

Medical Records

Civil Action Number: 1:10-CV-12345

Claimant: Lucky Phylla

Account Number: 987-65-4321

Exhibits

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DATE: May 11, 2010

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



ARKANSAS CHILDREN'S HOSPITAL
800 MARSHALL, LITTLE ROCK, ARKANSAS 72202-3591

LABORATORY

RUN DATE: 01/17/01 ARKANSAS CHILDREN'S HOSPITAL PAGE 6
SUB TIME: 0130 ACH LABORATORY DISCHARGE SUMMARY FINAL

Patient: [REDACTED] (Continued)

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

UNITS 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	390 CC	01/15/01	
PK CELLS	875 CC	875 CC	01/12/01	

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
 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
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

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.

[Handwritten signature]

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, avoid help.
PSH: "head fix" mild scoliosis

Physical: All: ♀ P/B/B / normal / weakness
Medi: ♀
Shoulders ↑ (R) thorax 9°
↑ (L) humer 8°
T8/T9 45°

X-ray: T12/L1 36°
L5/S1 0°
2nd DYN'S

Assessment: (C) torticollis / down
① 5/5 MB U/SI.
S: SEVERE BACK PAIN + SCOLIOSIS
Plan: symmetrical distinct reflex
LACK CURVATURE (C) = pelvic/stepladder level
X-RAYS M A I S P I T E
NO LOCALIZING FINDINGS

Patient Instructions: A: PAINFUL SCOLIOSIS
P: MRI, 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

NAME: _____	AGE: 1
DATE OF BIRTH: _____	SEX: male
ASSESSMENT: 1-11-2003	GRADE: 9
EXAMINER: _____	SCHOOL: Lake Hamilton
VISION SCREENING: Passed 9-25-02	DOMINANT HAND: Right
HEARING SCREENING: Passed 9-25-02	REEVAL CONF BY: 1-11-06
REFERRED BY: Reevaluation	LEARNING STYLE: 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

[redacted] 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.

[redacted] 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. [redacted] 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 2nd grader.
Frequent moves prior to enrollment at Lake Hamilton.
History of special education placement and services to include speech/language.
Records indicated that ' repeated 4th 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
Adaptive Behavior Quotient	78

EXHIBIT NO. 2F
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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

EXHIBIT NO. 2F
PAGE: 9 OF 22

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

He 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 his 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*

EXHIBIT NO. 2F
PAGE: 12 OF 22

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

Page EXHIBIT NO. 2F PAGE: 14 OF 22

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

Table with columns for Course/Activity, Gen Ed., Sp. Ed., Course Grade, and Total Amount of Time (weekly). Includes handwritten entries like ACTI, SH, and ACTT.

SCHEDULE OF SPEECH LANGUAGE PATHOLOGY SERVICES

Semester: 12-1

AND

Semester: 12-2

None Needed [checked]

SCHEDULE OF RELATED SERVICES

None Needed [checked]

Table with columns for Related Services, Location, Frequency, and Amount.

I (check one) [] give [] deny permission for (agency name) to bill my private insurance for the above services.

Name _____ Date 04/07/05 Page EXHIBIT NO. 2F
PAGE: 15 OF 22

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

203

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 _____

204

Name _____ Date 04/07/05 Page EXHIBIT NO. 2E
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INSTRUCTIONAL MODIFICATIONS, SUPPLEMENTAL AIDS, AND SUPPORTS

<p>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.</p>	<p>FREQUENCY CODES</p> <p>C Classwork H Homework T Test A All</p>								<p>TEACHER'S INITIALS</p>					
	<p>SUBJECT AREAS</p>													
	<p>ALTER ASSIGNMENTS BY PROVIDING: <input type="checkbox"/> None Needed</p>													
Reduced assignments/appropriate activities	A	A	A	A	A	A	A	A						
Extra time for completing assignments/appropriate activities	A	A	A	A	A	A								
Emphasis on major points	A	A	A	AA	A	A								
<p>ADAPT INSTRUCTION BY PROVIDING: <input type="checkbox"/> None Needed</p>														
Opportunity to repeat and explain instructions	A	A	A	A	A	A								
Study guide	A	A	A	A	A	A								
Extra time for written response	A	A	A	A	A	A								
Extra time for oral/augmentative communication response	A	A	A	A	A	A								
<p>ADAPT MATERIALS BY PROVIDING: <input type="checkbox"/> None Needed</p>														
Altered format of materials	A	A	A	A	A	A								
<p>ADAPT TESTS BY PROVIDING (Not Applicable to Preschool): <input type="checkbox"/> None Needed</p>														
Word bank	T	T	T	T	T	T	T							
Elimination of essay sections	TR	Y	Y	Y	Y	Y	Y							
Tests of reduced length and small group testing	T	TT	Y	Y	Y	Y								

205

Name _____

Date 04/07/05

Page _____

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PAGE: 18 OF 22

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
PAGE: 20 OF 22

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 PAGE: 21 OF 22

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	ACT I FCS Agri	ACT I Eng. 209

Name _____

Date _____

Page _____

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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

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PAGE: 2 OF 43

NAME

060882050000550

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

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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.

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

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: [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, Jr			
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	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 0730	PHYSICIAN B	

DATE 2/27/07	TIME 1045 AM	NAME	
(1) 3 pak one as directed NR			
(2) 4 fluids			
(3) Robitussin 8m qd Po q 4H pain cough & 3N 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 - qd 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 10/24/06 in skin rounds.			
NURSE	TIME 0900	PHYSICIAN	B

DATE 10/13/06	TIME 1030am	NAME:	SS#
(1) H ₂ O ₂ followed by Neosporin ointment bid X one week. (2) Keep dry. (3) RTC 10/16/06 (4) dural. can bid v one week			
NURSE	TIME 1130	PHYSICIAN	B

HOT SPRINGS REHABILITATION CENTER HOSPITAL
PHYSICIAN'S ORDERS

EXHIBIT NO. 3F
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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 Amoxicil 500 tid c-food x 10 days.			
② 4 fluids			
③ salt H ₂ 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 Dexamethasone 4mg # 6 + PRN sore throat.			
② Chlorbimeth 4mg + PO q 4hrs. PRN 3 times only			
Protocol			
NURSE	TIME	PHYSICIAN B	9/10/06

DATE	TIME	NAME	SS#
8/31/06	1575		
Acetaminophen 325mg # 2 tabs po q 4hr PRN x 3 days protocol			
De-pacil 100mg on q 4hr 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 / Omnesse Eye Consult & treat - decreased visual acuity			

NURSE	TIME	PHYSICIAN	SS#
	1500		225
			1/27/05

060802060000530

EXHIBIT NO. 3F
PAGE: 19 OF 43
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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~~ ~~Therapy~~ in throat noted. T 98° -
P 106 SpO2 97% R 20 BP 125/71. Tx per protocols. Cxpt -
C.D. 2/27/07 at 1045. Admined RTC in 5x5p
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. during skin rounds on October 24th.

B

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 ^{Dress} forearm - ^{Dressing}
 O - Wound left forearm 8 cm x 1 cm - very red.
 A - Burn left forearm
 P. P.C. Neosporin - use Silvadene
 OK 1 wk

10/27/06 (0825) ^{Dress} forearm ^{Dressing} A. Area appears closed - drain. Silvadene applied. 3 boxes ^{Dressing}

10/29/06 (0920) - ^{Dress} 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 ^{Dress} forearm burn

no pain, etc.
vs. stable ^{Dress} forearm burn well healed & residual ^{Dressing} resolved.
A/P ^{Dress} forearm burn & cellulitis - Vitamin E for ^{Dressing} 5000



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.

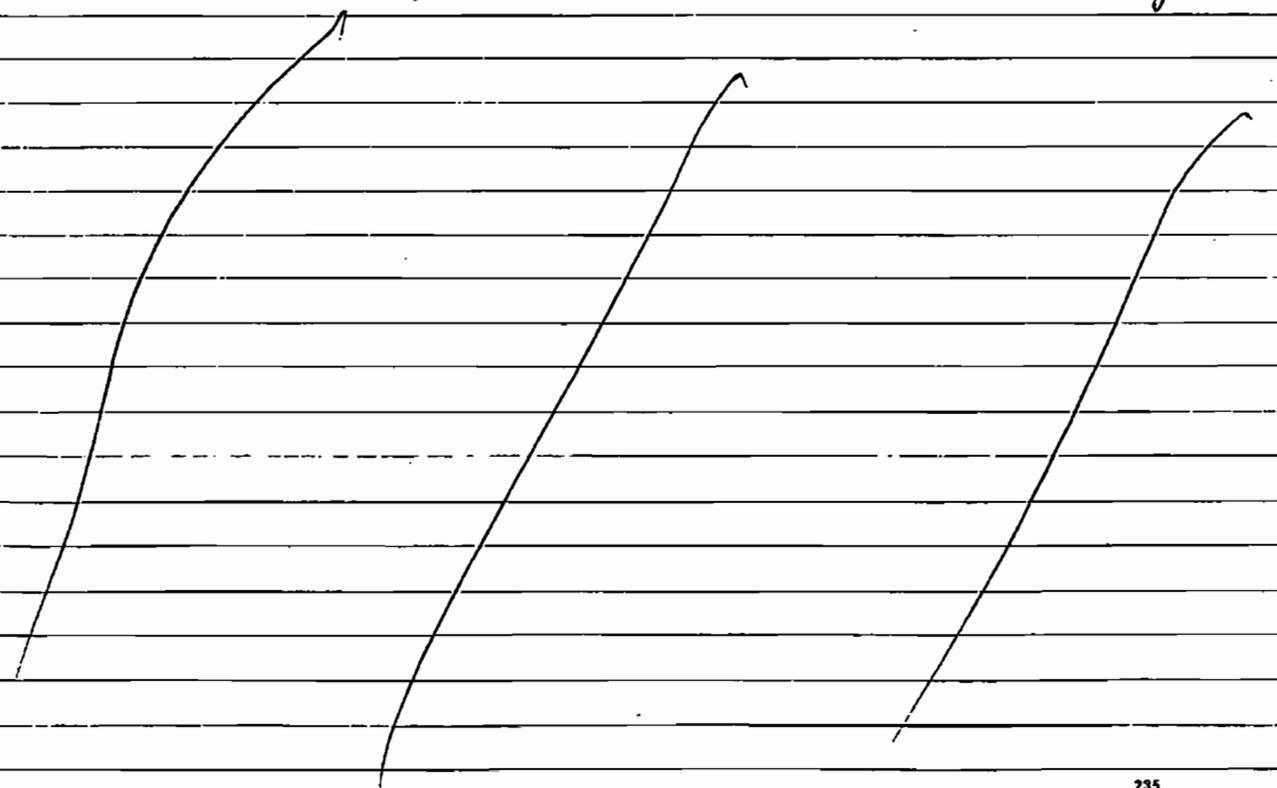
Date: -None-

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/ H₂O₂ 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 - 07/15/06

PE - φ
H/P ① tension headaches - discussed in patient.
- see orders.

B

[Large empty space with faint lines, possibly a placeholder for a drawing or additional notes]

PROGRESS NOTES

(Family Name) _____

(no) _____

1/24/05 (1020) 12/65, 78, 18, 96.5, 98% 5'7" 170lbs Admitted to HSRC 18yo w/ 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 2/60 J 2/30 07. Has glasses for driving. Wt lift 55 lbs 11th gr Skills w/ N. PPD (B) vala

11/29/05 98.2, 98, 18, 125/70, 95%
0940 C 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 @ 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 + @ 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/P 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/P cough.
Cepacol lozenges # 6 per protocol
Chlortrimeton 4mg Tpo per protocol.
Instructed to return in 4 hrs per
Report to clinic at 0715 in. AKA when
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	Member Alive Died Age Reason
Asthma	Amputation	Alcohol	Father <input checked="" type="checkbox"/> <input type="checkbox"/>
Cancer	Angioplasty	Drugs	Health Hx
Depression/Anxiety	Appendectomy	Cocaine	Mother <input checked="" type="checkbox"/> <input type="checkbox"/> 40
Diabetes	CABG	Meth	Health Hx
Heart Disease	Cholecystectomy	THC	Brother
Hypertension	C-section	Other	Sister
Obesity	Hernia	Education	Children
SCI	Hysterectomy	Grade	
Seizures	Joint Replacement	High School	
Stroke	Lithotomy	College	
TBI	ORIP	Employment	
Thyroid Disease	Other	Accessability	
LD			
Other	<i>Scabies requiring surgery</i>	<i>None</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 above/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"/>	Psych <input checked="" type="checkbox"/>	

Physical Examination
 Vitals HT *67"* WT *187* BP *130/79* P *91* R *20* O₂ 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
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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

060802060000530

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) Myopia (Nearsighted) 4) Insulin 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]

Allegedly KDA

Accid: Sprain/Ankle
Very hard on
(not by ETC)

HISTORY AND PHYSICAL

HEIGHT *H 5' 8" 168 lb* **PROBLEM INDICATED** *Since: 0* **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 *Seclusion & Surgery (cont)*

NEUROLOGICAL/MENTAL STATUS **PROBLEM INDICATED** *L7 R S4*
No Yes *Limit Daily*
Right arm. w/ walk = limp 45° hump

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 11th 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

SC1-20-05

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

060802060000530

EXHIBIT NO. 3F
 For use with
 1135A and 1136A
 VS-II Screeners

Keystone VS-II Record Form (Standard Targets)

Name _____ Date 11/24/05

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)
RIGHT EYE: ACUITY 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 = 357248	(One Miss) Allowed Per Line 20/40 = 795823	20/30 = 943852 20/25 = 428576 20/20 = 547638
LEFT EYE: ACUITY 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 = 578236 20/20 = 745932
BOTH EYES: ACUITY 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)
BOTH EYES: ACUITY 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)
BOTH EYES: ACUITY 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	PHORIA (EYE CO-ORDINATION) 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	FUSION	Four Balls	Four then Three	Three Balls
F-6	STEREOPSIS (Depth Perception)	Box Heart Cross	Star	Cross
F-7	COLOUR Severe (Red/Green) 79 23	None Correct	One Correct	Two Correct
F-8	COLOUR Mild (Blue/Violet) 92 56	None Correct	One Correct	Two Correct
	HORIZONTAL FIELD TESTS (3)	<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/Sec:
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

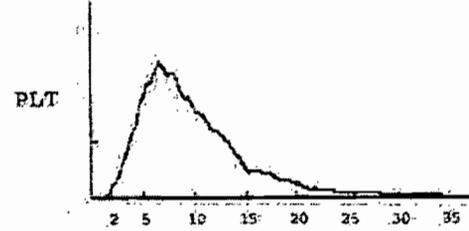
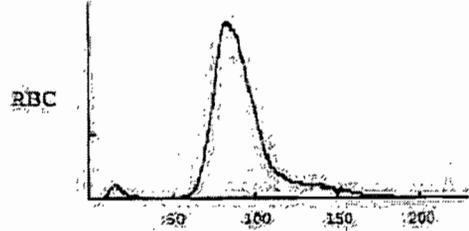
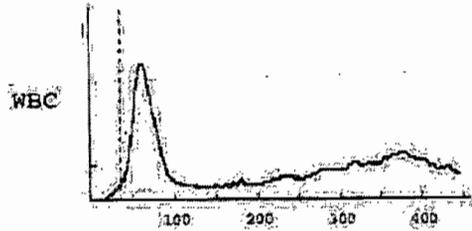
Specimen ID:
Patient:
Sex: M DOB:
Physician:
Comments: MC SW

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 _____ %				
BAND _____ %				
LYMP _____ %				
MONO _____ %				
EOSIN _____ %				
BASO _____ %				
VAR LYM _____ %				
META _____ %				
MYELO _____ %				
PRO MYELO _____ %				
BLAST _____ %				
POLYCHROM	[]	[]	[]	[]
HYPOCHROM	[]	[]	[]	[]
POIK	[]	[]	[]	[]
TARGET	[]	[]	[]	[]
SPHERO	[]	[]	[]	[]
ANISO	[]	[]	[]	[]
MICRO	[]	[]	[]	[]
MACRO	[]	[]	[]	[]
BASO STIP	[]	[]	[]	[]
VACUOLES	[]	[]	[]	[]
TOXIC GRAN	[]	[]	[]	[]

PLT EST _____
PLT MORPH _____

COMMENTS _____

060802060000530

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

255

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

256

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 E m

ABDOMEN: LK S not palpable
 Ascites: _____ Organomegaly: _____

SKIN CHANGES: surgical scars on back from T2 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°	WAL
	Extension	0° - 60°	
	Rotation	0° - 80° R & L	60 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	WAL	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

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:

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 ^{physical} labor - could lift 40-50 L
 once per hour but not every 5 min
 severe limited with comprehension of most jobs

REPORTING PHYSICIAN'S SIGNATURE, AND DATE

Signature: _____	Date: 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 scolliosis 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 Number
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** 12th 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**

Claimant:	SSN:
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

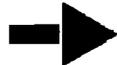
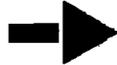
CLAIMANT:		SOCIAL SECURITY NUMBER:	
NUMBERHOLDER (IF CDB CLAIM):			
PRIMARY DIAGNOSIS: Scoliosis	RFC ASSESSMENT IS FOR:		
SECONDARY DIAGNOSIS:	<input checked="" type="checkbox"/> Current Evaluation	<input type="checkbox"/> Date	12 Months After Onset:
OTHER ALLEGED IMPAIRMENTS:	<input type="checkbox"/> 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
CONCENTRATED
EXPOSURE | AVOID EVEN
MODERATE
EXPOSURE | AVOID ALL
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,
dusts, gases,
poor ventilation,
etc. _____ → | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Hazards
(machinery,
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

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. 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

(501) 682-6162

MOONEY, REBEKAH

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:

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Mental

SSI Childhood - Please prepare SSA-538

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CPD was based on meeting/equaling listing _____

RFC Comparison Needed.

Specific problems or questions:

Name _____; **Age** 21 **ED** 12th 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 286

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.**