CLIENT: **Michael Curry**
DATE OF EVALUATION: **August 17, 2006**
DATE REPORT INITIATED: **September 18, 2006**
REPORT FINALIZED: **January 12, 2007**

Michael Curry is a 35-year-old Hispanic male seen for evaluation in my office in Oviedo, Florida. He presented unaccompanied to the evaluation. Michael was referred for a rehabilitation evaluation by his attorney. The purpose of this evaluation is to assess the extent to which handicapping conditions impede his ability to live independently, handle all activities of daily living, and to assess the disability's impact on his vocational status.

Demographic Information:

Client Name: Michael Curry; **Social Security #:** xxx-xx-xxxx; **Address:** 222 Saint Thomas Street, Kissimee, FL; **County:** Osceola; **Closest Metro Area:** Orlando; **Birthdate:** 10/27/71; **Age:** 35; **Sex:** Male; **Race:** Hispanic; **Marital Status:** Divorced; **Birthplace:** Puerto Rico; **Citizen:** Yes; **Elementary/Secondary Education:** Elementary in Puerto Rico and in Apopka, Florida. High School in Orlando, Florida; **Employer at time of injury:** Ranico Transport; **Position/Grade:** Terminal Manager; **Bilingual:** Yes Spanish/English; **Glasses:** No; **Dominant Hand:** Right see limitations; **Height:** 6'1'; **Weight (present):** 250 pounds; **Weight (pre-injury):** 235-240 pounds; **Date of Onset:** 8/27/05.

History: Michael indicates he received electrical burns to both hands when he came into contact with high voltage electrical lines. He states that he retained consciousness. He recalls O EMS treating him at the scene. He was subsequently taken by air ambulance to Florida Hospital. On admission, Glasgow Coma Scale (GCS) was 15. Hand surgery consultation was obtained. Michael noted decreased feeling in both hands. Examination of right hand revealed severe burns and soft tissue damage to the index, middle, ring and small fingers of right hand primarily. Admitting diagnosis was severe electrical burns to both hands with probable developing compartment syndrome on the volar aspect of the wrist and forearm. Michael was taken immediately to the OR.

Loss of Consciousness or Altered State of Consciousness: No.

Length of Unconsciousness or of Altered State: N/A.
Independent Recall: Has a full, independent recall of all events up to the time he was taken into the OR.

Rehabilitation Program(s) [In/Outpatient Since Injury]: Michael was admitted to Florida Hospital on 8/27/05 where he remained through 9/28/05. Over the course of his stay, he was taken to the OR multiple times where he underwent the following procedures:
8/29/05:

- Debridement of multiple area third-degree burns, bilateral UE's.

9/1/05:

- Amputation of multiple fingers, right hand.
- Forearm fasciotomies and debridement of multiple wounds.
- Same procedure on the left hand and amputation of the little finger.

9/7/05:

- Exploration of right forearm and wrist wounds.
- Treatment of multiple wounds involving the upper extremity.
- Left hand exploration and debridement of multiple forearm and hand wounds.

9/15/05:

- Exploration and debridement of multiple wounds involving the forearm, wrist and hand.
- Division and amputation of the left ring finger with a flap.
- Graft application of the first webspace.
- Right UE exploration and debridement of multiple wounds.
- Reconstruction of stump.

9/19/05:

- Exploration and debridement of left wrist and forearm wound.
- Repair of median nerve.
- Harvest of left lateral arm flap.
- Microvascular in-setting of the flap to the left forearm.
- Local tissue rearrangement, left upper arm and forearm area.

He was discharged on 9/28/05 with the following diagnosis:

- Electrical burns to bilateral hands and left big toe, S/P multiple incision and drainage, S/P amputation to the right hand second, third and fourth fingers and left hand ring and little fingers with multiple debridement, placement of Integra skin grafting and split-thickness skin grafting. He was to continue wound care and dressing changes and follow with Dr. Patel for further surgical debridement and skin grafting of his hands.
- Hypertension treated with Norvasc, Hydrochlorothiazide and Lopressor.
- Hypertriglyceridemia, treated with Tricor.

- Anemia secondary to acute blood loss, S/P blood transfusions.
- Contact dermatitis to right forearm, treated with Mycolog cream.
- Hypokalemia, improved after Potassium replacement.
- Pain, treated with Neurontin, OxyContin and Oxy IR.

He since returned for four additional surgeries. According to Michael, Dr. Patel has indicated he will require approximately ten additional procedures before he will reach maximum medical improvement.

Michael did participate in Occupational Therapy through Healthsouth Rehabilitation. He was evaluated on 12/20/05 and therapy was recommended 2 to 3 times per week. He participated in therapy through 2/21/06. He was discharged on 5/1/06 for failure to return for appointments. The discharge summary indicates that he had not met any of his goals. Michael says that he could not return to therapy because the insurance was not covering the cost and he could no longer afford to pay for the services. His injuries were not filed as a Worker's Compensation case, according to Michael. His medical expenses were covered by AIG. He has not had any additional therapy since 2/21/06.

Prior Medical History: Approximately age 13 or 14, he was run over by a truck. This incident resulted in a broken left ankle requiring two surgeries. Michael reports a full recovery from his injuries.
He denies any other accidents or injuries requiring medical care.
He was being treated for high triglycerides at the time of injury, using medication and diet.
Never treated with a psychologist of psychiatrist. No psychotropic medication.
Never diagnosed in school with learning disability, ADD, ADHD.
No history of alcohol or drug problems.

Chief Complaint(s)

Current Disability

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

Michael, *"I have amputations of fingers, nerves and tendons which cause my arms not to move properly. As a result, I have trouble shaving, going to the bathroom, dressing myself, playing volleyball or basketball. I can't do mechanic work or ride my motorcycle. I can't go jet skiing. I can't drive a truck and I can't write or file papers. Also, I have pain. The pain is in my*

arms. It effects both arms about the same, but depending on the days activities one can hurt more than the other. They also feel tight and stiff. If my mother, ex-wife or kids are with me, then they help me wipe myself. If I am home or can wait until I get home, then I get in the shower and clean up with a towel and soap." He indicates he has tried to use a bidet but, *"when I am seated, I cannot get between my buttocks enough to clean and I simply do not have the grip in either hand to make it work. In the shower, I prop one leg up so I can spread enough to use a wash cloth with liquid soap to get clean."*

Over amputee site: He is never pain free over the amputee sites bilaterally. The pain does vary in intensity. The lowest pain level reached even with medication is a 3. The average pain he experiences the majority of the day is rated at a 5. The worst pain level reached is a 7. He reaches a 7 a couple of times a week on average. A pain level of 7 is precipitated by rain or during sleep when his metabolism slows and the hands get cold. He has tried to wear a sock over his hands when he sleeps to keep them warm and it has helped.

Bilateral forearms: This pain is intermittent in nature and it tends to be present when the hand pain is at its worst. The pain tends to radiate up from the hands into the forearms. The arm pain tends to approach a 7 when it occurs, because it is a radiation of the level 7 pain in the hands.

He is bothered by the significant tightness in his hands. I observe significant scarring and tissue loss beyond the amputation sites, including over the wrists and forearms.

Michael and I went through the Pillet web site and he is extremely interested in the potential for prosthetics to be built when his surgeries are done.

Anticipated Treatments: According to Dr. Patel's record dated 7/25/06, Michael will require the following surgical procedures:

- Flap excision and tightening of left forearm.
- Release of web space contracture left hand.
- Flap and skin graft reconstruction of left hand.
- Tightening of loose tissue in the flap of right arm.
- Contracture release right hand.
- Tendon transfer to right wrist for ulnar flexion and Flexor tendon transfer for right thumb and little finger (requiring at least two surgical procedures).
- Multiple toe to finger transfers to right hand.

Michael will also require extensive occupational therapy to provide the proper rehabilitation and allow him to function at his maximum capacity.

Michael will require life long monitoring by numerous medical specialist for complications associated with severe electrical shock, as outlined in his Life Care Plan.

Psychosocial Issues

Patient: Patient admits to occasional depression but denies tension or nervousness. He worries about losing his job.

Family, Emotional Impact on Spouse/Children: His oldest child, a sixteen year old daughter, is going through a lot of depression. She is having a lot of trouble adjusting. The other children have varying degrees of upset and stress. The youngest have had the least trauma emotionally. He is spending a lot of time with his ex-wife and children. Michael indicates that he and his wife are trying to reconcile.

Physical Limitations

Loss of Tactile Sensation: He has a loss of sensation in his entire right hand. The right hand is hypersensitive to touch due to alteration in tactile sensation. Left hand has altered sensation throughout, but not to the same degree as his right hand. He can not tell temperature with either hand. He has burned himself because of his inability to tell hot and cold.

Reach: Full range of motion with his arms. No pain or limitations with reaching.

Lift: He can lift using his arms if something is placed near his elbows, but he can not lift using his hands. If he wants to lift and carry small items, such as a cup, he uses both hands together. He admits to dropping things frequently and feeling embarrassed when this happens.

Prehensile/Grip: He has no grip on the right secondary to the loss of three fingers. He can make a fist with his left hand, but his grip is weak.

Sitting: No limitations with sitting. He does note that he has difficulty going from prone to sitting due to the loss of his hand function to assist in pushing himself up.

Standing: No limitations in standing.

Walking/Gait: No limitations with walking.

Bend/Twist: No limitations.

Kneel: No limitations.

Stoop/Squat: No limitations. He can stoop and squat, but he can not use his hands to pick anything up once he has stooped to the ground.

Climb: He can climb steps and stairs, but he can not climb a ladder due to loss of hand function.

Balance: No limitations.

Breathing: He says that he has had chest pain. He will have chest pains if he tries to relax in a sitting position. He has to lay down flat. He does not report shortness of breath with chest pains.

Headaches: He will have two or three headaches a month for which he takes pain medication. He says that he can go to sleep and wake and still have the headache. They can last up to two days. He rates his average headache pain at an 8.

Vision: No change in his vision. He has not had his eyes tested, but he says that he does not feel there is any difference in his vision.

Hearing: Intact.

Driving: He can drive. In the beginning, he had a steering wheel knob and a built up switch so that he could turn the key, but now he does not require this equipment.

Physical Stamina (average daily need for rest or reclining): He admits to a reduction in his stamina because of his levels of pain.

Environmental Influences

Problems on exposure to:

Air Conditioning: Yes, if it is too cold his pain will increase.
Heat: No.
Cold: Yes.
Wet/Humid: Yes.

Sudden Changes: Yes.
Fumes: In the beginning he did have a constant burn smell, but this has resolved.
Noise: Yes.
Stress: Yes, he does become frustrated easily when he can not do something.
Other: He becomes frustrated when he has to watch someone try to do something that he knows how to do, but can no longer accomplish because of his injuries.

Present Medical Treatment

Doctors	Specialty	Phone	Fax	Frequency	Last Seen
Raj Patel, M.D. Orlando	Plastic Surgeon			1 X / month	3 wks ago
Marco Rodriguez, M.D. Orlando. Sees him for management of pain medications.	PCP			1 X / 3mons	4 wks ago

Therapies/Notes: He participated in OT for a short period of time. He could not continue therapy because his insurance did not cover therapy and he could not afford it.

Medication	Strength	Frequency	Tablets Day	Purpose
Tricor	Unsure	qd	30	Triglyceride levels

Additional Medications/Notes: He takes a pain medication, but he does not remember the name.
Over-the-Counter Medication(s): None.
Assistive Devices: He has a shampoo dispenser. No adaptive equipment.

Medical Summary

Date of Medical Summary: 8/8/06

Michael Curry is a 34-year-old Hispanic male who suffered electrical burns to bilateral hands following contact with high voltage electrical lines.

AIR FLIGHT: 8/27/05
Called to scene of electrical injury by Orlando EMS. Upon arrival, Michael was on a stretcher. Per EMS, Michael was standing on a rock truck holding residential power lines up so other trucks could drive under them and was burned. He denied loss of consciousness or falling. He walked off the truck.

Examination revealed 2nd and 3rd degree burns to both hands/fingers with white ash, 2nd degree burns to bilateral wrists with skin sluffing and reddening to mid forearms bilaterally. There was possible exit wound on top base of great toe. Michael was hot loaded in aircraft and transported to Orlando Regional Medical Center.

FLORIDA HOSPITAL: 8/27/05 – 9/28/05; 10/4/05 – 10/10/05; 11/2/05; 5/2/06

Florida Hospital: 8/27/05 – 9/28/05
Arrived via air transport. History indicates Michael was standing on a rock truck trying to lift some power lines above the truck. He grabbed the lines with both hands and was electrically shocked. He did not fall or lose consciousness. Upon arrival, he complained of pain in both hands.

Examination revealed Glasgow Coma Scale of 15. Motor and sensory examinations were intact for bilateral LE and UE's from wrist to shoulder. CT scans of the chest, pelvis, cervical, thoracic and lumbar spines were unremarkable. Michael's cervical collar was removed and morphine was administered for pain.

Hand surgery consultation was obtained. Michael noted decreased feeling in both hands. Examination of right hand revealed severe burns and soft tissue damage to the index, middle, ring and small fingers of right hand primarily. There was also superficial damage around the wrist and swelling of hand and wrist. Fingers were held contracted and were resistive to passive extension. Sensation was intact according to Michael, to light touch to all fingertips although it was diminished. There was good capillary refill to the index, middle and ring fingers and they were dusky. There were butterfly motions of the fingers. Radial and ulna pulses were strong and palpable. Dorsum of the hand was supple, as was dorsum of the forearm and volar aspect of the forearm was slightly tense.

Examination of the LUE revealed surface damage to the thumb web space, as well as to all fingers, especially the dorsum of the right and small fingers just proximal to the nail plate. There was good capillary refill to all the fingertips and the fingers were held flexed. Sensation was intact to light touch to all the fingertips according to Michael; however, sensation was diminished. There were butterfly motions to all fingers. Radial and ulna pulses were

strong and 2+. There was swelling of the hand and the volar surface of the wrist and forearm. There was no swelling of the dorsum of the forearm or the dorsum of the hand.

Admitting diagnosis was severe electrical burns to both hands with probable developing compartment syndrome on the volar aspect of the wrist and forearm. Michael was taken immediately to the OR where he underwent bilateral extended, carpal tunnel releases and forearm fasciotomies. Following surgery, he was admitted to the Burn Unit and was followed closely. Michael subsequently underwent the following operative procedures:

8/29/05

- Debridement of multiple area third-degree burns, bilateral UE's.

9/1/05

- Amputation of multiple fingers, right hand.
- Forearm fasciotomies and debridement of multiple wounds.
- Same procedure on the left hand and amputation of the little finger.

9/7/05

- Exploration of right forearm and wrist wounds.
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9/15/05

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9/19/05

- Exploration and debridement of left wrist and forearm wound.
- Repair of median nerve.
- Harvest of left lateral arm flap.
- Microvascular in-setting of the flap to the left forearm.
- Local tissue rearrangement, left upper arm and forearm area.

Michael was also treated for small full-thickness burn to the dorsum of his left foot. He had history of hypertriglyceridemia and was continued on his Tricor while in the hospital. He had hypertension and was treated with Norvasc, Hydrochlorothiazide and Lopressor. He was treated for anemia

secondary to acute blood loss and received blood transfusions. Hypokalemia was noted and he was treated with potassium. Level of pain on admission was 10 on scale of one to ten. Pain was treated throughout hospitalization with Neurontin, OxyContin and Oxy IR. Level of pain at discharge was rated 3-4/10.

Michael was discharged to home with instructions to follow up with primary care physician and the pain clinic for medication adjustment. He was to follow up with Dr. Patel for dressing changes and for additional incision and drainage and debridement. Activity level was as tolerated with increased ROM to his arms and hands. Discharge diagnoses:

- Electrical burns to bilateral hands and left big toe, S/P multiple incision and drainage, S/P amputation to the right hand second, third and fourth fingers and left hand ring and little fingers with multiple debridement, placement of Integra skin grafting and split-thickness skin grafting. He was to continue wound care and dressing changes and follow with Dr. Patel for further surgical debridement and skin grafting of his hands.
- Hypertension treated with Norvasc, Hydrochlorothiazide and Lopressor.
- Hypertriglyceridemia, treated with Tricor.
- Anemia secondary to acute blood loss, S/P blood transfusions.
- Contact dermatitis to right forearm, treated with Mycolog cream.
- Hypokalemia, improved after Potassium replacement.
- Pain, treated with Neurontin, OxyContin and Oxy IR.

Florida Hospital: 10/4/05 – 10/10/05

Admitted for further skin grafting and flap. Michael had debridement of the right wrist and forearm wound, harvest of the right lateral arm flap, microvascular insetting of right lateral arm flap to the right wrist, local tissue rearrangement and Doppler implantation. He also had debridement of skin graft to the right hand amputation stump, as well as debridement of the skin graft off the left first webspace. He was taken to the recovery room, had vasospasms and was started on a Cardizem drip to help decrease the spasms. He did have blood loss and was transfused with one unit of packed red blood cells. He was returned to the OR secondary to vascular compromise of his flap to the right wrist. Plastic surgery did exploration of the flap and redo arterial and multiple venous anastomoses, as well as local tissue rearrangement and again implanted the Dopppler. He was monitored closely following his surgeries and improved gradually without any further incidence and was discharged to home. He was to follow up with Dr. Patel and Vicodin was prescribed for pain.

Florida Hospital: 11/2/05

Michael underwent exploration of free flap of left wrist and forearm, debridement of multiple areas of tissue necrosis around the flap, free flap re-arrangement and local tissue re-arrangement to the wrist and the forearm. Michael tolerated the procedure well with no complications and was discharged to home.

Florida Hospital: 5/2/06
Michael presented to ER with complaint of pain in left chest and mild dizziness for past two weeks. He had history of being involved in MVA 2 weeks earlier. He saw his primary care physician last week and was told he needed a stress test. CT of the abdomen and pelvis were negative, as was chest x-ray. EKG was also performed. Michael was diagnosed with musculoskeletal pain. He was prescribed Lortab and discharged to home.

HEALTHSOUTH REHABILITATION: 12/20/05 – 5/1/06
Michael participated in hand and occupational therapy. He was missing right 2nd, 3rd and 4th digits at metacarpal phalangeal joint level. Right fifth finger had flexion contracture. Left 5th finger was missing at metacarpal phalangeal joint level. Michael rated his pain at rest to be 5-6/10 and 4-5/10 with ROM. He had severe scar tissue formation/contractures in digits, decreased active ROM, pain and decreased functional use of arms. OT was recommended 2-3X/week. Recommended modalities included scar tissue management, passive ROM, joint mobilization, active assisted ROM, splinting, therapeutic exercises and instruction in home exercise program.

Progress note dated 1/19/06 indicates that Michael presented with severe scarring over left 1st digit web space that interfered with left thumb abduction and over 5th web space of right 5th digit, which seemed to be radially deviating. Both areas had been splinted to avoid further contractures. Continuation of therapy was recommended to:

- Decrease scar tissue formation to moderate in hands to facilitate ADL's
- Increase passive or any active ROM in hands by 5-10 degrees to facilitate ADL's
- Decrease flexion contractures/avoid further contractions in hands

Last OT note dated 2/21/06 indicates that there was no significant progress to report. Michael was formally discharged from OT on 5/1/06 due to failure to show after 2/21/06. At discharge, he had not met any of his goals.

<u>Records Reviewed</u>:

Air Flight: 8/27/05
Florida Hospital: 8/27/05 – 9/28/05; 10/4/05 – 10/10/05; 11/2/05; 5/2/06
HealthSouth Rehabilitation: 12/20/05 – 5/1/06

Photographs of Michael's Injuries (In File)

ADDENDUM: 10/6/06

PATEL, RAJ M.D.: 7/25/06
Michael was seen for follow-up post reconstruction bilateral upper extremities electrical injures. On his left hand he has a web space contracture, which will require release with a flap and skin graft reconstruction later on. Also, in his left forearm, the flap is loose with extra skin. Flap excision and tightening will need to be done.

Michael's right upper extremity has more severe functional loss. There is hypertrophic and significant scarring around the lateral arm and the lateral elbow at the sight of the flap. He has extra tissue, loose tissue in the flap that can be surgically tightened. He has significant functional loss in the wrist. He needs an ulnar flexion of the wrist. He will need a tendon to provide a ulnar flexion. Dorsal flexion of the wrist is intact. He needs a flexor tendon function for the thumb and little finger. He has a contracture, which will need to be released and reconstructed. The tendon reconstruction is a two-step procedure. In the first step, tendon rods are inserted. In the second step, tendon grafts will be tethered to the spaces. He will need a two to three month interval in between before the tendon grafts can be done. The reconstruction may require more than one surgery. Because of his previous surgeries, all surgeries are going to be complicated due to the scarring. The need for future therapy was discussed.

A toe transfer to the right hand was discussed. Since he is missing the index, middle and ring fingers, the transfer of one or more toes can be considered to improve his function. It was explained that there is no good functioning hand prosthesis. The surgery requires microsurgery and there is always a risk of loss of blood supply to the toes. This procedure is especially risky because of previous electrocution injury and previous scarring. For now, I will try to improve his function by doing all the tendon work and then later on consideration can be given to transfers. Brachialis tendon is available on the right side for transfer. First, the right hand can be operated on and then later on the left hand can be operated on.

Records Reviewed:

Patel. Raj, M.D.: 7/25/06 (in file with letter to Dr. Patel)

Activities Of Daily Living

Sleep Pattern

Arises: 5:30-6:00 a.m.
Retires: 10:30-11:00 p.m.
Sleep Difficulties: There are times that he has trouble sleeping, but usually he sleeps well. He has difficulty dressing. He can pull his shirt over his head, but he can not do buttons or zippers. He can pull on his pants, but then his boxers will come up with the pants and he can not get them down. He has tried to go back to briefs, but he can not get them on. He can not put on socks, but he can put on some slip on shoes. He can not tie laces. He has no adaptive equipment. He can brush his teeth with set-up. He can urinate independently, but he has to have help wiping after having a bowel movement. Showering he can do by himself. He has a shampoo dispenser in the shower that he can press on to get shampoo. He uses liquid bath soap, because he can not hold a bar of soap. He uses a sponge to bathe with and a towel for intimate hygiene. He needs assistance with writing. He is not able to use a key board. He has no adaptive software for his computer to allow for voice control.

Independence In

Dressing: See note above.
Housework: None.
Cooking: He can not cook. He can not even make himself a sandwich.
Laundry: No.
Yard Work: No.

Social Activities

Organizations Pre/Post: None pre or post.
Volunteer Work Pre/Post: None pre or post.
Socialization Pre/Post: He did socialize prior to injury, and now he finds he stays at home much more.
Hobbies (Present): He tries to stay working to keep his mind occupied. He shares time with his kids.
Hobbies (Previous): Volleyball, basketball and hockey. He liked to ride dirt bikes and motorcycles.

Personal Habits

Smoking: No.

Alcohol: No.
Drugs: No.
History of Abuse and/or Treatment Programs: None.

Socioeconomic Status

Spouse: He is divorced but he indicates they are trying to reconcile.
Children: 5 children: ages 16, 15, 14, and two 5 year olds. His children live with their mothers.
Number in Residence: One, but he spends a lot of time with his ex-wife and children. Couple trying to reconcile.
Type of Residence: Two story house, but the only thing upstairs is a game room.

Income

Disability Policy: None.
W.C.: None.
S.S.D.I.: None.
Wages: Yes.
Food Stamps: No.
Other Income: None.

Current Financial Situation: He did not receive Worker's Compensation from this injury. He says he had AIG and it was only a supplement. They paid all of his bills, but there was no money left over for him. He continued to receive his salary from his employer during his recovery. In fact, he reports having missed very few days of work.

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: 11th grade. No GED.
Last School Attended: High School in Orlando

Apprenticeship/OJT: Learned current trade on the job.
Literacy: He can read, but writing is difficult.
Licenses/Certifications: Excavator and truck driver.
Miscellaneous Education Information: He is a licensed excavator and licensed to operate a semi-truck.

Military Experience

Branch: Not applicable.

Employment History

Released to Return to Work: He was not out of work for any extended period of time.
Work History Since Injury: He did lose some days from work, but he continued to work through his recovery and rehabilitation.

Employer: Ranico Transport; **City/State:** Orlando, FL; **Position:** Terminal manager; **Start Date:** 1986; **End Date:** current; **Schedule:** Full-time he estimates that he averages 70 hours of work per week. **Length:** 20 years; **Wage:** $800 / week. He is on salary so he is not paid overtime.; **Duties:** He manages and coordinates the trucks that work for his company.; **Reason for Leaving:** Still employed.

Observations

Orientation: Alert and oriented x's three.
Stream of Thought: Clear and rational.
Approach Toward Evaluation: Positive.
Attitudes/Insight: Good.
Appearance: Overtly impaired with obvious scarring and amputation.

Tests Administered

Michael was unable to complete the clinical interview, history and intake of four plus hours, along with testing in one day. His testing was rescheduled on two separate occasions, and was finally completed on 11/9/06.

As part of this evaluation, Michael is asked to complete the Slosson Intelligence Test-Revised-3; the Beck Depression Inventory-II; the Beck Anxiety Inventory; the Beck Hopelessness Scale and the Minnesota Multiphasic Personality Inventory-2, (MMPI-2).

On the Slosson Intelligence Test-Revised-3, Michael demonstrated a raw score of 112, with a mean age equivalent of 13.5 years, a T-score of 35, and a percentile rank of 7%. His total standard score (IQ) is 76 with a confidence interval of 9 (95%).

On the Beck Depression Inventory-II, Michael's score of four does not reach clinically significant levels. Although the depression scale on his MMPI-2 also remains within normal limits, it approaches clinical significance, and therefore, is not fully consistent with the Beck. The MMPI-2 is much less susceptible to denial and is likely a more accurate reflection of his current status. Clinical interview and test results are not consistent with DSM-IV-TR criteria for a finding of Major Depression.

On the Beck Anxiety Inventory, his score of fifteen does indicate a moderate clinical anxiety. This is consistent with findings on his MMPI-2. Clinical interview and test results do meet DSM-IV-TR criteria for a finding of Anxiety Disorder-Moderate.

On the Beck Hopelessness Scale, his score of two suggests a pessimistic outlook on his 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. His results on this scale are also consistent with his MMPI-2 results. Michael appears to be coping at a basic level with many of the psychological issues stemming from his disability, at least in the sense that he 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) subscales, 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 Michael'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. Michael's T-scores are well 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. Michael's scores do not exceed these parameters; therefore, his MMPI-2 is considered valid. There is no evidence of impression management and no indication of either "fake good" or "fake bad" profiles. He shows no indication of malingering in his clinical scales.

Michael demonstrates a significant elevation on scales six, eight and nine. Persons with this code type harbor intense feelings of inferiority and insecurity. They lack self-confidence and self-esteem. They often feel guilty about perceived failures. Michael likely experiences anxiety, depression and withdrawal from everyday activities. Feelings of hopelessness and pessimism are common, although Michael denies this on the Beck Hopelessness Scale. I believe he uses denial on this scale and on the Beck Depression Inventory. Individuals with this code type tend to be dependent personalities and tend to overreact to stressful situations. They demand a great deal of attention and often appear emotionally labile. The profile also reflects feelings of inferiority, low self-esteem, and feelings of inadequacy. Severe disturbance in thought process may be present.

Axis I: Anxiety Disorder-Moderate-300.02.
Adjustment Disorder with depressed mood-309.0.
Chronic Disability/Chronic Pain Disorder due to general medical condition and psychological factors-307.89.

Axis II: Deferred.

Axis III: S/P debridement of multiple areas of third-degree burns, bilateral UE's.
Amputation of multiple fingers, right hand.
Forearm fasciotomies and debridement of multiple wounds.
Same procedure on the left hand and amputation of the little finger.
Exploration of right forearm and wrist wounds.
Treatment of multiple wounds involving the upper extremity.
Left hand exploration and debridement of multiple forearm and hand wounds
Exploration and debridement of multiple wounds involving the forearm, wrist and hand.

Division and amputation of the left ring finger with a flap.
Graft application of the first webspace.
Right UE exploration and debridement of multiple wounds.
Reconstruction of stump.
Exploration and debridement of left wrist and forearm wound.
Repair of median nerve.
Harvest of left lateral arm flap.
Microvascular in-setting of the flap to the left forearm.
Local tissue rearrangement, left upper arm and forearm area.
Hypertension treated with Norvasc, Hydrochlorothiazide and Lopressor.
Hypertriglyceridemia, treated with Tricor.
Anemia secondary to acute blood loss, S/P blood transfusions.
Contact dermatitis to right forearm, treated with Mycolog cream.
Hypokalemia, improved after Potassium replacement.
Pain, treated with Neurontin, OxyContin and Oxy IR.
Decrease scar tissue formation to moderate in hands to facilitate ADL's.
Increase passive or any active ROM in hands by 5-10 degrees to facilitate ADL's.
Decrease flexion contractures/avoid further contractions in hands.

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

Axis V: Current GAF – 60.
Highest GAF in past year – 60.

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 on electrical injuries, complications associated with electrical injuries and finger amputations, and attention is paid to any practice guidelines for these diagnoses. All research is promulgated by multiple sources and cited in the Life Care Plan. Correspondence with treating physicians was also issued. All of these steps are taken to help in establishing the medical, case management, rehabilitation and psychological foundations for the Life Care Plan.

Michael remains significantly disabled secondary to the August 27, 2005 onset of disability. He will require continued medical management and future surgical revisions of his injuries. He could greatly benefit from the opportunity to return to occupational therapy in order to learn compensatory strategies for self care in ADL's, undergo evaluation and training with aids for independent function; and be assessed for proper adaptive equipment to enhance his independence.

Michael will require some attendant care to assist him with acitivites of daily living while he continues to undergo surgical revisions. As he completes his surgical requirements and participates in therapy to learn to care for himself, his need for assistance should be reduced. Case management services would be beneficial to help him coordinate services and provide support. In order to be independent he, will require adaptive equipment and the training to properly use this equipment. He will continue to require household maintenance and cleaning services through life expectancy, along with medical monitoring and care.

A Vocational Worksheet, attached as Appendix B, outlines Michael's capacity to earn pre-injury as compared to his capacity to earn post-injury, along with his 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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PAUL M. DEUTSCH & ASSOCIATES, P.A.

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