CLIENT:	**Mackenzie Lynn**
DATE OF EVALUATION:	**September 12, 2006**
DATE REPORT INITIATED:	**September 25, 2006**
PRELIMINARY REPORT FINALIZED:	**December 8, 2006**

Mackenzie Lynn is a 25-year-old female seen for evaluation in my office in Oviedo, Florida accompanied by her husband Levi Lynn. Mackenzie was referred for a rehabilitation evaluation by her attorney. The purpose of this evaluation is to assess the extent to which handicapping conditions impede her ability to live independently, handle all activities of daily living, and to assess the disability's impact on her vocational potential.

Demographic Information:

Client Name: Mackenzie Lynn; **Social Security #:** xxx-xx-xxxx; **Address:** 5421 Eddy Road, Orlando, FL; **County:** Seminole; **Closest Metro Area:** Orlando; **Phone:** xxx-xxx-xxx; **Birthdate:** 6/11/81; **Age:** 25; **Sex:** Female; **Race:** Caucasian; **Marital Status:** Married; **Birthplace:** El Salvador; **Citizen:** No; **Elementary/Secondary Education:** Elementary and High School in El Salvador; **Employer at time of injury:** Doggie Clips; **Position/Grade:** She was working for no salary in order to learn the business, as they were about to purchase it from Levi's family.; **Bilingual:** Spanish and English; **Glasses:** No; **Dominant Hand:** Right; **Height:** 5'6" premorbid; **Weight (present):** 75-80 pounds; **Weight (pre-injury):** 100 pounds; **Date of Onset:** 4/28/05.

History: Mackenzie indicates that she went into the hospital to deliver her baby. *"I just remember I went to deliver my baby on Thursday and seven hours later I started having pain and I had a rash over my abdomen. They told me the pain was normal and the rash was an allergy to the sheets. After that, I do not remember too much."* Records reveal that she developed purpura fulminans resulting in bilateral above knee amputations, below the elbow amputation of right arm and above the elbow amputation of the left arm. Complications included cardiomyopathy, DIC (disseminated intravascular coagulation) requiring hysterectomy and oophorectomy and intra-abdominal abscess. Levi notes, *"we got to the hospital and she gave birth to William at 7:10 a.m. Approximately six or seven hours later, she developed pains in her abdomen and started getting sick and vomiting. Whenever she went to use the restroom, she had severe diarrhea. She also had*

severe burning on urination. Thursday evening, she developed a rash on the abdomen and Friday morning a midwife came in. She had also developed a fever for which she was given Tylenol. The midwife gave her Benadryl for the rash. She was given discharge orders to go home that evening. The pain just got worse. Friday evening, I told them we were not leaving because there was too much pain and something was wrong. They tried to take her blood pressure and found it was way too low and blamed it on a malfunctioning machine. Later her legs started to go numb and were tingling. Saturday, they ordered a CT Scan. She was unable to drink the die without throwing up. They also did an ultrasound of her abdomen. Saturday evening, the doctor rushed her down to ICU. She was taken into OR for exploratory surgery with the intent of taking out her uterus. They told us she had less than a ten percent chance of surviving the surgery. At 3 a.m. Sunday morning, they told us she survived the surgery. They said the infection had rotted her uterus and the body had stopped the blood flow to the uterus. The next morning, they told us she would not live through the day. We continued to hear that she would not survive the day for about a week. They thought it was Strep A and this is what it turned out to be. Tuesday they transported her to Florida Hospital by air. The first doctor to see her was the infectious disease doctor, and he gave her a 15% chance of survival. On May 10th, they told Mackenzie that they would have to amputate her arms and legs for her to be able to survive and she would have to make a decision as quickly as possible. At first she did not want to do this, but ultimately she did make the decision."

Loss of Consciousness or Altered State of Consciousness: Not applicable.

Rehabilitation Program(s) [In/Outpatient Since Injury]: Initially she was in the hospital from 4/28/2005 through 5/3/2005. She was transferred to Florida Hospital and remained there from 5/3/2005 until approximately 8/6/2005, when she was taken by air ambulance to the Rehabilitation Institute of Chicago (RIC). While in Florida Hospital, Levi notes she had been on continuous dialysis, but that was discontinued. She had multi-organ failure including cardiomyopathy with her ejection fraction down to 15% at one point, but at last check it was back up to 50%. Brain activity was apparently not effected in testing. In her intestines, she ended up having blockages and several times she had to be scoped, but the blockages cleared on their own. On discharge from Florida Hospital, she was admitted to RIC for two to three days, then was admitted to Southeastern Medical Center from 8/9/05 through 8/13/05 due to infection. She was then transferred back to RIC. She remained there until October 25, 2005, when she returned home to Orlando.

While in RIC, she underwent PT and OT almost eight hours per day. *"OT and PT provided different types of therapies including group and individual*

sessions, training in activities of daily living and even attempts at training me to change diapers and work with a baby using a doll. I tried, but many ADL's and baby care services, I could not learn to perform."

"On return to Orlando, I started PT and OT." Thirty days combined is available through the insurance. They came to her home every other day until that ran out. No therapy is available now. Currently she is getting exercise for her legs through Max Wilson. Max is her local prosthetist and he is working to build her lower extremities. She is walking a little on her own now. She can walk forty to fifty steps with assistance X2 for safety. The safety assist personnel stand in front and in back in case she falls. Max only works on the lower extremities. He is *"trying to set her up to work with someone for her upper extremities. Max is donating a lot of the time and prosthetics."* They are hoping the insurance will cover these, but it is not looking good.

Prior Medical History: Had history of car accident about six or seven years ago in El Salvador injuring her neck and requiring some mild conservative care to her neck. She had full recovery.
She fell at Bennigan's and broke her *"tailbone"*. Reports still having pain. Reported it as Worker's Compensation accident, but when she moved to Orlando with Levi, they discontinued her therapy and the case was dropped. She contacted them to get therapy restarted, but they put her off. The current situation developed and nothing else went forward.

She had her appendix removed at age nine.
When her father was shot/murdered when she was thirteen, she had counseling for four months.
No learning problems or disabilities in school.
No history of alcohol or drug problems.

Chief Complaint(s)

Current Disability

Disabling Problems: (By client/family history and report. No physical examination occurred).

Mackenzie, *"Well my primary problems are that I have no arms and legs and only one elbow on the right side. My left arm is above the elbow. My legs are both gone above the knee. I can't work like I use to, and I loved to work. I can't do my hair, make up, shower or go to the bathroom on my own. I can't run or feed the baby. I can't cook and I use to love cooking. Just simple stuff*

like opening a door is hard for me. Using the computer is difficult. I can't drive or even get in the car by myself. Someone told me at RIC that with the right equipment I could drive, but I have not had a driving evaluation. The baby is learning to crawl into my chair instead of me having to learn to pick him up and that is exciting. I am also disappointed that I can't work in the job that I always wanted to do. I love animals and I really wanted to work with the dogs, grooming and caring for them."

Levi, *"There are a lot of the motherly things that she cannot do. Pick him up, feed him, change the diaper, put him to bed. Even taking her own medicine and getting water to be able to take it, she cannot do on her own."*
They currently have a live-in Nanny. She gets $225 per week, plus room and board. She is paid in cash and they are not currently paying matching social security, quarterly unemployment or the remaining, required benefits. Levi notes, *"I cannot even afford to pay her. This is just the way it has to be right now."* She takes care of the baby and also helps care for Mackenzie and Levi's eight year old son. Her name is Melinda Rodiguez. She is from Trinidad and is in the USA legally, but she does not have a Social Security card as yet.

Mackenzie has phantom pains in her lower extremities primarily, only occasionally in the upper extremities. Lower extremity phantom pains occur every other day on average. On a scale of 1-10, her average phantom pain is rated from a 6 to an 8. It can reach a 10 at times and she cries with this pain. She can have pain at the level of a 10 once a week. The right leg is the more painful and will have phantom pains more often. Phantom pains in her arms occur only occasionally and this is brought on by propelling her wheelchair too much at one time. This pain occurs once every two weeks on average. She rates upper extremity pain as a 6 when it does occur. Her right arm is more prone to having phantom pain. She is not on any medication for phantom pains. She does have a prescription for OxyContin that she can take when the pain is severe, but she does not like to take it. She was on Neurontin at one time, but it was causing her to lose her hair and she decided that she did not want to take this medication.

She did have upper extremity prostheses, but her limbs have shrunk and the prostheses no longer fit. She says they were painful and not functional. She was afraid that some of the parts on the prostheses would hurt her baby when she handled him. The prosthetist that is making her lower limb prostheses is trying to find someone to donate parts for upper extremity prostheses so they can make her a new set.

She has lower extremity prostheses and she is learning to use these. She has no stubbies now, but she did when she was in rehab. They found she did not need to start with stubbies, because she has good balance.

Mackenzie is picked up daily around 9:00 a.m. by one of the employees from Orlando Prosthetic & Orthotic, Inc. She spends the day at the prosthetist, Max Wilson's office from around 9:30 a.m. until Levi picks her up at 5:00 p.m. They work with her on gait training and they will adjust her prostheses off and on for the whole day. Levi picks her up after he gets off from work. The prosthetist and the other staff members have told her that she can continue to do this daily until she can walk.

As noted, they have a live-in Nanny who takes care of the children and helps with cooking and cleaning. On the weekends, Mackenzie will be left alone when Levi has to go to work. He works every other weekend and the Nanny is off on the weekends. She does have family that will come and help sometimes, but there are times that she is alone with the children. Mackenzie admits that it is hard to care for her children. Her 8 year old, Robert, will help with the baby. He changes the baby's diapers and he will help Mackenzie if she needs anything. Levi makes the baby's bottles and Mackenzie will heat them in the microwave.

Anticipated Treatments: Continued work with the prosthetist to be fitted and learn to use the lower and eventually upper extremity prosthesis.

Psychosocial Issues

Patient: She does not feel that she is depressed, but admits that once in a while she will cry when she is by herself. **(See testing on use of denial and repression.)**

Family, Emotional Impact on Spouse/Children: Mackenzie feels that Robert, her 8 year old son, is more emotional than she is. It has not effected his school performance or his behavior as yet. He has commented that he wishes things could be the way they were when she could play with him. Levi admits that he is handling things a day at the time. Mackenzie says that Levi has not changed at all. He is very calm and does not talk much. He admits that he holds everything in. I got the impression that Levi is more effected emotionally than he is willing to reveal to Mackenzie. He is likely experiencing caregiver burnout and could benefit from some respite time and some counseling. Based on clinical interview and test results, I believe individual and family counseling is necessary now, and is likely to become more necessary as Mackenzie is forced to confront more significant family and child rearing issues in years to come.

Levi notes they were not married at the time Mackenzie went into the hospital. They got married while she was in ICU.

Physical Limitations

Loss of Tactile Sensation: She has altered sensation in the residual limbs of both arms. She can feel hot and cold, but touch is dulled. She has loss of sensation and numbness in the scarring areas of her residual limbs on both lower extremities. Left residual upper extremity has some hypersensitivity to light touch with a shock-like sensation. This is only occasionally and depends on where it is touched.

Reach: She has full range of motion in her shoulders without pain or limitations.

Lift: She can pick up a water bottle using both upper extremity residual limbs. No other ability to lift.

Prehensile/Grip: She has no ability to grip. She can sign her name using her mouth to hold the pen and guiding it with her arms.

Sitting: Extended sitting can cause her to have pain in her lower extremity residual limbs. Also will cause phantom pains. She has pain in her lower back with extended sitting. She will stay in her wheelchair for about 2 hours at a time and then switch to the bed or a chair to rest. She will usually rest for about 30 minutes then transfer back into her wheelchair.

Standing: She can stand using her prostheses, but someone has to put her into a standing position. Once she is in a standing position, she can maintain her standing balance.

Walking/Gait: She can walk about 40 to 50 feet using her prostheses. This is with someone walking in front of her and behind to catch her when she falls. She is working on walking, 5 days per week with the prosthetist now. She can not stand and walk on her residual limbs, but she can scoot on the floor from place to place by moving her hips.

Bend/Twist: She can bend at the waist without discomfort.

Kneel: Nonfunctional.

Stoop/Squat: Nonfunctional.

Climb: Nonfunctional.

Balance: Good.

Breathing: No dyspnea.

Headaches: She has daily headaches and she attributes this to insomnia. She feels tired and then she will get a headache. She does not take anything for her headaches.

Vision: Intact.

Hearing: Intact.

Driving: No driving evaluation. She will need adaptive equipment, but she should be able to learn to drive with training. She did drive prior to injury.

Physical Stamina (average daily need for rest or reclining): She tires easily and she has insomnia so she does not feel that she is getting enough rest. She is on Ambien and she takes one half a night, but it is not providing her with much relief from insomina.

Environmental Influences

Problems on exposure to:

Air Conditioning: No.
Heat: Yes, she gets hot flashes due to hysterectomy. She can not take hormones due to blood clots.
Cold: No.
Wet/Humid: Yes.
Sudden Changes: Yes, she has increase in phantom pain with approach of storms.
Fumes: Yes, more sensitive to fumes and odors.
Noise: Yes, she does not like noisy environments. Difficult to tolerate.
Stress: She does not feel that she has difficulty handling stress.

Present Medical Treatment

Doctors	Specialty	Phone	Fax	Frequency	Last Seen
Dr. Carl Demps Orlando, FL	Internist			1 X/ 4 months	Unsure

Max Wilson Prosthetist Daily 7/8/06
He is also providing the gait training at his facility.

Therapies/Notes: She is not participating in any formal PT or OT, as her insurance benefits were exhausted.

Medication	Strength	Frequency	Tablets	Purpose	Prescribed by
Ambien	5 mg	1/2 qhs	15	Sleep	Demps
Paroxetine		Qd	30	Depression	Demps
Synthoid		qd	30	Thyroid	Demps
Oxycontin	5 mg	prn	30 q 6 mnths	Pain	Demps

Over-the-Counter Medication(s): Advil, one bottle per month.
Drugstore and Phone Number: Target Pharmacy
Assistive Devices: Mackenzie's current equipment, along with future equipment needs and supplies are outlined in the Life Care Plan.
Comments: Levi indicates that the prosthetist, Max Wilson, has mentioned to he and Mackenzie, that as we develop her Life Care Plan, he would like for us to speak to the University of Miami because they specialize in pricing of prosthetics.

Medical Summary

Date of Medical Summary: 9/11/06

Mackenzie Lynn is a 25 year old female who is S/P purpura fulminan resulting in bilateral above knee amputations, right arm below elbow amputation and left above elbow amputation. Complications included cardiomyopathy, DIC (disseminated intravascular coagulation) requiring hysterectomy and oophorectomy, and intra-abdominal abscess.

SOUTHEASTERN MEDICAL CENTER: 8/9/05 – 8/13/05
Mackenzie presented with complaint of chest heaviness. History indicates she had postpartum dilated cardiomyopathy (ejection fraction 15% on 7/26/05) in late April of 2005. It was complicated by DIC (disseminated intravascular coagulation) requiring hysterectomy, oophorectomy and amputation of all four limbs.

Mackenzie was at RIC (Rehabilitation Institute in Chicago) for rehabilitation. She noted an episode of chest pressure after rehabilitation the previous week in which she had shortness of breath and chest heaviness, which resolved

after starting diuresis. She diuresed well with complete resolution of her chest pain until one day prior to admission when earlier in the day she received a 500cc IV bolus to "flush the calcium from her kidneys." A few hours later, she noted chest pressure after a session of rehabilitation. The chest pressure returned again in the evening and she was transferred to NMH for evaluation.

Repeat echocardiogram on 8/9/05 showed 4-chamber enlargement, severe left ventricle dysfunction, and improved ejection fraction of 20%. Cardiac MRI showed ejection fraction of 30%, systolic dysfunction with no evidence of myocardial scarring; most consistent with post-partum cardiomyopathy. Coreg was increased and Lisinopril and Spirolactone were prescribed. Digoxin was discontinued. It was noted that if left ventricle function did not show improvement in 2-3 months, she should be considered for ICD (implantable cardioverter defibrillator).

Mackenzie had elevated temperature during her hospital course. MR of the abdomen/pelvis revealed complex abscess from lower pole of right kidney to anterior surface of the psoas/iliacus muscle. The abscess was not conducive to IR drainage. Surgical service recommended medical management, as Mackenzie was not acutely decompensating. She was placed on two-week course of Zosyn and follow up MRI in two weeks was recommended to evaluate abscess progression.

Mackenzie was transferred back to RIC (Rehabilitation Institute of Chicago) for continued rehabilitation on 8/13/05. She was to complete her two-week course of antibiotics. She was on Dilaudid and Fentanyl for pain.

ORLANDO REGIONAL MEDICAL CENTER: 11/22/05; 11/30/05 - 12/2/05; 12/8/05; 3/8/06

Orlando Regional Medical Center: 11/22/05
MR of the abdomen revealed no evidence for abdominal abscess.

Orlando Regional Medical Center: 11/30/05 – 12/2/05
History indicates Mackenzie developed purpura fulminans during her pregnancy resulting in bilateral above knee amputations. She also had a below the elbow amputation of right arm and above the elbow amputation of the left arm. Her course was complicated by deep venous thrombophlebitis. She also had an abscess in the right lower abdomen. That was treated medically and recent MRI showed resolution of the abscess with only some stranding left. Her protime was adjusted through Coumadin. A central line was in place for blood drawing.

On date of admission, Mackenzie had a greenish-brown drainage from the Groshong site. She was not having fevers and white blood count was normal with normal differential. She was admitted for removal of the Groshong catheter and placement of other venous access so she could receive antibiotics and blood draws. She was scheduled to be on Coumadin until 2/06.

Mackenzie was taken to the OR on 12/1/05 and underwent placement of left subclavian central venous catheter and removal of right internal jugular Groshong catheter. She tolerated the procedure well and was discharged to home on 12/2/05.

Orlando Regional Medical Center: 12/8/05
Mackenzie underwent intra-operative ultrasound for deep venous localization, placement of right internal jugular dual-lumen Hickman catheter and removal of left subclavian central venous catheter. She tolerated the procedure well and was discharged to home.

Orlando Regional Medical Center: 3/8/06
Bilateral venous imaging revealed no evidence of deep venous thrombosis.

GENTIVA HEALTHCARE: 10/14/05
PT Evaluation. Mackenzie was minimal contact assist with bed mobility, transfers from supine to sit and with sitting balance. She was total assist with all other transfers and coming to standing. Moderate assist was required for grooming, feeding, dressing and bathing. She required maximum assist with maintaining balance, coordination and endurance during ambulation. Standing balance was also maximum assist. On gait evaluation, Mackenzie was able to walk 75 feet with all four prostheses and platform, rolling walker with poor coordination, balance and motor control.

Therapy was recommended 3X/week to improve balance/coordination and motor control in gait and to increase gait distance and endurance.

Note dated 12/14/05 indicated PT was discontinued

DEMPS, CARL M.D.: 11/2/05 – 3/23/06

Demps, Carl M.D.: 11/2/05
Internal medicine evaluation. Mackenzie was S/P purpura fulminan resulting in bilateral above knee amputations, right arm below elbow amputation and left above elbow amputation. Complications included cardiomyopathy, infected central lines. Right lower quadrant abscess was treated with antibiotics. Last MRI showed decreased size. She was found to have hypothyroidism. Depression, anxiety and insomnia were also reported.

Plan was to consider port and discontinue Grosshong. Mackenzie was to remain on Coumadin until 3/06. MRI of the abdomen ordered.

Demps, Carl M.D.: 11/30/05
Mackenzie had central line infection and was admitted to Florida Hospital.

Demps, Carl M.D.: 1/12/06
Mackenzie complained of very bad headache since morning. There were no associated visual symptoms, photophobia or nausea. She had new Grosshong in place for deep venous thrombosis. Headache was possibly migraine. Toprol decreased.

Demps, Carl M.D.: 2/23/06
Mackenzie complained of urinary frequency and strong urine odor. She denied dysuria, hematuria, flank pain and fever. Blood pressure was still 80/60 after decreasing Toprol. She was treated for UTI. Toprol and Warfarin were discontinued and Cipro was prescribed. Plan was to have echocardiogram before considering discontinuation of Lisinopril.

Demps, Carl M.D.: 3/23/06
Mackenzie continued with cardiomyopathy with low blood pressure and ejection fraction of 50%. Lisinopril was discontinued. Plan was to discuss resumption of estrogen at next visit secondary to complaint of hot flashes.

ORLANDO CARDIOLOGY GROUP: 3/16/06
Mackenzie was referred for echocardiogram for history of cardiomyopathy. Testing revealed:

- Borderline left ventricular function
- Mild valvular heart disease
- Evidence of diastolic dysfunction
- No evidence of pericardial effusion or intracardiac shunt

Records Reviewed:

Orlando Cardiology Group: 3/16/06
Orlando Regional Medical Center: 11/22/05; 11/30/05 - 12/2/05; 12/8/05; 3/8/06
Gentiva HealthCare: 10/14/05
Medical Bills
Southwestern Medical Center: 8/9/05 – 8/13/05
Demps, Carl M.D.: 11/2/05 – 3/23/06

Activities Of Daily Living

Sleep Pattern

Arises: 8:00-8:30 a.m.
Retires: 1:00 a.m.
Average Hours Sleep/24 Hours: 6 to 7 hours including naps.
Sleep Difficulties: She has difficulty staying asleep. She is not awakened by pain, she just wakes and can not go back to sleep.

Independence In

Dressing: She can put on her shirt. She wears a sports bra and she is able to put this on independently. She tries to put on pants but it is difficult. She can undress indepently.
Housework: She can no longer do housework.
Cooking: She is unable to cook now.
Laundry: No.
Yard Work: No.

Social Activities

Organizations Pre/Post: None pre. She now belongs to the Amputee Coalition of America.
Volunteer Work Pre/Post: None.
Socialization Pre/Post: They are not able to socialize like they did prior to injury. She use to travel to visit friends often prior to injury and she is not able to do this now.
Hobbies (Present): Watch TV. She attempts to use the computer. She was just given Dragon Naturally Speaking, but she has not learned how to use it yet.
Hobbies (Previous): Worked with dogs. She loved to cook. She liked to run.

Personal Habits

Smoking: No.
Alcohol: No.
Drugs: No.
History of Abuse and/or Treatment Programs: No.

Socioeconomic Status

Spouse: Levi
Spouse Age: 33.
Occupation: Target, produce team leader.
First Marriage: 2nd for both.
Children: She has two children - one son age 8 – Robert, and William, who is theirs, age 16 months.
Number in Residence: Mackenzie, Levi, Robert, William and Melinda the live-in Nanny.
Type of Residence: Single story home.

Income

Disability Policy: None.
S.S.D.I.: $618 / month; each child gets $10 / month.
S.S.I.: None.
Wages: None.
Food Stamps: No.
Other Income: Husband's wages.
Medicaid: No.
Medicare: Will be eligible after 18 months. SSDI started 1/2006, so Medicare elligibility should be in August 2007, approximately.

Current Financial Situation: Levi transferred from Target in Jacksonville to the store in Lake Mary and now he is in the store in Sanford.

Other Agency Involvement

State Vocational Rehabilitation: No.
State Employment Services: No.
Rehabilitation Nurse: No.
Other Agency: No.
Felony Convictions? No.

Education & Training

Highest Grade Completed: High school graduate.
Last School Attended: El Salvador.
Apprenticeship/OJT: She was working at a doggie daycare and grooming business at the time she went into the hospital to deliver William. She was

learning the business, because she and Levi planned on purchasing this business for Mackenzie to manage.
Literacy: Yes.
Licenses/Certifications: No.

Military Experience

Branch: Not applicable.

Employment History

Released to Return to Work: No work since injury.
Work History Since Injury: No return to work. At the time of injury, they were in the process of purchasing a dog daycare business. She was working with the daycare, learning how to do the business.

Doggie Clips is the business they were about to purchase. The attorneys have the contract. She was working there for no pay while she learned the job. She was going to run the business. The business belonged to Levi's sister and her financé. The purchase canceled when this impairment occurred.

Employer: Doggie Clips; **City/State:** Orlando, FL; **Position:** Learning the business prior to purchase. **Length:** One month. **Wage:** No wages.
Duties: She was learning to manage and operate the doggie daycare and grooming shop. **Reason for Leaving:** They were suppose to purchase the building after the birth of their child.

Employer: Bennigans; **City/State:** Orlando; **Position:** Hostess; **Schedule:** 40 hours / week; **Length:** 2-1/2 years between the two restaurants.; **Wage:** $7 / hour plus tips. $400 every two weeks, on average. **Reason for Leaving:** They were going to purchase the daycare.

Observations

Orientation: Alert and oriented x's three.
Stream of Thought: Clear and rational.
Approach Toward Evaluation: Positive.
Attitudes/Insight: Positive/fair.
Appearance: Makes good appearance/overtly disabled.

Tests Administered

As part of this evaluation, Mackenzie was asked to complete the Beck Depression Inventory-II; the Beck Anxiety Inventory; the Beck Hopelessness Scale, and the Minnesota Multiphasic Personality Inventory-2, (MMPI-2).

On the Beck Depression Inventory-II, her score of four is not indicative of an elevated clinical depression. This is consistent with the results of the clinical interview. The combination of test results and clinical interview do not meet the criteria within the DSM-IV-TR for a diagnosis of Major Depressive Disorder.

On the Beck Anxiety Inventory, her score of ten would not typically indicate a clinically significant level of anxiety. With this individual's tendency to use denial and repression as a defense mechanism in coping with psychological response to disability, I am concerned that this is a sufficient elevation to suggest at least a mild degree of anxiety is present day to day for Mackenzie. Certainly on her MMPI-2, we see an elevation approaching clinical significance on scale 9, hypomania, that would support this.

On the Beck Hopelessness Scale, her score of one suggests an optimistic outlook on her future. Research indicates scores of nine or more are predictive of eventual suicide in depressed suicide ideators. Research also indicates the Hopelessness Scale is far more predictive of suicidal tendencies in the future than the results of the depression scale, and must be used in conjunction with clinical interview for more accurate results. Her results on this scale are also consistent with her MMPI-2 results. Mackenzie appears to be coping at a basic level with many of the psychological issues stemming from her disability, at least in the sense that she does not appear suicidal or self-destructive. I do not glean any suicidal ideation from clinical interview or test results.

On the MMPI-2, a valid profile is obtained based on a review of the validity scales. Consideration is first given to the VRIN (variable response inconsistency) and TRIN (true response inconsistency) subscale, which used paired responses of similar and opposite items to measure inconsistencies in response patterns. An inconsistent response pattern represented by significantly elevated T-scores invalidates the profile. In Mackenzie's case, the T-scores are within normal limits. Next, I evaluated the F, F sub b and F sub p scales, which represent infrequently endorsed items that are sensitive to random and fixed responding. Again, significantly elevated T-scores will

invalidate the MMPI-2 results. Mackenzie's T-scores are within normal limits.

Finally, I reviewed the L, K and S scales. In this instance, T-scores greater than 79 on the L scale, 75 on the K scale and 70 on the S scale tend to reflect individuals who are demonstrating protocols characterized by a pervasive pattern of nonacquiescence. This is a pattern often referred to as a "fake good" profile. The individual is trying to present a better picture of them self than actually exists. Mackenzie's scores do not exceed these parameters, therefore, her MMPI-2 is considered valid. Mackenzie's L scale score of T-66 is noteworthy. It suggests that she is not being completely frank in answering items on the inventory, and may be claiming virtues and denying negative characteristics to a greater extent than most people. The result of such a test-taking attitude is that the individual's scores on most other scales may be lowered artificially in the direction of appearing better adjusted psychologically. The result is that T-scores at or above 65 suggest such extreme denial and/or defensiveness that the protocol should be to interpret the clinical scales with caution, recognizing that many of the scales are likely muted in relation to what is actually being experienced by Mackenzie on a daily basis. A good example is scale one. She is well within normal limits on a scale dealing with somatic concerns and normed on non-disabled individuals. Had she honestly answered these questions, a clinically elevated scale would have been normal for her considering her disability, and when compared to my database of over 2000 MMPI-2's with catastrophically disabled patients, she would not have been found to be elevated. In this case, she is found to be outside expected outcomes.

On the clinical scales, Mackenzie describes herself as being as healthy or healthier than the average member of the population on all scales with the exception of scale 9, hypomania. She is just shy of reaching clinical significance, but based on the muted nature of her results, she is likely well above clinical significance. Individuals with this elevation show unrealistic self-appraisal, may demonstrate a good deal of nervous energy, show flights of ideas, become bored and restless, prefer action to words and may not utilize energy wisely. These individuals may have many projects going at once, and they can appear confused. With the restrictions placed on her by her physical disability, she is limited in her ability to use and direct this energy. The result may be increased anxiety and tension.

Axis I: Anxiety Disorder-300.02.
Adjustment Disorder with anxious features-309.0.

Axis II: Deferred.

Axis III: S/P purpura fulminan resulting in bilateral above knee amputations, right arm below elbow amputation and left above elbow amputation.
4-chamber enlargement, severe left ventricle dysfunction, and improved ejection fraction of 20%.
Borderline left ventricular function.
Mild valvular heart disease.
Evidence of diastolic dysfunction.
No evidence of pericardial effusion or intracardiac shunt

Axis IV: Life Stressors secondary to disability and psychological response to exposure to disability.

Axis V: Current GAF – 50.
Highest GAF in past year – 50.

Conclusions:

Careful consideration has been given to all of the medical, psychosocial, and rehabilitation/mental health counseling data contained within this file and my report. In addition to this data, consideration is given to the research literature pertaining to rehabilitation after amputation of extremities, and attention is paid to the practice guidelines for rehabilitation after amputation promulgated by multiple sources and cited in the Life Care Plan. Correspondence with treating physicians was issued and the Life Care Plan was also reviewed by our Consulting Physiatrist, Andrea Zotovas, M.D. All of these steps are taken to help in establishing the medical, case management, rehabilitation and psychological foundations for the Life Care Plan.

Mackenzie remains significantly disabled secondary to the April 28, 2005 event and subsequent complications. She is nonfunctional for independent living skills at this time, and it is anticipated that she will require extensive rehabilitation, equipment, assistive technology and an accessible environment in order to improve her ability to function on a more independent basis. Some level of support care will always be needed to assist with certain activities of daily living and homemaking chores. As she ages, her need for assistance will increase as age and disability combine to create greater dependence.

The Life Care Plan outlines all of her needs dictated by the onset of disability throughout her life expectancy. In addition to the recommendations specifically for Mackenzie, education and counseling is provided to her

husband and oldest son, in order to assist them in adjusting to her disability. All of these recommendations, along with additional considerations will be outlined in the Life Care Plan, attached as Appendix A.

A Vocational Worksheet, attached as Appendix B, outlines Mackenzie's capacity to earn pre-injury as compared to her capacity to earn post-injury, along with her loss of earning capacity and related vocational issues.

After you have had an opportunity to review this narrative report and the attached appendices, please do not hesitate to contact me should you have further questions.

Respectfully Submitted,

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Licensed Mental Health Counselor, (FL MH#0000117)
PAUL M. DEUTSCH & ASSOCIATES, P.A.

ATTACHMENTS: Appendix A - Life Care Plan
Appendix B - Vocational Worksheet