are based.

C. MANIPULATIVE LIMITATIONS

None established. (Proceed to section D.)

- |   | LIMITED                    | UNLIMITED                |
|---|----------------------------|--------------------------|
| 1. Reaching all directions (including overhead) _____   | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Handling (gross manipulation) _____  | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Fingering (fine manipulation) _____  | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Feeling (skin receptors) _____   | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Describe how the activities checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in item 1 through 4. Cite the specific facts upon which your conclusions are based. |                            |                          |

D. VISUAL LIMITATIONS

None established. (Proceed to section E.)

- |  | LIMITED                    | UNLIMITED                |
|--|----------------------------|--------------------------|
| 1. Near acuity _____   | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Far acuity _____  | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Depth perception _____  | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Accommodation _____   | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Color vision _____  | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Field of vision _____   | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Describe how the faculties checked "limited" are impaired. Also explain how and why the evidence supports your conclusions in items 1 through 6. Cite the specific facts upon which your conclusions are based. |                            |                          |

Continued on **276**

**E. COMMUNICATIVE LIMITATIONS**

None established. (Proceed to section F.)

- |                     | LIMITED                  | UNLIMITED                |
|---------------------|--------------------------|--------------------------|
| 1. Hearing _____ →  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Speaking _____ → | <input type="checkbox"/> | <input type="checkbox"/> |
3. Describe how the faculties checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in items 1 and 2. Cite the specific facts upon which your conclusions are based.

**F. ENVIRONMENTAL LIMITATIONS**

None established. (Proceed to section II.)

- |  | UNLIMITED                | AVOID<br>CONCENTRATED<br>EXPOSURE | AVOID EVEN<br>MODERATE<br>EXPOSURE | AVOID ALL<br>EXPOSURE    |
|--|--------------------------|-----------------------------------|------------------------------------|--------------------------|
| 1. Extreme cold _____ →  | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>           | <input type="checkbox"/> |
| 2. Extreme heat _____ →  | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>           | <input type="checkbox"/> |
| 3. Wetness _____ →   | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>           | <input type="checkbox"/> |
| 4. Humidity _____ →  | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>           | <input type="checkbox"/> |
| 5. Noise _____ →   | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>           | <input type="checkbox"/> |
| 6. Vibration _____ →   | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>           | <input type="checkbox"/> |
| 7. Fumes, odors, _____ →<br>dusts, gases,<br>poor ventilation,<br>etc. | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>           | <input type="checkbox"/> |
| 8. Hazards _____ →<br>(machinery,<br>heights, etc.)                    | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>           | <input type="checkbox"/> |

9. Describe how these environmental factors impair activities and identify hazards to be avoided. Also, explain how and why the evidence supports your conclusions in items 1 through 8. Cite the specific facts upon which your conclusions are based.

## II. SYMPTOMS

For symptoms alleged by the claimant to produce physical limitations, and for which the following have not previously been addressed in section I, discuss whether:

- A. The symptom(s) is attributable, in your judgment, to a medically determinable impairment.
- B. The severity or duration of the symptom(s), in your judgment, is disproportionate to the expected severity or expected duration on the basis of the claimant's medically determinable impairment(s).
- C. The severity of the symptom(s) and its alleged effect on function is consistent, in your judgment, with the total medical and nonmedical evidence, including statements by the claimant and others, observations regarding activities of daily living, and alterations of usual behavior or habits.

III. TREATING OR EXAMINING SOURCE STATEMENT(S)

A. Is a treating or examining source statement(s) regarding the claimant's physical capacities in file?

Yes

No (Includes situations in which there was no source or when the source(s) did not provide a statement regarding the claimant's physical capacities.)

B. If yes, are there treating/examining source conclusions about the claimant's limitations or restrictions which are significantly different from your findings?

Yes

No

C. If yes, explain why those conclusions are not supported by the evidence in file. Cite the source's name and the statement date.

IV. ADDITIONAL COMMENTS:

See 448

THESE FINDINGS COMPLETE THE MEDICAL PORTION OF THE DISABILITY DETERMINATION.

MEDICAL CONSULTANT'S SIGNATURE:

MEDICAL CONSULTANT'S CODE:

DATE:

*Jerry Thomas*

29

12/17/2002 **280**

CASE ANALYSIS

SSN

NAME

STATE

AR

DATE

02/07/2008

I have reviewed all the evidence in the file, and the mental assessment of 12/18/07 is affirmed as written.

THESE FINDINGS COMPLETE THE MEDICAL PORTION OF THE DISABILITY DETERMINATION.

SIGNATURE <i>Paula Lynch</i>	SPECIALTY	OFFICE
NAME (PRINTED OR TYPED) Paula Lynch	PAGE <u>1</u> OF <u>1</u>	

**REQUEST FOR MEDICAL  
ADVICE**

Date Referred  
02/07/2008

Social Security Administration  
FORM NO. 8F  
PAGE 2 OF 19

To: Review by specialist(s) in

**MENTAL**

From:

**WALDEN, REBECCA**

Examiner Name

Examiner Telephone Number

**WALDEN, REBECCA**

(501) 682-7714

Reviewer Name

Reviewer Telephone Number

( ) -

Claimant Name

Sex

Birth Date (mo, da, yr)

Application Date (mo, da, yr)

M  F

10/05/2007

Type of Claim

DIB

DAC

DWB

SSI ADULT

SSI CHILD

BLINDNESS

**Case History**

INITIAL

RECON

ALJ

DHO

TERI

Congressional or Controlled Inquiry

CDR Involved

Reopening of Prior Decision

CPD Date \_\_\_\_\_

Prior ALJ, AC, Court Decision

Cess. Date \_\_\_\_\_

Prior Disability Established \_\_\_\_\_ to \_\_\_\_\_

Age 18 Redetermination

Other

Date Last Insured or Prescribed Period

Alleged Onset

10/05/2007

Please Review the Medical Evidence and Respond to the following:

Please provide an assessment of the individual's current residual functional capacities.

Physical

Mental

SSI Childhood - Please prepare SSA-538

Please provide an assessment of whether there has been medical improvement (MI) in the individual's impairment(s) since CPD. If MI has occurred, a decision is needed as to whether MI is related to the individual's ability to work.

CPD was based on meeting/equaling listing \_\_\_\_\_

RFC Comparison Needed.

Specific problems or questions:

**Name:** \_\_\_\_\_ **Age:** 21 **ED:** 12 **SE MPD:** <sed

**AOD/DOF:** 10/5/07 **DLI:** \_\_\_\_\_ **Case Type:** 16

**Allegations:** Scoliosis / RC no change

**Pain/Date:** 10/22/07

**ADLs/Date:** 10/22/07

Continued on Attached Sheet

<b>Claimant:</b>	<b>SSN:</b>
Attachment to Form SSA-448 (5-2004)	Page 1 of 1
	2/7/2008

**Initial MSS/ Date/ Source:** 11/29/07 MSS: mod limits. lift 40-50lbs once per hr, but not every 5min. Severe limits w/ comprehension of most jobs. (9) Dr.

12/3/07 MSS: able to cope w/ the cognitive demands of most work like tasks. (3) Dr.

**Recon MSS/ Date/ Source:** None

**Initial Rating (RFC)/ Date/ MC:** Unskilled RFC by Dr. on 12/18/07

**Recon Orienting Paragraph:** 21yo alleges scoliosis. IQ's range from 71 to 76, dx w/ adjustment d/o. GAF 60-70.

**PY Rating:** affirmed light **MN Rating:**

**Types of Work:** None **Earnings Info:**

**Evidence In File:**

**Source:** Lake Hamilton High School

2/11/97 IQ: VIQ 63, PIQ 82, FSIQ 70. (8)

**Source:** Ph.D., CE

12/3/07 MSE CE + IQ: stutters, doesn't move fast, slow to communicate. Doesn't handle stress well. Spoke slowly and did not stutter. Mood nl. VIQ 71, PIQ 85, FSIQ 76. Dx: adjustment d/o w/ mixed emotional features. GAF 60-70. Mental impairments did not interfere w/ AF. (1-4)

**Recon MER in File:**

**Source:** Hot Springs Rehab

11/8/04 Psych Eval: reading d/o, mathematics d/o. Shipley Abstraction IQ 88, Picture Vocabulary Test IQ 82. Beta III IQ 70. (43)

**REQUEST FOR MEDICAL  
ADVICE**

Date Referred  
12/18/2007

Social Security **EXHIBIT NO. 8F**  
PAGE: 4 OF 19

To: Review by specialist(s) in

**MENTAL**

From:

**MOONEY, REBEKAH**

Examiner Name

Examiner Telephone Number

**MOONEY, REBEKAH**

(501) 682-6162

Reviewer Name

Reviewer Telephone Number

( ) -

Claimant Name

Sex

Birth Date (mo, da, yr)

Application Date (mo, da, yr)

M  F

10/05/2007

Type of Claim

DIB

DAC

DWB

SSI ADULT

SSI CHILD

BLINDNESS

**Case History**

INITIAL

RECON

ALJ

DHO

TERI

Congressional or Controlled Inquiry

CDR Involved

Reopening of Prior Decision

CPD Date \_\_\_\_\_

Cess. Date \_\_\_\_\_

Prior ALJ, AC, Court Decision

Age 18 Redetermination

Prior Disability Established \_\_\_\_\_ to \_\_\_\_\_

Other

Date Last Insured or Prescribed Period

Alleged Onset

10/05/2007

Please Review the Medical Evidence and Respond to the following:

Please provide an assessment of the individual's current residual functional capacities.

Physical

Mental

SSI Childhood - Please prepare SSA-538

Please provide an assessment of whether there has been medical improvement (MI) in the individual's impairment(s) since CPD. If MI has occurred, a decision is needed as to whether MI is related to the individual's ability to work.

CPD was based on meeting/equaling listing \_\_\_\_\_

RFC Comparison Needed.

Specific problems or questions:

**Name** \_\_\_\_\_; **Age** 21 **ED** 12<sup>th</sup> w/ sp ed **MPD** <sed <unskill

**AOD/DOF** 10/5/07 **DLI** N/A **Case Type** DI

**Allegations** scoliosis

**Pain/Date** 10/22/07 pain when moving head side to side, stand 2hrs, sit 2 hrs,

**ADLs/Date** 10/22/07 problems sleeping b/c of headaches, problems w/ pc, makes simple meals, does light hw, drives, shops, walk 20mins,

Continued on Attached Sheet

**284**

Claimant: \_\_\_\_\_

SSN: \_\_\_\_\_

Attachment to Form SSA-448 (5-2004)

Page 1 of 1

12/18/2007

**MSS/Source** 12/16/07 Mental impairment do not appear to significantly interfere w/ his day to day functioning, can drive & shop, can perform most ADL's, communicates & interacts in socially adequate manner, speak slowly as if he has difficulty getting words out, nevertheless he communicates effectively although somewhat slowly, able to cope w/ cognitive demands of work like tasks, able to sustain & attend concentration on basic tasks as well as persistence, displayed good focus, able to complete tasks w/in acceptable timeframe w/ possible exception of written expression which is slow

**Orienting Paragraph** 21yr old doesn't allege any mental. MSCE w/ IQs obtained due to special ed & no prior work. IQs were in 70s w/ BIF. Clmt showed he was able to interact adequately & can drive, shop & perform most ADL's, he communicates effectively although somewhat slowly, he is able to cope w/ cognitive demands of work-like tasks, is able to sustain & attend concentration on basic tasks as well as persist, he displayed good focus & was able to complete tasks w/in acceptable timeframe w/ possible exception of written expression which would be slow.

**PY Rating** Light **MN Rating** Pending

**Types of Work** Never worked **Earnings Info**N/A

**Evidence In File:**

2/11/1997 IQs VIQ 63, PIQ 82, FSIQ 70 (MER 8)

12/6/07 MSCE: socialization skills not good, slow to communicate, delayed, doesn't handle stress, slow thinking,

MS mood nml, affect appropriate, speech slow, thought logical, thought relevant, & goal directed, thought content appropriate,

IQs V 71, P 85, FS 76, functioning w/in borderline range of intelligence

Dx adjustment d/o w/ mixed emotional features, GAF 60-70

Mental impairment do not appear to significantly interfere w/ his day to day functioning, can drive & shop, can perform most ADL's, communicates & interacts in socially adequate manner, speak slowly as if he has difficulty getting words out, nevertheless he communicates effectively although somewhat slowly, able to cope w/ cognitive demands of work like tasks, able to sustain & attend concentration on basic tasks as well as persistence, displayed good focus, able to complete tasks w/in acceptable timeframe w/ possible exception of written expression which is slow.

## PSYCHIATRIC REVIEW TECHNIQUE

Name	SSN
NH (If different from above)	SSN

### I. MEDICAL SUMMARY

A. Assessment is from: \_\_\_\_\_ to 12/18/2007

#### B. Medical Disposition(s):

1.  No Medically Determinable Impairment
2.  Impairment(s) Not Severe
3.  Impairment(s) Severe But Not Expected to Last 12 Months
4.  Meets Listing \_\_\_\_\_ (Cite Listing)
5.  Equals Listing \_\_\_\_\_ (Cite Listing)
6.  RFC Assessment Necessary
7.  Coexisting Nonmental Impairment(s) that Requires Referral to Another Medical Specialty
8.  Insufficient Evidence

#### C. Category(ies) Upon Which the Medical Disposition is Based:

1.  12.02 Organic Mental Disorders
2.  12.03 Schizophrenic, Paranoid and Other Psychotic Disorders
3.  12.04 Affective Disorders
4.  12.05 Mental Retardation
5.  12.06 Anxiety-Related Disorders
6.  12.07 Somatoform Disorders
7.  12.08 Personality Disorders
8.  12.09 Substance Addiction Disorders
9.  12.10 Autism and Other Pervasive Developmental Disorders

These findings complete the medical portion of the disability determination.

MC/PC's Signature <i>Kay Cogbill</i>	Date 12/18/2007
MC/PC's Printed Name	Code <b>286</b>

**II. DOCUMENTATION OF FACTORS THAT EVIDENCE THE DISORDER**

**A. 12.02 Organic Mental Disorders**

Psychological or behavioral abnormalities associated with a dysfunction of the brain ... as evidenced by at least one of the following:

1.  Disorientation to time and place
2.  Memory impairment
3.  Perceptual or thinking disturbances
4.  Change in personality
5.  Disturbance in mood
6.  Emotional lability and impairment in impulse control
7.  Loss of measured intellectual ability of at least 15 IQ points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above.

Disorder \_\_\_\_\_

Pertinent symptoms, signs, and laboratory findings that substantiate the presence of this impairment:

Insufficient evidence to substantiate the presence of the disorder (explain in Part IV, Consultant's Notes).

**B. 12.03 Schizophrenic, Paranoid and Other Psychotic Disorders**

Psychotic features and deterioration that are persistent (continuous or intermittent), as evidenced by at least one of the following:

1.  Delusions or hallucinations
2.  Catatonic or other grossly disorganized behavior
3.  Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
  - a.  Blunt affect, or
  - b.  Flat affect, or
  - c.  Inappropriate affect
4.  Emotional withdrawal and/or isolation

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above.

Disorder \_\_\_\_\_

Pertinent symptoms, signs, and laboratory findings that substantiate the presence of this impairment:

Insufficient evidence to substantiate the presence of the disorder (explain in Part IV, Consultant's Notes).

**C. 12.04 Affective Disorders**

Disturbance of mood, accompanied by a full or partial manic or depressive syndrome, as evidenced by at least one of the following:

1.  Depressive syndrome characterized by at least four of the following:

- a.  Anhedonia or pervasive loss of interest in almost all activities, or
- b.  Appetite disturbance with change in weight, or
- c.  Sleep disturbance, or
- d.  Psychomotor agitation or retardation, or
- e.  Decreased energy, or
- f.  Feelings of guilt or worthlessness, or
- g.  Difficulty concentrating or thinking, or
- h.  Thoughts of suicide, or
- i.  Hallucinations, delusions or paranoid thinking

2.  Manic syndrome characterized by at least three of the following:

- a.  Hyperactivity, or
- b.  Pressures of speech, or
- c.  Flight of ideas, or
- d.  Inflated self-esteem, or
- e.  Decreased need for sleep, or
- f.  Easy distractibility, or
- g.  Involvement in activities that have a high probability of painful consequences which are not recognized, or
- h.  Hallucinations, delusions or paranoid thinking

3.  Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes)

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above

Disorder adjustment disorder with depressed mood

Pertinent symptoms, signs, and laboratory findings that substantiate the presence of this impairment (explain in Part IV, Consultant's Notes, if necessary):

Insufficient evidence to substantiate the presence of the disorder (explain in Part IV, Consultant's Notes). **289**

**D. 12.05 Mental Retardation**

- Significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of the impairment before age 22, with one of the following:
1.  Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow instructions such that the use of standardized measures of intellectual functioning is precluded\*
  2.  A valid verbal, performance, or full scale IQ of 59 or less\*
  3.  A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function\*
  4.  A valid verbal, performance, or full scale IQ of 60 through 70\*
- A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above.
- Disorder \_\_\_\_\_
- Pertinent symptoms, signs, and laboratory findings that substantiate the presence of this impairment:

\*NOTE: Items 1, 2, 3, and 4 correspond to listings 12.05A, 12.05B, 12.05C, and 12.05D, respectively.

Insufficient evidence to substantiate the presence of the disorder (explain in Part IV, Consultant's Notes).

**E. 12.06 Anxiety-Related Disorders**

Anxiety as the predominant disturbance or anxiety experienced in the attempt to master symptoms, as evidenced by at least one of the following:

1.  Generalized persistent anxiety accompanied by three of the following:
  - a.  Motor tension, or
  - b.  Autonomic hyperactivity, or
  - c.  Apprehensive expectation,
  - d.  Vigilance and scanning
2.  A persistent irrational fear of a specific object, activity or situation which results in a compelling desire to avoid the dreaded object, activity, or situation
3.  Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror, and sense of impending doom occurring on the average of at least once a week
4.  Recurrent obsessions or compulsions which are a source of marked distress
5.  Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above.

Disorder \_\_\_\_\_

Pertinent symptoms, signs, and laboratory findings that substantiate the presence of this impairment:

Insufficient evidence to substantiate the presence of the disorder (explain in Part IV, Consultant's Notes).

**F. 12.07 Somatoform Disorders**

Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms, as evidenced by at least one of the following:

1.  A history of multiple physical symptoms of several years duration beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly
2.  Persistent nonorganic disturbance of one of the following:
  - a.  Vision, or
  - b.  Speech, or
  - c.  Hearing, or
  - d.  Use of a limb, or
  - e.  Movement and its control (e.g., coordination disturbances, psychogenic seizures, akinesia, dyskinesia), or
  - f.  Sensation (e.g., diminished or heightened)
3.  Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above.

Disorder \_\_\_\_\_

Pertinent symptoms, signs, and laboratory findings that substantiate the presence of this impairment:

Insufficient evidence to substantiate the presence of the disorder (explain in Part IV, Consultant's Notes).

**G. 12.08 Personality Disorders**

Inflexible and maladaptive personality traits which cause either significant impairment in social or occupational functioning or subjective distress, as evidenced by at least one of the following:

1.  Seclusiveness or autistic thinking
2.  Pathologically inappropriate suspiciousness or hostility
3.  Oddities of thought, perception, speech and behavior
4.  Persistent disturbances of mood or affect
5.  Pathological dependence, passivity, or aggressivity
6.  Intense and unstable interpersonal relationships and impulsive and damaging behavior

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above.

Disorder \_\_\_\_\_

Pertinent symptoms, signs, and laboratory findings that substantiate the presence of this impairment:

Insufficient evidence to substantiate the presence of the disorder (explain in Part IV, Consultant's Notes).

**H. 12.09 Substance Addiction Disorders**

Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

If present, evaluate under one or more of the most closely applicable listings:

1.  Listing 12.02-Organic mental disorders\*
2.  Listing 12.04-Affective disorders\*
3.  Listing 12.06-Anxiety-related disorders\*
4.  Listing 12.08-Personality disorders\*
5.  Listing 11.14-Peripheral neuropathies\*
6.  Listing 5.05-Liver damage\*
7.  Listing 5.04-Gastritis\*
8.  Listing 5.08-Pancreatitis\*
9.  Listing 11.02 or 11.03-Seizures\*

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above.

Disorder \_\_\_\_\_

Pertinent symptoms, signs, and laboratory findings that substantiate the presence of this impairment:

Insufficient evidence to substantiate the presence of the disorder (explain in Part IV, Consultant's Notes).

\*NOTE: Items 1,2,3,4,5,6,7,8, and 9 correspond to listings 12.09A, 12.09B, 12.09C, 12.09D, 12.09E, 12.09F, 12.09G, 12.09H, and 12.09I, respectively. If items 1, 2, 3, or 4 are checked, only the numbered items in subsections IIA, IIC, IIE, or IIG of the form need be checked. The first block under the disorder heading in those subsections should not be checked, unless the evidence substantiates the presence of the disorder separate from the substance addiction disorder.

**I. 12.10 Autistic Disorder and Other Pervasive Developmental Disorders**

Qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Often there is a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

1.  Autistic disorder, with medically documented findings of all of the following:

- a.  Qualitative deficits in reciprocal social interaction
- b.  Qualitative deficits in verbal and nonverbal communication and in imaginative activity
- c.  Markedly restricted repertoire of activities and interests

2.  Other pervasive developmental disorders, with medically documented findings of both of the following:

- a.  Qualitative deficits in reciprocal social interaction
- b.  Qualitative deficits in verbal and nonverbal communication and in imaginative activity

A medically determinable impairment is present that does not precisely satisfy the diagnostic criteria above.

Disorder \_\_\_\_\_

Pertinent symptoms, signs, and laboratory findings that substantiate the presence of this impairment:

Insufficient evidence to substantiate the presence of the disorder (explain in Part IV, Consultant's Notes).

**III. RATING OF FUNCTIONAL LIMITATIONS**

**A. "B" Criteria of the Listings**

Indicate to what degree the following functional limitations (which are found in paragraph B of listings 12.02-12.04, 12.06-12.08 and 12.10 and paragraph D of 12.05) exist as a result of the individual's mental disorder(s).

NOTE: Item 4 below is more than a measure of frequency and duration. See 12.00C4 and also read carefully the instructions for this section.

Specify the listing(s) (i.e., 12.02 through 12.10) under which the items below are being rated \_\_\_\_\_  
12.04

FUNCTIONAL LIMITATION	DEGREE OF LIMITATION					
	None	Mild	Moderate	Marked*	Extreme*	
1. Restriction of Activities of Daily Living	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
2. Difficulties in Maintaining Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
3. Difficulties in Maintaining Concentration, Persistence, or Pace	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
4. Episodes of Decompensation, Each of Extended Duration	<input checked="" type="checkbox"/>		One or Two <input type="checkbox"/>	Three* <input type="checkbox"/>	Four* or More <input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>

\*Degree of limitation that satisfies the functional criterion.

**B. "C" Criteria of the Listings**

1. Complete this section if 12.02 (Organic Mental), 12.03 (Schizophrenic, etc.), or 12.04 (Affective) applies and the requirements in paragraph B of the appropriate listing are not satisfied.

NOTE: Item 1 below is more than a measure of frequency and duration. See 12.00C4 and also read carefully the instructions for this section.

Medically documented history of a chronic organic mental (12.02), schizophrenic, etc. (12.03), or affective (12.04) disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do any basic work activity, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1.  Repeated episodes of decompensation, each of extended duration
2.  A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate
3.  Current history of 1 or more years' inability to function outside a highly supportive living arrangement with an indication of continued need for such an arrangement.

Evidence does not establish the presence of the "C" criteria

Insufficient evidence to establish the presence of the "C" criteria (explain in Part IV, Consultant's Notes).

2. Complete this section if 12.06 (Anxiety-Related) applies and the requirements in paragraph B of listing 12.06 are not satisfied.

Complete inability to function independently outside the area of one's home

Evidence does not establish the presence of the "C" criterion

Insufficient evidence to establish the presence of the "C" criterion (explain in Part IV, Consultant's Notes).

IV. CONSULTANT'S NOTES

MER supports a diagnosis of adjustment disorder with depressed mood. IQ scores and af were in the BIF range, although this was not formally diagnosed. There is not evidence of marked or severe impairment in af. Rating is unskilled.

Section 223 and section 1633 of the Social Security Act authorize the information requested on this form. The information provided will be used in making a decision on this claim. Completion of this form is mandatory in disability claims involving mental impairments. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange of information between Social Security and another agency.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

**Paperwork Reduction Act Statement** - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213. Send only comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.**

CASE ANALYSIS

SSN

NAME

STATE

AR

DATE

02/07/2008

I have reviewed all the evidence in the file, and the mental assessment of 12/18/07 is affirmed as written.

THESE FINDINGS COMPLETE THE MEDICAL PORTION OF THE DISABILITY DETERMINATION.

SIGNATURE <i>Paula Lynch</i>	SPECIALTY	OFFICE
NAME (PRINTED OR TYPED) Paula Lynch	PAGE <u>1</u> OF <u>1</u>	

**REQUEST FOR MEDICAL  
ADVICE**Date Referred  
02/07/2008Social Security EXHIBIT NO. 9F  
PAGE 2 OF 9

To: Review by specialist(s) in

**MENTAL**

From:

**WALDEN, REBECCA**

Examiner Name

Examiner Telephone Number

**WALDEN, REBECCA**

(501) 682-7714

Reviewer Name

Reviewer Telephone Number

( ) -

Claimant Name

Sex

 M  F

Birth Date (mo, da, yr)

Application Date (mo, da, yr)

10/05/2007

Type of Claim

 DIB DAC DWB SSI ADULT SSI CHILD BLINDNESS**Case History** INITIAL RECON ALJ DHO TERI Congressional or Controlled Inquiry CDR Involved Reopening of Prior Decision

CPD Date \_\_\_\_\_

 Prior ALJ, AC, Court Decision

Cess. Date \_\_\_\_\_

 Prior Disability Established \_\_\_\_\_ to \_\_\_\_\_ Age 18 Redetermination Other

Date Last Insured or Prescribed Period

Alleged Onset

10/05/2007

Please Review the Medical Evidence and Respond to the following:

 Please provide an assessment of the individual's current residual functional capacities. Physical Mental SSI Childhood - Please prepare SSA-538 Please provide an assessment of whether there has been medical improvement (MI) in the individual's impairment(s) since CPD.  
If MI has occurred, a decision is needed as to whether MI is related to the individual's ability to work. CPD was based on meeting/equaling listing \_\_\_\_\_ RFC Comparison Needed. Specific problems or questions:

Name: \_\_\_\_\_ Age: 21 ED: 12 SE MPD: &lt;sed

AOD/DOF: 10/5/07 DLI: \_\_\_\_\_ Case Type: 16

Allegations: Scoliosis / RC no change

Pain/Date: 10/22/07

ADLs/Date: 10/22/07

 Continued on Attached Sheet

301

**Claimant:** \_\_\_\_\_ **SSN:** \_\_\_\_\_  
Attachment to Form SSA-448 (5-2004) Page 1 of 1 2/7/2008

**Initial MSS/ Date/ Source:** 11/29/07 MSS: mod limits, lift 40-50lbs once per hr, but not every 5min. Severe limits w/ comprehension of most jobs. (9) Dr. \_\_\_\_\_

12/3/07 MSS: able to cope w/ the cognitive demands of most work like tasks. (3) Dr. \_\_\_\_\_

**Recon MSS/ Date/ Source:** None

**Initial Rating (RFC)/ Date/ MC:** Unskilled RFC by Dr. \_\_\_\_\_ n 12/18/07

**Recon Orienting Paragraph:** 21yo alleges scoliosis. IQ's range from 71 to 76, dx w/ adjustment d/o. GAF 60-70.

**PY Rating:** affirmed light **MN Rating:**

**Types of Work:** None **Earnings Info:**

**Evidence In File:**

**Source:** LakeHamiltonHigh School

2/11/97 IQ: VIQ 63, PIQ 82, FSIQ 70. (8)

**Source:**

12/3/07 MSE CE + IQ: stutters, doesn't move fast, slow to communicate. Doesn't handle stress well. Spoke slowly and did not stutter. Mood nl. VIQ 71, PIQ 85, FSIQ 76. Dx: adjustment d/o w/ mixed emotional features. GAF 60-70. Mental impairments did not interfere w/ AF. (1-4)

**Recon MER in File:**

**Source:** Hot Springs Rehab

11/8/04 Psych Eval: reading d/o, mathematics d/o. Shipley Abstraction IQ 88, Picture Vocabulary Test IQ 82. Beta III IQ 70. (43)

**REQUEST FOR MEDICAL  
ADVICE**Date Referred  
12/18/2007Social Security Number  
PAGE: 4 OF 9

To: Review by specialist(s) in

**MENTAL**

From:

**MOONEY, REBEKAH**

Examiner Name

Examiner Telephone Number

**MOONEY, REBEKAH**

(501) 682-6162

Reviewer Name

Reviewer Telephone Number

( ) -

Claimant Name

Sex

Birth Date (mo, da, yr)

Application Date (mo, da, yr)

 M  F

10/05/2007

Type of Claim

 DIB DAC DWB SSI ADULT SSI CHILD BLINDNESS**Case History** INITIAL RECON ALJ DHO TERI Congressional or Controlled Inquiry CDR Involved Reopening of Prior Decision

CPD Date \_\_\_\_\_

 Prior ALJ, AC, Court Decision

Cess. Date \_\_\_\_\_

 Prior Disability Established \_\_\_\_\_ to \_\_\_\_\_ Age 18 Redetermination Other

Date Last Insured or Prescribed Period

Alleged Onset

10/05/2007

Please Review the Medical Evidence and Respond to the following:

 Please provide an assessment of the individual's current residual functional capacities. Physical Mental SSI Childhood - Please prepare SSA-538 Please provide an assessment of whether there has been medical improvement (MI) in the individual's impairment(s) since CPD. If MI has occurred, a decision is needed as to whether MI is related to the individual's ability to work. CPD was based on meeting/equaling listing \_\_\_\_\_ RFC Comparison Needed. Specific problems or questions:**Name** \_\_\_\_\_ **Age** 21 **ED** 12<sup>th</sup> w/ sp ed **MPD** <sed <unskill**AOD/DOF** 10/5/07 **DLI** N/A **Case Type** DI**Allegations** scoliosis**Pain/Date** 10/22/07 pain when moving head side to side, stand 2hrs, sit 2 hrs,**ADLs/Date** 10/22/07 problems sleeping b/c of headaches, problems w/ pc, makes simple meals, does light hw, drives, shops, walk 20mins, Continued on Attached Sheet**303**

Claimant: \_\_\_\_\_

SSN: \_\_\_\_\_

Attachment to Form SSA-448 (5-2004)

Page 1 of 1

12/18/2007

**MSS/Source** 12/16/07 Mental impairment do not appear to significantly interfere w/ his day to day functioning, can drive & shop, can perform most ADL's, communicates & interacts in socially adequate manner, speak slowly as if he has difficulty getting words out, nevertheless he communicates effectively although somewhat slowly, able to cope w/ cognitive demands of work like tasks, able to sustain & attend concentration on basic tasks as well as persistence, displayed good focus, able to complete tasks w/in acceptable timeframe w/ possible exception of written expression which is slow.

**Orienting Paragraph** 21yr old doesn't allege any mental. MSCE w/ IQs obtained due to special ed & no prior work. IQs were in 70s w/ BIF. Clmt showed he was able to interact adequately & can drive, shop & perform most ADL's, he communicates effectively although somewhat slowly, he is able to cope w/ cognitive demands of work-like tasks, is able to sustain & attend concentration on basic tasks as well as persist, he displayed good focus & was able to complete tasks w/in acceptable timeframe w/ possible exception of written expression which would be slow.

**PY Rating** Light **MN Rating** Pending

**Types of Work** Never worked **Earnings Info** N/A

**Evidence In File:**

2/11/1997 IQs VIQ 63, PIQ 82, FSIQ 70 (MER 8)

12/6/07 MSCE: socialization skills not good, slow to communicate, delayed, doesn't handle stress, slow thinking,

MS mood nml, affect appropriate, speech slow, thought logical, thought relevant, & goal directed, thought content appropriate,

IQs V 71, P 85, FS 76, functioning w/in borderline range of intelligence

Dx adjustment d/o w/ mixed emotional features, GAF 60-70

Mental impairment do not appear to significantly interfere w/ his day to day functioning, can drive & shop, can perform most ADL's, communicates & interacts in socially adequate manner, speak slowly as if he has difficulty getting words out, nevertheless he communicates effectively although somewhat slowly, able to cope w/ cognitive demands of work like tasks, able to sustain & attend concentration on basic tasks as well as persistence, displayed good focus, able to complete tasks w/in acceptable timeframe w/ possible exception of written expression which is slow.

# MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

NAME	SOCIAL SECURITY NUMBER
CATEGORIES (From 1C of the PRTF)  12.04	ASSESSMENT IS FOR: <input checked="" type="checkbox"/> Current Evaluation <input type="checkbox"/> 12 Months After Onset: <input type="checkbox"/> Date Last Insured: _____ (Date) _____ (Date) <input type="checkbox"/> Other: _____ (Date) to _____ (Date)

## I. SUMMARY CONCLUSIONS

This section is for recording summary conclusions derived from the evidence in file. Each mental activity is to be evaluated within the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis. Detailed explanation of the degree of limitation for each category (A through D), as well as any other assessment information you deem appropriate, is to be recorded in Section III (Functional Capacity Assessment).

If rating category 5 is checked for any of the following items, you **MUST** specify in Section II the evidence that is needed to make the assessment. If you conclude that the record is so inadequately documented that no accurate functional capacity assessment can be made, indicate in Section II what development is necessary, but **DO NOT COMPLETE SECTION III.**

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Ratable on Available Evidence
<b>A. UNDERSTANDING AND MEMORY</b>					
1. The ability to remember locations and work-like procedures.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
2. The ability to understand and remember very short and simple instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
3. The ability to understand and remember detailed instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>B. SUSTAINED CONCENTRATION AND PERSISTENCE</b>					
4. The ability to carry out very short and simple instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
5. The ability to carry out detailed instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
6. The ability to maintain attention and concentration for extended periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
7. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
8. The ability to sustain an ordinary routine without special supervision.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
9. The ability to work in coordination with or proximity to others without being distracted by them.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
10. The ability to make simple work-related decisions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Ratable on Available Evidence
Continued – <u>SUSTAINED CONCENTRATION AND PERSISTENCE</u>					
11. The ability to complete a normal work-day and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>C. <u>SOCIAL INTERACTION</u></b>					
12. The ability to interact appropriately with the general public.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
13. The ability to ask simple questions or request assistance.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
15. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>D. <u>ADAPTATION</u></b>					
17. The ability to respond appropriately to changes in the work setting.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
18. The ability to be aware of normal hazards and take appropriate precautions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
19. The ability to travel in unfamiliar places or use public transportation.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
20. The ability to set realistic goals or make plans independently of others.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

**II. REMARKS:** If you checked box 5 for any of the preceding items or if any other documentation deficiencies were identified, you **MUST** specify what additional documentation is needed. Cite the item number(s), as well as any other specific deficiency, and indicate the development to be undertaken.

Continued on Page 3

Continued on Page 4

**III. FUNCTIONAL CAPACITY ASSESSMENT**

Record the elaborations on the preceding capacities in this section. Complete this section ONLY after the SUMMARY CONCLUSIONS section has been completed. Explain your summary conclusions in narrative form. Include any information which clarifies limitation or function. Be especially careful to explain conclusions that differ from those of treating medical sources or from the individual's allegations.

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Rateable on Available Evidence
<b>A. UNDERSTANDING AND MEMORY</b>					
1. The ability to remember locations and work-like procedures	1. X	2.	3.	4.	5.
2. The ability to understand and remember very short and simple instructions.	1. X	2.	3.	4.	5.
3. The ability to understand and remember detailed instructions.	1. X	2.	3.	4.	5.
<b>B. SUSTAINED CONCENTRATION AND PERSISTENCE</b>					
4. The ability to carry out very short and simple instructions.	1. X	2.	3.	4.	5.
5. The ability to carry out detailed instructions.	1.	2. X	3.	4.	5.
6. The ability to maintain attention and concentration for extended periods.	1.	2. X	3.	4.	5.
7. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	1. X	2.	3.	4.	5.
8. The ability to sustain an ordinary routine without special supervision without being distracted by them.	1.	2. X	3.	4.	5.
10. The ability to make simple work-related decisions.	1. X	2.	3.	4.	5.
11. The ability to complete a normal work-day and work week without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1.	2. X	3.	4.	5.
<b>C. SOCIAL INTERACTION</b>					
12. The ability to interact appropriately with the public.	1. X	2.	3.	4.	5.
13. The ability to ask simple questions or request assistance.	1. X	2.	3.	4.	5.
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	1.	2. X	3.	4.	5.
15. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	1. X	2.	3.	4.	5.
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	1. X	2.	3.	4.	5.
<b>D. ADAPTATION</b>					
17. The ability to respond appropriately to changes in the work setting.	1.	2. X	3.	4.	5.
18. The ability to be aware of normal hazards and take appropriate precaution.	1. X	2.	3.	4.	5.
19. The ability to travel in unfamiliar places or use public transportation.	1. X	2.	3.	4.	5.
20. The ability to set realistic goals or make plans independently of others.	1.	2. X	3.	4.	5.

**The claimant is able to perform work where interpersonal contact is incidental to work performed, e.g. assembly work; complexity of tasks is learned and performed by rote, few variables, little judgment; supervision required is simple, direct and concrete. (unskilled)**

Continued on Page 4

THESE FINDINGS COMPLETE THE MEDICAL PORTION OF THE DISABILITY DETERMINATION.

MEDICAL CONSULTANT'S SIGNATURE

*Kay Cogbill*

DATE:

12/18/2007

Continuation Sheet – Indicate section(s) being continued.

---

**Privacy Act Notice:** The information requested on this form is authorized by Section 223 and Section 1633 of the Social Security Act. The information provided will be used in making a decision on this claim. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange of information between Social Security and other agencies.

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CV Department  
General Hospital  
106-198 North Street, Geneva, N.Y. 14456

ED Chart # \_\_\_\_\_  
Room # \_\_\_\_\_  
DOB \_\_\_\_\_



LABORATORY ORDERS

MEDICATION & TREATMENT ORDERS

<input type="checkbox"/> STAT	<input type="checkbox"/> Hemat	<input type="checkbox"/> Urinal	<input type="checkbox"/> Chem	<input type="checkbox"/> Urea	<input type="checkbox"/> Creat	<input type="checkbox"/> Bilirubin	<input type="checkbox"/> SGOT	<input type="checkbox"/> SGPT	<input type="checkbox"/> ALP	<input type="checkbox"/> GGT	<input type="checkbox"/> Amylase	<input type="checkbox"/> Lipase	<input type="checkbox"/> Urine							
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<input type="checkbox"/> Clonid	<input type="checkbox"/> Hemat	<input type="checkbox"/> Urinal	<input type="checkbox"/> Chem	<input type="checkbox"/> Urea	<input type="checkbox"/> Creat	<input type="checkbox"/> Bilirubin	<input type="checkbox"/> SGOT	<input type="checkbox"/> SGPT	<input type="checkbox"/> ALP	<input type="checkbox"/> GGT	<input type="checkbox"/> Amylase	<input type="checkbox"/> Lipase	<input type="checkbox"/> Urine							
<input type="checkbox"/> Clonid	<input type="checkbox"/> Hemat	<input type="checkbox"/> Urinal	<input type="checkbox"/> Chem	<input type="checkbox"/> Urea	<input type="checkbox"/> Creat	<input type="checkbox"/> Bilirubin	<input type="checkbox"/> SGOT	<input type="checkbox"/> SGPT	<input type="checkbox"/> ALP	<input type="checkbox"/> GGT	<input type="checkbox"/> Amylase	<input type="checkbox"/> Lipase	<input type="checkbox"/> Urine							

TIME	TEMP	HR	RR	BP	SpO2	ECG	GEN	TYPE	INPUT	OUTPUT
0700	37.8	78	18	120/80	98	Normal	Normal			
0800	37.8	78	18	120/80	98	Normal	Normal			
0900	37.8	78	18	120/80	98	Normal	Normal			
1000	37.8	78	18	120/80	98	Normal	Normal			
1100	37.8	78	18	120/80	98	Normal	Normal			
1200	37.8	78	18	120/80	98	Normal	Normal			
1300	37.8	78	18	120/80	98	Normal	Normal			
1400	37.8	78	18	120/80	98	Normal	Normal			
1500	37.8	78	18	120/80	98	Normal	Normal			
1600	37.8	78	18	120/80	98	Normal	Normal			
1700	37.8	78	18	120/80	98	Normal	Normal			
1800	37.8	78	18	120/80	98	Normal	Normal			
1900	37.8	78	18	120/80	98	Normal	Normal			
2000	37.8	78	18	120/80	98	Normal	Normal			
2100	37.8	78	18	120/80	98	Normal	Normal			
2200	37.8	78	18	120/80	98	Normal	Normal			
2300	37.8	78	18	120/80	98	Normal	Normal			

CHARGES: [Faint handwritten notes]

1930 - looking generally well, alert, oriented  
- good oral intake, stool soft, normal  
- no pain, no nausea, no vomiting  
- temp 37.8, HR 78, RR 18, BP 120/80, SpO2 98  
- ECG normal, chest exam normal  
- lungs clear, heart sounds normal, no murmurs  
- abdomen soft, no tenderness, no distention  
- stool soft, normal

Signature: \_\_\_\_\_  
Physician Signature: \_\_\_\_\_

10/2/57

PATIENT'S NAME  
 SOCIAL SECURITY NO.  
 BIRTH DATE  
 BIRTH PLACE  
 HOSPITAL NUMBER  
 ADMISSION DATE  
 ROOM NUMBER  
 GROUP NAME NO.

EMERGENCY TREATMENT  
 AUTHORIZATION FOR RELEASE OF INFORMATION  
 PERMISSION IS HEREBY GIVEN TO THE GENEVA GENERAL HOSPITAL TO FURNISH INFORMATION FROM MY HOSPITAL RECORDS TO MY INSURANCE COMPANY.

WITHOUT E.O. PHYS.  CONSERVATION  CHEMOTHERAPY  EMERGENCY  
 CHINESE  JAPANESE  KOREAN  OTHER

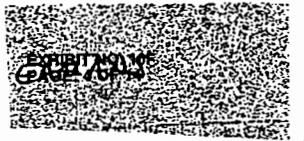
WITHOUT E.O. PHYS.  CONSERVATION  CHEMOTHERAPY  EMERGENCY  
 CHINESE  JAPANESE  KOREAN  OTHER

CLINICAL NOTES: [Handwritten notes describing patient history and treatment, including dates and symptoms.]

WORKING CONDITION: [Handwritten notes on patient's functional status.]  
 DISPOSITION: [Handwritten notes on patient's final status or transfer.]

DATE OF EXAMINATION	3/24/91
HISTORY	EXHIBIT NO. 10 PAGE 3 OF 14 acc. of fall from falling out of car to street, disc. 1/3
REASON FOR VISIT	to confusion, trauma
HEIGHT, WEIGHT, TEMP.	H. W. T.
PULSE, RESP., BP	P. R. BP
GENERAL APPEARANCE	well
SKIN	no rashes
HEAD, FONTANEL	occipital C
EYES: CONJUNCTIVAE	no conjunctivae
MUSCLE BALANCE	no swelling
FUNDI	
EARS: LEFT	
RIGHT	
NOSE	
MOUTH	
TEETH	
PHARYNX	
NECK	
HEART	
LUNGS	
ABDOMEN	not palpated
GENITALIA	not tested
EXTREMITIES	From C. they
NEURO: CN'S	
MOTOR	
SENSORY	
REFLEXES	
CEREBELLAR	
PELVIC	
RECTAL	
IMPRESSION	Rebound soft tissue injury
RECOMMENDATIONS	
SCREENING & LABORATORY	
IMMUNIZATIONS	
MEDICATIONS	
RETURN VISIT	for check

GENERAL HOSPITAL  
New York



EMERGENCY ROOM  
RECORD

- # of friend after 2:30

DATE OF EXAMINATION	① 10-5-92	③ 10-29-92	④ 1-18-93	⑤ 2-17-93
HISTORY	11:53 AM 10-4-92 in a lot of pain all night has had cold out off for week. c/o D ear/pain cough at night asthma penicillin - fever	4:27 PM Daring much better Cold starting resting to sleeping	2:53 PM 1-14-93 Cong Temp headache Runny nose Temp has been 101 Bedi profuse last dose at 12 noon	10:00 AM for my friend COMPLEX - 1420 College
REASON FOR VISIT	ear stuff last pm Gonos +	ear flu (Dressed) +	headache, Cong Temp (Dressed) +	✓ EAR
HEIGHT, WEIGHT, TEMP.	H W 37 T 98.1	H W 38 T 98.3	H W 39 T 102	H W 31 1/2 T 97.6
PULSE, RESP., BP	P R BP	P R BP	P R BP	P R BP
GENERAL APPEARANCE	Well	Well	uncomfortable but not	tired/c/o ear pain
SKIN	✓	✓	✓	✓
HEAD, FONTANEL	✓	✓	✓	✓
EYES; CONJUNCTIVAE	✓	✓	✓	✓
MUSCLE BALANCE	✓	✓	✓	✓
FUNDI	✓	✓	✓	✓
EARS: LEFT	✓	✓	✓	✓
RIGHT	Bulging, red, distended Tyndall	red normal sounding	red, full Tyndall	red, full Tyndall
NOSE	✓	✓	✓	✓
MOUTH	✓	✓	✓	✓
TEETH	✓	✓	✓	✓
PHARYNX	✓	✓	✓	✓
NECK	✓	✓	✓	✓
HEART	✓	✓	✓	✓
LUNGS	Clear	✓	✓	✓
ABDOMEN	soft - 4/10 cm	✓	✓	✓
GENITALIA	✓	✓	✓	✓
EXTREMITIES	✓	✓	✓	✓
NEURO: GN'S	✓	✓	✓	✓
MOTOR	✓	✓	✓	✓
SENSORY	✓	✓	✓	✓
REFLEXES	✓	✓	✓	✓
CEREBELLAR	✓	✓	✓	✓
PELVIC	✓	✓	✓	✓
RECTAL	✓	✓	✓	✓
IMPRESSION	ROM	Resolved	but unresponsive to paracetamol	ROM
RECOMMENDATIONS		Admission X-ray scheduled for 10/20/92	Apotho Care liquid NKA PP phone will call in if	Sept - Cardiac 1/12 tsp 900 ER Discharge 3rd day Amox 250 tid x 10d
SCREENING & LABORATORY	Red Form 44 12 top page 80			
IMMUNIZATIONS	Amoxil 250 5ml			
MEDICATIONS	1/4 tsp potid x 10d			
RETURN VISIT				

RXP

M. Williams

10

✓ call 3/10/93

9.45  
10

DATE OF EXAMINATION	(1) 6-9-92 6:00 pm	(2) 6-12-92	(3) 7-2-92	(4) 9-15-92 10 am
HISTORY	Ear pain, ST congestion, cough headache-onset 5 days - vomited temp 102	Rash on Penis and io. Swollen & itches x 4 days	Doing well 4:0	ST, stomachache, g/f/10 painful to urinate onset today
REASON FOR VISIT	cough / congest	Rash	ear fu	ST / stomachache
HEIGHT, WEIGHT, TEMP.	H W 35 T 100°	H W 35 T 98	H W 35 T	H W 37-5 T 98.6
PULSE, RESP., BP	P R BP	P R ESTOPS	P R BP	P R BP
GENERAL APPEARANCE	misc. looking poor	well now	well	well, unimpaired
SKIN	dry	skin below &		
HEAD, FONTANEL				
EYES: CONJUNCTIVAE				
MUSCLE BALANCE				
FUNDI				
EARS: LEFT				
RIGHT	red, 92.5M springy	2/3		
NOSE	dry			
MOUTH				
TEETH				
PHARYNX	red - high arch		clear	3rd arch inflamed
NECK				high arch
HEART				
LUNGS				
ABDOMEN		PHSM		distended, umbilical
GENITALIA				burn & red on both sides + 1/2 inch
EXTREMITIES		dry on each of acetone + the area purple red		
NEURO: GN'S				
MOTOR				
SENSORY				
REFLEXES				
CEREBELLAR				
PELVIC				
RECTAL				
IMPRESSION	ROM, pharynx, red - high arch	possible irritative (low enzyme) no CF	Residual CM	pharynx not well
RECOMMENDATIONS	Keep record of headache	UA - (2) PH 5.0 prot. - Trace @ x3	Diet + Nutritional changes	Key's etc, watch for more will call @ 11 am Has no phone
SCREENING & LABORATORY	Normal A/B, NKA, 1/4 of 1/4, 1/4 of 1/4	UP: 56, normal, NKA - liquid, FEU's 7/2, mom to call us, high IT TO	NO Urinary, N/A, VS - kidneys, Phloph	TC, Urea, normal, 1/8
IMMUNIZATIONS				
MEDICATIONS	Aspirin, X10			
RETURN VISIT	1/2 of 1/4, 1/4 of 1/4	pediatric diet	for	3/16 pending test

100  
allied  
100

DATE OF EXAMINATION	(3) 6-24-91	(M) 7-29-91	(3) 7-31-91	(M) 8-7-91
HISTORY	Seen at CGH 7P on 1st in falling out of car. Etc. to Smith, disapp. talk.	Temp. ear! Pain, headach. Stomachache grabbings at groin area Etc. in 10/20/90 groin area 1 mo ago in CAR ACCIDENT Was called above TYLENOL 1.00 PM	c/o 31 E with patches over this am afebrile	Pain on stomach & chest since last I took AEB. Child has had c-fox since already per mom. Nascat & fleas
REASON FOR VISIT	In contusion, trauma		↓ ST	↓ rash
HEIGHT, WEIGHT, TEMP.	H W T	H W T 34 10 33	H W T 33	H W T
PULSE, RESP., BP	P R BP	P R BP	P R BP	P R BP
GENERAL APPEARANCE	Well	Well, playing	Well	Well
SKIN	no red faint scaly patches @ right area of swelling	✓	✓	Multiple papular red areas 10% on antitrib. and flexor small stams
HEAD, FONTANEL	✓	✓	✓	Remainder of exam. ✓
EYES; CONJUNCTIVAE	✓	✓	✓	No vesicles - no hives
MUSCLE BALANCE	✓	✓	✓	
FUNDI	✓	✓	✓	
EARS: LEFT	✓	✓	✓	
RIGHT	✓	✓	✓	
NOSE	✓	✓	✓	
MOUTH	✓	✓	✓	
TEETH	✓	✓	✓	
PHARYNX	✓	✓	✓	
NECK	✓	Supple	2 nod tonsils, 14 exudate, slightly swollen	
HEART	✓	Clear	✓	
LUNGS	✓	Clear	✓	
ABDOMEN	not seen not felt	soft & masses or granular	✓	
GENITALIA	From (C) hyp	✓	✓	
EXTREMITIES	✓	✓	✓	
NEURO: GM'S	✓	✓	✓	
MOTOR	✓	✓	✓	
SENSORY	✓	✓	✓	
REFLEXES	✓	✓	✓	
CEREBELLAR	✓	✓	✓	
PELVIC	✓	✓	✓	
RECTAL	✓	✓	✓	
IMPRESSION	Revised w/ time w/ injury	R/O UTI vs viral illness	Pharyngitis No strep	Probably flea bites vs. papular urticaria
RECOMMENDATIONS		Inferol per 940 for fever		
SCREENING & LABORATORY		U/A dip NEG 3 Urinal culture small PH 7.5 apothecary	TC @ Tylenol	Benadryl 1 tsp po q 6h
IMMUNIZATIONS				
MEDICATIONS				
RETURN VISIT	in allent	BTB	in allent	BTB

DATE OF EXAMINATION	③ 9-13-91	① 10-15-91	③ 11-5-91 (cont)	③ 12-5-91
HISTORY	clb. h.a. freq. episodes 2-3x wk x2 mo. ↑ temp 9/11	c/o ST x 4 days - ALSO, evnl pain φ fever	② 11-26-91 cold sympt x/wk chest hunting	In. Preg @ North Street
REASON FOR VISIT	h.a.	no meds ✓ acc, ST	cough	5y
HEIGHT, WEIGHT, TEMP.	H: 35 1/2	H: W: T: 99.7	H: W: T:	H: 42 W: 33 T:
PULSE, RESP., BP	P: R: BP:	P: R: BP:	P: R: BP:	P: R: BP: 74/50
GENERAL APPEARANCE	well	well	well	well
SKIN	✓	✓	✓	✓
HEAD, FONTANEL	✓	✓	✓	✓
EYES: CONJUNCTIVAE	✓	✓	✓	✓
MUSCLE BALANCE	✓	✓	✓	✓
FUNDI	not done	✓	✓	✓
EARS: LEFT	✓	Bulging opaque	no	no
RIGHT	✓	Et clear mucus	no	no
NOSE	✓	✓	✓	al cong
MOUTH	✓	✓	✓	✓
TEETH	✓	✓	✓	✓
PHARYNX	✓	✓	✓	✓
NECK	✓	✓	✓	✓
HEART	no @	✓	no @	no @
LUNGS	clear	✓	clear	clear
ABDOMEN	✓	✓	✓	✓
GENITALIA	✓	✓	✓	✓
EXTREMITIES	✓	✓	✓	✓
NEURO: GN'S	✓	✓	✓	✓
MOTOR	✓	✓	✓	✓
SENSORY	✓	✓	✓	✓
REFLEXES	✓	✓	✓	✓
CEREBELLAR	✓	✓	✓	✓
PELVIC	✓	✓	✓	✓
RECTAL	✓	✓	✓	✓
IMPRESSION	Headaches Stress/Tension vs ? Migraine	② DM	WHL + cough	well No brnchy Cough + Cong delay 5
RECOMMENDATIONS	Keep Diary		Amoxicillin if not work add RBC	Amoxicillin 945 Tace L. pro
SCREENING & LABORATORY	DC these	Samples of	1/2 g 100	DM # 4 DM # 3 - no
IMMUNIZATIONS	True Adm 5-9-91	Amoxicillin (SD no tod x 10d)	at h's primarily	MM # 2 overdosed R
MEDICATIONS				Amoxicillin
RETURN VISIT	o/p Wendy	7/13		

GENEVA GENERAL HOSPITAL

DISCHARGE SUMMARY

DISCHARGE DATE: 11/14/86

ADMISSION DATE: 11/13/86

CHIEF COMPLAINT: Child dropped on floor.

HISTORY OF PRESENT ILLNESS: is a 2 month old white male who was allegedly dropped by his mother while holding him and trying to free a cat from speaker wires. No loss of consciousness. His was brought to the E.R. right away. At that time he had a normal exam, but was somewhat irritable. Skull films revealed an occipital skull fracture.

PAST MEDICAL HISTORY: Unremarkable.

SOCIAL HISTORY: Mother is a 20 year old unwed mother. No family support. Lives with a girlfriend. She had been cited once by child protective for neglect.

PHYSICAL EXAM: On admission revealed an alert, active two month old male, weighed 5 kilos. Temperature 98, pulse 108, respiratory rate 24. Head - no evidence for ecchymosis or obvious depression. Eyes - pupils equal and react to light. Extra-ocular movements full, conjunctiva clear. Pharynx - clear. Neck - supple without adenopathy. Lungs - clear. Heart - sounds normal without murmur. Abdomen - soft without organomegaly. Neurological - he had symmetrical facies, normal strength tone. 2+ symmetrical deep tendon reflexes, a good grasp and suck.

HOSPITAL COURSE: He was observed for 24 hours. He tolerated feedings well. Neuro. check were normal. He was discharged following social service reassessment of the situation. Mother was warned that any further citations would possibly result in the child being taken from the home. Follow-up in one week.

DISCHARGE DIAGNOSIS: Occipital skull fracture.

D-11/26/86-RW

T-12/4/86-cjk

NAME: \_\_\_\_\_

M

853706

DATE: 11/13/80

56 204

Notes should be signed by Social Worker

(S) Pt sleeping - 2 mos old baby boy

(1) Pt was brought to E.R. by Mother

Mother states she "dropped kid on hardwood floor"

Relates that her cat was tangled up in speaker wires and that she went ~~to~~ to free him - When she did this she just dropped the baby. States she thought she was holding the baby. That this was a normal reaction

2) Mother is single 20 y old - Supported by Social Services - Unemployed - States to have no family support - Pt's father unresponsive  
Pt and his Mother live in a girlfriend in upstairs apt.

(A) appeared very vague during this interview  
Did not appear to be concerned re: baby's dx.

Is interested in leaving the hospital as soon as baby is admitted - "Doesn't know what she would do here". Explained that S would be calling <sup>this in to</sup> THE Child Prot Registry - Concerned that welfare will take her baby due to the fact that she is already being followed by that worker. Encouraged mother to stay awhile w/ baby. Mother slightly defensive as is her friend ( )

(P) 1) Call in to Child Abuse Register

2) Assist in investigation

3) Assist in disc, if indicated, in family support in home

Jocuk

GENEVA GENERAL HOSPITAL

PROGRESS NOTES

Date	Notes Should Be Signed by Physician
1/13/53	<p>4:00 dropped child on hardwood floor</p>
	<p>MR E</p>
	<p>2 mo old w 5' allegedly "dropped" by mother while holding him + facing cat from speaker wires. <del>was</del> No LOC. Brought to EIC Nixon but somewhat unstable</p>
	<p><del>MR</del> Sent 2040 removed mother - No family report. Lives in jail. Her brought child in for well.</p>
	<p>MR alert, active 2 mo 5' Wt 5 lb Head &amp; ecchymosis, obvious depression, Swelling Eyes PERRL. EOM full. Cognit: clear Pharynx clear Abd. soft Chest clear WRR @ Hx rgt perjury Also Spinal fluid. All strength, tone DRC 24 = Good fmg, stable. Skin clear Count of 5'</p>

GENEVA GENERAL HOSPITAL

PROGRESS NOTES

Date	Notes Should Be Signed by Physician
	6/13 Skull films - occipital skull fx
	Frag (1) Skull fx
	(2) Pan. Skull situation.
	P. Pediculate
	Frag US + new - Observation
	See Lewis cannot

**GENEVA GENERAL HOSPITAL**

DATE OF EXAM: 11/13/86

EXAMINATION REQUESTED

Skull

AGE:

SPECIFIC INFORMATION OR QUESTION TO BE ANSWERED

PROVISIONAL DIAGNOSIS

R/O Fx

CLINICAL INFORMATION

dropped on floor -  
fell onto back - lg raised  
area (L) occiput

INP   
OPD

ECF   
E.R.

NURSING HOME   
O.R.

A	H	7
B	J	8
C	K	9
D	L	10
E	M	11
F	N	12
G	P	13
H	R	14
I	S	15
J	T	16
K	U	17
L	V	18
M	W	19
N	X	20
O	Y	21
P	Z	22

TRANSPORT

WHEELCHAIR

STRETCHER

BED

BEN CASEY

PORT

STAT

PRE-OP

ROUTINE

PHONE REPORT

ADDITIONAL INFORMATION & CAUTIONS

COMPENSATION

YES

NO

DATE TIME: \_\_\_\_\_

PREVIOUS X RAY HERE: YES  NO

REQUESTED BY: \_\_\_\_\_

REGISTERED BY: M.L.D. *me*

DO NOT WRITE BELOW

08 38 70 6

SKULL

BD:  
11/13/86  
BJS

REXXER INP WW  
Dr.

CLINICAL INFORMATION: dropped on floor, fell onto back - lg. raised area left occiput - r/o fx.  
SKULL FILMS: There is a linear fracture of the left parietal bone. The fracture is not depressed. There is 4 mm separation of the main fracture fragments on the frontal view. The remainder of the bony structures are intact. Dr.



**GENEVA GENERAL HOSPITAL** GENEVA, N.Y. 14456  
**TAYLOR-BROWN MEMORIAL HOSPITAL**  
 WATERLOO, N.Y. 16165

MEDICAL RECORDS NO. 204

PATIENT LAST NAME FIRST MI. MARRIAGE NAME (MR) FORMER NAME(S)

PATIENT'S ADDRESS STREET CITY, STATE ZIP PHONE NO. DOG CODE 45

DATE OF BIRTH AGE SEX M S W D SEP R VETERAN PATIENT'S S.S. NO. PATIENT'S OCCUPATION RELIGION NOO ANNOTED

EMPLOYER/ADDRESS/PHONE

SPOUSE'S NAME INSURANCE MEDICAID EMERGENCY PHONE NUMBERS

NAME OF NEAREST RELATIVE OTHER THAN HUSBAND OR WIFE RELATION ADDRESS PHONE - AC NO.

DATE ADM. HOUR PREV. ADM. DATE ADM. STATUS ADMISSION CODE ADMITTING DIAGNOSIS (I10) 801.00 FRACTURED SKULL

DATE HOSP. DISCH. HOUR DATE TRANS. TO I.C.U. DATE DISCHARGED FROM I.C.U. DATE TRANS. TO ALT CARE DATE DISCH. FROM ALT CARE DATE DISCH. FROM ALT CARE

11-14-86 13 ATTENDING PHYSICIAN CONSULTING PHYSICIAN(S) ADMITTING PHYSICIAN

MEDICAL RECORDS USE ONLY ROOM NO. 204 2 PIN NO.

PRINCIPAL DIAGNOSIS: (CONDITION ESTABLISHED, AFTER STUDY, TO BE CHIEFLY RESPONSIBLE FOR OCCASIONING THE ADMISSION)

*Skull fracture*

ETIOLOGY	PROCEDURE
801.01	87.17 #13
E8849	

SECONDARY DIAGNOSIS: (ALL CONDITIONS THAT COEXIST AT THE TIME OF ADMISSION OR DEVELOP SUBSEQUENTLY WHICH AFFECT TREATMENT RECEIVED AND/OR LENGTH OF STAY)

COMPLICATIONS:

OPERATIONS OR TREATMENTS:

DOCTOR PLEASE COMPLETE

HISTORY	DISCHARGE NOTE
PHYSICAL	DIAGNOSIS
PAP NOTE	SIGNATURE
IMMUNIZATION STATUS	ANES. NOTE PRE-OP
NEWBORN-ADM P.E.	ANES. NOTE POST-OP
NEWBORN-DB P.E.	OPERATION
PROGRESS NOTE	AUTOPSY PROTOCOL
CIRCUMCISION	MICROSCOPIC #/1
CONJUGATION REQUEST	PRENATAL
SIGNATURE ROUTINE ORDERS	LABOR REPORT
DISCHARGE ORDERS	AWAITING LAB
CODING FOLLOW-UP	

CONDITION OF PATIENT ON DISCHARGE:  RECOVERED  IMPROVED  UNIMPROVED  NOT TREATED

DISPOSITION:  HOME  EXPIRED  AMA TRANSFERRED TO: \_\_\_\_\_

ATTENDING PHYSICIAN *[Signature]* M.D.