



PHYSICIANS REPORT OF THE INDEPENDENT MEDICAL EXAM

**COMPREHENSIVE OBSERVATION ACCOUNT
SAMPLE**

Joe Attorney
Address
City, State Zip

RE: I.M.E. Observation of Janice J. Fromin

CLIENT:	Janice J. Fromin
OBSERVING PHYSICIAN:	Jeffrey E. Sherman, D.C.
EXAMINING PHYSICIAN:	Richard Reynolds, M.D.
	8910 Wilshire Blvd. Ste. 123
	Beverly Hills, California
DATE OF EXAMINATION:	September 15, 2006
TIME OF EXAMINATION:	3:30 p.m.

Dear Mr. Attorney:

The following is an account of the Independent Medical Examination that took place on the above mentioned date for your SAMPLE client, Janice J. Fromin.

- 3:15 p.m. I arrived at the office of Dr. Richard Reynolds and informed the receptionist, Nancy Balm, that I would be observing the examination of Janice Fromin. She advised me that Janice had not arrived and asked if I would like to sit and wait.
- 3:28 p.m. Janice Fromin arrived and was given forms to fill out. She asked about validation of parking and was told that the office does not validate. She was given instructions and sat down to fill out the forms. I then introduced myself to Ms. Fromin and offered to answer any questions she may have had.
- 3:50 p.m. Dr. Reynolds greeted Ms. Fromin and I and asked that she "fill out the information as completely as possible." He said that he was "going to review the information and ask her some questions afterward."
- 3:58 p.m. Janice Fromin finished with the paperwork and handed it to the front desk. She was told the examination would begin in 20 minutes.
- 4:10 p.m. I spoke with the front office to determine when we would be seen. I was told that "the patient was not an emergency and that she had missed a previous appointment." I advised Ms. Balm that the examination is re-scheduled for today and that other factors have no bearing on the present situation. I asked her to find out the time the examination was to begin. She spoke with Dr. Reynolds and was told that the examination would begin in 10 minutes.
- 4:22 p.m. We were taken the exam room and the history began
- 5:00 p.m. The history was complete and the examination of Janice J. Fromin began.

The doctor removed a neurological reflex hammer, a measuring tape, a pinwheel and a dynamometer.

The doctor instructed the patient to stand. Toe and heel walking were performed and were unremarkable. He then asked that she do a knee bend two times.

Active range of motion was assessed in the cervical spine; flexion, extension, right rotation, left rotation, right lateral flexion, and left lateral flexion. No goniometer was used and the patient described pain in right rotation.

Active range of motion was then assessed in the upper extremities bilaterally for flexion and abduction. During flexion, the right arm was full however the left arm was limited to 90 degrees with pain. During abduction the right arm was full however the left arm was limited to 90 degrees with pain. Appley's (under) scratch test was performed showing a limitation to the left arm approximately 3 inches below the inferior angle of the scapula. The right arm was full to approximately at the inferior angle of the scapula.

The dynamometer was then used to measure grip strength at 3 trials bilaterally. When I asked the doctor what reading he received, he stated that it would be in his report.

Resisted arm flexion, internal rotation and external rotation were performed revealing left sided weakness in all motions. Resisted shoulder external rotation was then performed with the arms flexed to 90 degrees and at the patient's side. This test revealed weakness in the left arm.

Inspection was performed of the patients left shoulder. Palpation to the left shoulder revealed tenderness in the left anterior deltoid area.

Inspection was performed of the patient's neck, upper back and trapezius area. Palpation revealed pain in the left trapezius area. Palpation was negative in the rhomboid musculature bilaterally.

Resisted elbow flexion, extension, pronation and supination were performed. Resisted wrist extension, wrist flexion, finger abduction, and finger adduction were performed. Resisted left elbow flexion revealed pain in the left triceps area.

Tinel's test was performed and found to be negative. Ulnar nerve tapping revealed pain in the left triceps area.

The pulse was then taken bilaterally. Wright's test was done bilaterally with left and right head rotation. The patient stated that pain was felt in the left trapezius musculature when the right arm was hyperabducted. Pain was also felt behind the left shoulder with the left arm hyperabducted and the head in right rotation. Resisted arm abduction with arm at the side revealed left sided weakness. Resisted arm abduction with the arm at 90 degrees revealed left sided weakness and the patient only able to abduct to approximately 45 degrees. Resisted arm external rotation with the arms at 90 degrees revealed weakness in the left arm with restriction in motion to approximately 50 degrees.

Upper extremity reflexes were then performed of the Biceps, Brachioradialis and Triceps reflexes. All of which were found to be +2 bilaterally.

The patient was then asked to stand on one leg (Trendelenburg's sign) which was negative.

Palpation was then performed to the patients right and left hip areas and was unremarkable.

Lumbar spine active range of motion was performed. Flexion was limited with the patient unable to perform due to the bending of her knees; Extension was performed to approximately 20 degrees; Left and right rotation was performed and full; Right and left lateral flexion was not performed.

Mensuration was then performed of the biceps and triceps musculature at approximately 4 inches above the medial epicondyle and 5 inches below the medial epicondyle. I could not determine measurements.

Dr. Reynolds then asked the patient to describe if she could feel light touch. He touched lightly with his hands over the upper extremities bilaterally. No difference from side to side was felt. Dermatomal examination was performed with a pinwheel from superior to inferior over the lateral and medial forearm, over the hand anteriorly from lateral to medial, and over the lateral, medial, and posterior portion of the upper arm bilaterally. No dermatomal landmarks were followed however a difference in sensation was found over the lateral upper arm in comparison from right to left.

Reflexes were then performed of the lower extremity, Knee Jerk and Ankle Jerk and were found to be +2 bilaterally. The doctor then inspected the feet bilaterally.

Light touch was performed over the lower extremities with the doctor touching lightly with his hands over the lower extremities bilaterally. No difference was noted from side to side. Dermatomal examination was performed with the pinwheel over the lower extremity bilaterally from superior to inferior over the lateral, anterior, and medial thigh; over the lateral, anterior, and medial leg; And over the foot. No dermatomal landmarks were followed.

The patient was asked to lie supine and a Straight Leg Raise was performed which was followed with Braggard's Test.

Resisted foot dorsiflexion, plantarflexion, internal rotation, and external rotation were performed. Resisted knee extension was then performed with finger pressure.

Patrick's Faber was then performed bilaterally as well as McMurray's test. Both of which were unremarkable.

Lower extremity mensuration was then performed approximately 5 inches superiorly to the superior pole of the patella and was found to be 16 1/4" bilaterally. Mensuration was also performed approximately 9 inches above the medial malleolus and was found to be 11 1/2" bilaterally.

5:40 p.m. Examination of Janice Fromin was completed. She was instructed that she could change and use the restroom if necessary.

5:40 p.m. I asked Dr. Reynolds if I could have a copy of the notes that he took during the examination to which I was denied.

- 5:41 p.m. Janice Fromin then asked the doctor what his diagnosis was of her. He instructed her that his purpose was for examination only and that she was not a patient in the office. He stated that the examination was an Independent Medical Examination and he was not in a position at this time to render opinion. He further stated that even if she were a patient, due to the fact that still he has to review medical records and review the examination, he did not even have a conclusion for himself at the present time. So after approximately 2 more hours of review he would form his opinion.
- 5:43 p.m. I asked if I could have a copy of the records that she filled out to which I was also denied.
- 5:44 p.m. Dr. Reynolds and I left the examination room as Ms. Fromin changed.
- 5:47 p.m. Ms. Fromin and I left the doctors office.

The examiner failed to perform the following tests which were indicated by the patient's injuries. These include but are not limited to:

CERVICAL SPINE OMISSIONS

Upper Extremity Sensory Evaluation In All Dermatomes:

If the mechanism of injury suggests the possibility of spinal cord injury, temperature sensation and joint position sense must be tested. Altered sensation can indicate nerve damage, either in the peripheral nerve, the nerve root, or the spinal cord. Pain sensation and light touch should be tested due to the fact that 1) they evaluate different spinal tracts and 2) they are likely conducted by different size peripheral fibers, and so loss of light touch occurs at an earlier stage of injury producing a more pronounced loss at an earlier stage than does diminished pain sensation. Vibratory sense should also be tested because it can be lost when other senses are in-tact, and therefore, can function as a more sensitive indicator of neural damage.

Dermatomal screening is incomplete if each separate dermatome is not tested separately and in the proper landmarked areas. When dermatomal levels are tested together, a complete neural deficit can be overlooked.

Maximal Foraminal Compression:

Location of the pain or altered sensation should be noted. This test produces axial compression in extension, rotation, and lateral flexion and causes a decrease in the interforaminal space. This in turn causes encroachment on nerve roots. Pain radiating into the arm suggest nerve root irritation. This test is useful in determining pain from nerve root damage. Foraminal compression tests may also cause pain locally due to facet syndrome.

Cervical Distraction:

A decrease in pain suggests nerve root compression such as might be found in herniated cervical discs or osteoarthritis that encroaches the intervertebral foramen. An increase in pain suggests ligamentous damage or adhesions in the surrounding structure, supporting muscles, or nerve roots.

Shoulder Depression:

Shoulder depression passively stretches the neural bundle. When nerve root irritation exists, radiation of pain to the extremity is observed. This test is useful in determining nerve root

irritation and may be positive if dural adhesions are present due to nerve root injury. This test may produce local pain with stretching muscular strain, muscular or ligamentous adhesion, or cervical joint sprain.

Resisted Head Flexion and Extension:

These tests produce tension on muscular bundles of the cervical spine area anteriorly during flexion and posteriorly during extension while maintaining a constant joint position. Since no motion of the joint is produced, pain indicates injury of muscular tissue and further differentiates pain origin. These tests are useful to differentiate muscular strain from joint sprain.

Costoclavicular Test:

This is a method of reproducing the symptoms of arm pain, tingling, or numbness caused by compression of the neurovascular bundle known as the Brachial Plexus and Subclavian Artery. A positive finding suggests thoracic outlet syndrome. The test creates compression differently from Adson's test or Wright's test. Although they all produce the same findings they differentiate the causes of thoracic outlet syndrome.

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