CLIENT: **Nathan Brett**
DATE OF EVALUATION: **January 11, 2006**
DATE REPORT INITIATED: **January 18, 2006**
REPORT FINALIZED: **February 3, 2006**

Nathan Brett is a 31-year-old Caucasian male seen for evaluation in my office in Oviedo, Florida. He presented unaccompanied to this evaluation. Nathan 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: Nathan Brett; **Social Security #:** xxx-xx-xxxx; **Address:** 1212 Lakeshore Blvd. Orlando, FL; **County:** Seminole; **Closest Metro Area:** Orlando; **Phone:** xxx-xxx-xxxx; **Birthdate:** 10/7/74; **Age:** 31; **Sex:** Male; **Race:** Caucasian; **Marital Status:** Single; **Birthplace:** Florida; **Citizen:** Yes; **Elementary/Secondary Education:** Elementary and High School in Florida; **Employer at time of injury:** Eastfork Truck Sales; **Position/Grade:** Sales *''Buying, selling & trading one ton trucks and lower.''*; **Bilingual:** No; **Glasses:** No; **Dominant Hand:** Right; **Height:** 5'11''; **Weight (present):** 236 pounds; **Weight (pre-injury):** 220 pounds; **Date of Onset:** 3/29/04.

History: Nathan was involved in a motor vehicle collison on 3/29/04. Nathan notes he retained consciousness at the scene of the accident. He recalls that he pulled himself from the vehicle and realized instantly that he could not put weight on his lower body. He almost fell to the ground, but caught himself on the *''drip rail''* of the passenger van and held on until his *''buddies''* came around and pulled him out. *''The cops were there, but they were afraid to come get me because they were afraid the tanker might explode. My buddies came and pulled me away from the scene also fearing the tanker might explode. They pulled me back to where the officers were and we waited for the ambulance, which arrived roughly fifteen minutes later. It is hard to judge time, but it seems like I was in the ambulance for fifteen minutes before we left for the hospital. After they arrived, they strapped me onto a gurney and secured me.''* Nathan indicates he remained awake and alert throughout all of this. He was taken to Orlando Regional Medical Center.

Seminole County EMT records indicate he was a back seat passenger, but Nathan indicates he was in fact a front seat passenger. He was found to be alert and complaining of severe left hip pain. On arrival in the ER, Nathan notes he was untreated for awhile and in a great deal of pain. They finally administered morphine and then conducted x-rays. It was determined that he had a left acetabular fracture. *''They told me something about my pelvic bone being shattered and that I needed surgery right away. I decided I wanted to be treated by Dr. Martin. He had performed surgery on me before and has a good reputation. I assume my dad got in touch with him and arrangements were made for a transfer to Eastfork General Hospital.''* The transfer was accomplish and he was admitted to Eastfork General Hospital.

Loss of Consciousness or Altered State of Consciousness: Yes.
Length of Unconsciousness or of Altered State: No loss of consciousness.
Independent Recall: Full, independent recall of all events.

Rehabilitation Program(s) [In/Outpatient Since Injury]: Admitted to Eastfork General Hospital on 3/29/04 with a primary diagnosis of fracture acetabulum-closure (808.0). Secondary diagnoses were: hypovolemia, AC posthemorrhagic anemia, hypopotassemia, elevated blood pressure without hypertension, contusion of right knee. Nathan indicates he has had MRI only of the right knee, but both knees feel the same and Dr. Martin said both knees would need replacement.

On 3/29/04, Dr. Martin conducted an ORIF of the left femur. Nathan indicates he put in a plate and six screws. *''He told me it killed the top of the hip, but being young he had to take the chance that it would come back. Nevertheless, he had to come back six months later on August 13, 2004 and complete a total hip replacement. I remember because it was Friday the 13th and the same day Hurricane Charley hit.''*

Nathan notes that after the 3/29/04 ORIF, he had PT initiated in the hospital. They started getting him up from the bed the day after surgery. His right knee was severely swollen from the accident and his left knee also hurt severely as well. It was the left knee which struck the dash and drove the femur up through the hip. The first thing he noticed on having the PT getting him up was the knee pain and then pain throughout the hip. The PT worked with him daily, but he indicates he was on morphine and his memory for the number of times the PT came into the room was poor. PT continued through discharge on 4/05/04.

Nathan was discharged to his sister's home with a prescription for a wheelchair, walker and a bedside commode although the bedside commode was never provided. He notes

he was, ''provided a bunch of medication including one that was delivered by abdominal injection. This was Lovenox and his sister provided the injection. He was provided services by Eastfork Home Health. *''If I am not mistaken, they just came twice. They check my blood pressure and my wound. I was paying out of pocket for all of these costs. I've paid off everyone but the hospital and I am making payments to the hospital. I still owe them at about $70,000. Physical therapy started the next day after I got to my sister's house. I was on Percocet to try and ease the pain. The PT came a few times and taught me the exercises. Once I had them down, she told me to call her if I had a problem, but then she left me to continue them without her attendance or supervision. I remained very disciplined about doing the exercises. I still have the exercise sheet she had me doing. I did the exercises once or twice a day, and continued this for three weeks and gradually began tapering down. I did get to a point where I was walking without the walker or cane, but I was almost walking sideways because of the pain and the way I had to favor my left hip. It still hurts now.''*

Finally, Dr. Martin determined that surgery was going to have to be done. *''He said I could have the hip fused and he gave me several other choices. He told me there was not a lot of literature on 29 year olds getting total hip replacements, but there was no doubt I was going to have to get it replaced in the future. I made the decision to go with the hip replacement. This was done on August 13, 2004. I had some relief of pain, but there is still pain and throbbing in the pelvis and the whole hip area, along with pain and numbness in the both knees. Dr. Martin said the feeling that I have lost in the base of the knees would come back some day, but he indicates I will have to have both knees replaced some day. I have fallen to the ground twice when the right knee gave out on me. The first time I caught myself on the couch before I struck the ground and the second time I caught myself on the bed.''*

''After the hip surgery, I had PT from the same lady. I had been in the hospital from the hip surgery five days to a week. I was discharged to my sisters house again and stayed there three weeks to a month. I had about the same amount of home health services, just two visits at the most. PT came out similar to the first time. She came to teach me the exact same exercises. She came out for several days, encouraged me to get up out of bed, made sure both my sister and I knew the exercises, but she knew I was paying out of my pocket so she kept the visits to a minimum.''

Currently prescriptions are costing me over $600 per month.

Prior Medical History: 1993, approximately, left foot run over at auto auction. Initial x-rays at the hospital did not provide a diagnosis, but it remained sore and painful for two years, so he sought help from Dr. Martin who diagnosed a broken sesmoid (sp?) bone. He did surgery for repair. Recovered fully.

''I have had stitches and minor injuries, but nothing serious. Mostly as a child.''
No surgeries other than a couple of teeth pulled.
Never saw a psychologist of psychiatrist other than noting going to ''Counseling Associates''. In 2002, I refused to take a breathalyzer test when stopped for reckless driving. Part of the sentence was going to Counseling Associates which involved my seeing a counselor for a time.

No history of alcoholism or drug abuse. No felony convictions.
Never diagnosed with ADD or ADHD while in school.
He does note he was in several SLD classes. Also notes he graduated and never failed a grade. *''I never did like school and never tried as hard as I should have.''*

Chief Complaint(s)

Current Disability

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

Nathan, *''The way I understand it is I had a pelvic bone fracture and that is where it appeared the plate was, but I don't know all the right words for the bones. Eventually, I had to have a total hip replacement. Currently my primary problem is pain in my left hip including my pelvis and going through to my groin. I have pain in my mid and lower back, which I think is from my limping. I have pain in both knees with my right knee hurting a little bit more than my left, but they are both pretty bad.''*

<u>Left Hip & Pelvis</u>: Never completely pain free in the left hip and pelvis. *''It always aches and a lot of times it throbs. Taking Percocet you can forget how bad it can hurt.''* The following ratings are based on the fact that he is on Percocet. The pain varies in intensity throughout the day. The lowest the level of pain will reach in a 24-hour day is a three or four. The average pain he experiences the majority of the day is a five, but it can vary somewhat because some days he is on his feet more than others. The worst level the pain reaches is a nine. It can reach a nine most often when it is raining and cold, if he is sitting in a car over two hours, or if he has to be on his feet more

than a couple of hours without a break. The pain will reach a nine at least a couple of times per week. He has to attend the auto auction every Tuesday and Wednesday and occasionally Monday and Thursday and these are very tough days. Attending the auction is a principal part of his business.

Right Knee: Never completely pain free in the right knee. *''It always aches with occasional sharp pains. It is helped by the Percocet.''* The following ratings are based on the fact that he is on Percocet. The pain varies in intensity throughout the day. The lowest the level of pain he will reach in a 24-hour day is a three. The average pain he experiences the majority of the day is a three to four, but it can vary somewhat because some days he is on his feet more than other days. The worst level of pain he reaches is an eight. It can reach a eight most often when it is raining and cold, if he is sitting in a car over two hours, or if he has to be on his feet more than a couple of hours without a break.

Left Knee: Never completely pain free in the left knee. ''It always aches with occasional sharp pains. It is helped by the Percocet.'' The following ratings are based on the fact that he is on Percocet. The pain varies in intensity throughout the day. The lowest level of pain he will reach in a 24-hour day is a three. The average pain he experiences the majority of the day is a three to four, but it can vary somewhat because some days he is on his feet more than other days. The worst level of pain he reaches is a seven to eight. It can reach a seven to eight most often when it is raining and cold, if he is sitting in a car over two hours, or if he has to be on his feet more than a couple of hours without a break.

Mid & Low Back: Never completely pain free in the mid to low back. *''It always aches with occasional throbbing. It is helped by the Percocet and the Flexeril.''* The following ratings are based on the fact that he is on Percocet. The pain varies in intensity throughout the day. The lowest level of pain he will reach in a 24-hour day is a three. The average pain he experiences the majority of the day is a five, but it can vary somewhat because some days he is on his feet more than other days. The worst level of pain he reaches is an eight. It can reach an eight most often when it is raining and cold, if he is sitting in a car over two hours, or if he has to be on his feet more than a couple of hours without a break.

Anticipated Treatments: Nathan anticipates future bilateral knee replacements and future replacements of his total hips. Nathan indicates that, *''the average replacement for the hip is fifteen years, but he told me he did not have literature*

on younger hip replacements. He also told me I would have problems with arthritis in all the areas where I have had injuries.''

Psychosocial Issues

Patient: Nathan admits to feeling depressed and *''I drink more than I should now that I am hurt.''* He denies being real anxious but, *''I am on Zoloft for anxiety. I do feel tense and stressed.''* (see testing). *''I feel like jumping off the top of a building sometimes. I wouldn't do it, but I have thought about it. I am not brave enough to do anything like jump off a building.''* (see Beck Suicide Index).

Family, Emotional Impact on Spouse/Children: Nathan indicates his family is adjusting well. *''My dad is probably doing the worst. We, the family, have all worked together at the truck sales so long. I don't make the money I use to make. I am on a fifty-fifty with the company, so whatever I lose the company loses the same amount, so I have hurt the company with all of this. If I only make $75,000 then I have grossed $150,000. If I am down $100,000 then the company is down $50,000 for the year.''*

Physical Limitations

Loss of Tactile Sensation: He has numbness on the scar area on his left hip from the initial injury and the hip replacement surgery. Both knees have numbness from the impact. The scar on his left hip is also hypersensitive to even light touch.

Reach: He has full range of motion with his upper extremities, but if he has to stretch to reach something necessitating he stand on his toes he has pain in his lower body, hips and knees.

Lift: He can lift with his upper extremities and he indicates that he has not lost upper body strength, but he is unable to lift and carry anything. He estimates that the heaviest thing he can pick up and carry is maybe 30 pounds.

Prehensile/Grip: Intact bilaterally.

Sitting: He has pain in his mid to lower back, left hip and both knees with extended sitting. He can sit for no more than a couple of hours before he has to get up and move around. He does note that when sitting, he is constantly squirming to find a comfortable position.

Standing: He is limited to standing for brief periods of time only. He notes that when standing, he typically will lean on something and if a chair is available he will sit rather than stand.

Walking/Gait: He can walk for about a 1/4 of a mile at a time, and he does do this related to his business, but walking is always difficult and will increase his pain.

Bend/Twist: He is limited in his ability to bend and twist at the waist and notes that he can no longer swing a golf club.

Kneel: Nonfunctional.

Stoop/Squat: Nonfunctional.

Climb: He is limited in his ability to climb stairs or steps and he notes that when he does have to climb he has to have a rail to hang on to.

Balance: He does favor his left side when walking and he frequently is off balance because of this.

Breathing: He indicates that he use to walk five miles a day, and he has noticed now that he will get out of breath much easier because he is out of shape due to an inability to exercise.

Headaches: No headaches.

Vision: Intact.

Hearing: Intact.

Driving: He can drive, but after about 2 hours, he will have to stop and stretch. If he is on a long trip, he usually leaves the driving to someone else.

Physical Stamina (average daily need for rest or reclining): He tires much more easily and he attributes some of his fatigue to his medications.

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: No.
Noise: Yes, becomes very irritable and aggravated.
Stress: Yes.

Present Medical Treatment

Doctors Last	Specialty Seen	Phone	Fax	Frequency	
Loren Martin MD	Orthopedic Surgeon			1X/month	1/4/06
Anthony Hanford, DO	PCP			1X/6 weeks	12/05

Medication	Strength	Frequency	Tablets	Purpose	Prescribed by
Percocet	7.5 mg/325	1-2X/day	60	Pain	Martin
Flexeril	10 mg	3X/day	90	Muscle Relaxant	Martin
Ambien CR	12.5	1X at night	30	Sleep Aid	Martin
Zoloft	100 mg	1/day	30	Anxiety	Hanford
Lisinopril -HCTZ	20/12.5	1/day	30	Blood Pressure	Hanford
Ibuprofen	600 mg	As needed	60	Pain	Martin

Over-the-Counter Medication(s): Zantac 150mg, 1X/day.
Drugstore and Phone Number: CVS .
Assistive Devices: He does use a scooter at the auto auction. None at this time, but he will need crutches, walker and cane as he progresses through his surgeries.

Medical Summary

Date of Medical Summary: 1/12/06

Nathan Brett is a 31-year-old Caucasian male who sustained orthopedic injuries as the result of a motor vehicle accident.

SEMINOLE COUNTY EMERGENCY SERVICES: 3/29/04
Responded to scene of motor vehicle collision. Report indicates that Nathan was restrained rear seat passenger of vehicle that hit a tractor-trailer that turned over on its side. He was sleeping at the time of impact. Upon arrival, he was found standing with other passengers of the vehicle being attended to by sheriff and police officers. He complained of severe hip pain. He was fully immobilized to a long spine board, secured to stretcher and loaded into the

ambulance. LE assessment revealed no obvious trauma. He was transported to Orlando Regional Medical Center without incident.

EASTFORK GENERAL HOSPITAL: 3/29/04 - 4/5/04; 8/13/04 - 8/17/04

Eastfork General Hospital: 3/29/04 - 4/5/04
Arrived via ambulance. History indicates Nathan sustained injuries, which included a right knee injury, as well as a fracture dislocation to his left hip. He was initially taken to Florida Hospital (place of initial treatment is conflicting) where he was evaluated in the emergency room. He was then transferred to Eastfork General Hospital for definitive management. He denied loss of consciousness or neck injury. He did complain of some back pain.

Examination revealed mild tense effusion of the right knee. CT of the pelvis revealed a comminuted, displaced fracture at the left acetabulum with an associated hematoma within the gluteus musculature on the left. There was no obvious fracture of the left femoral head. Pars intra-articularis defect was incidentally noted at the L5-S1 level.

Nathan was taken to the OR on date of admission where he underwent open reduction and internal fixation using three interfragmentary screws, as well as reconstruction plate.

Hospital course was significant for post-operative anemia and right knee pain and swelling.

MRI of the right knee on 4/2/04 revealed:

- Two separate fractures of the articular surface of the tibia. The posterior fracture undermined the attachment of the posterior cruciate ligament, rendering that ligament unstable.
- Tear of the deep portion of the posterior limb of the medial meniscus.
- Hemarthrosis.
- Some soft tissue contusion posterior to the femur.

Nathan remained stable following surgery and was discharged to the care of his sister. Home health was arranged for nursing services and physical therapy. Nathan stated he was going to borrow a walker and wheelchair from his family. He refused a bed-side commode. (Note that Nathan had no health insurance and had to pay for equipment and services out-of-pocket.) Functional status at discharge was weight bearing as tolerated on RLE and partial weight bearing on LLE. He was able to ambulate 225 feet with rolling walker and supervision X 1.

Eastfork General Hospital: 8/13/04 - 8/17/04
Admitted for total left hip arthroplasty secondary to avascular necrosis. History indicated Nathan was followed in Dr. Martin's office following left hip ORIF and developed avascular necrosis. He underwent left total hip replacement, uncemented, using a Natural-Hip system, size 3 left femoral stem porous coated, size 59 porous coated shell, and size 38 X 59 acetabular Durasul insert with a 38 mm neutral Cobalt Chrome Head.

Nathan tolerated the procedure well. He had mild anemia post-operatively, as well as nausea and pruritus, which resolved when taken off Morphine Sulfate. He was started on PT on post-operative day #1. Home health PT services were arranged and he was discharged. Activity level was weight bearing as tolerated and ambulation with walker. Medications included Percocet and Lovenox.

EASTFORK HOME HEALTH: 4/6/04 - 4/28/04; 8/18/04 - 8/26/04

Eastfork Home Health: 4/6/04 - 4/28/04
Provided PT services S/P ORIF of left hip. At time of initial evaluation, Nathan was assist with dressing, minimal human assist with transfers or with use of assistive device, assist with use of device to walk alone, supervision or assistance to negotiate stairs/uneven surfaces. PT was recommended 1-3X/weekly for strengthening and progressive gait training.

At time of discharge on 4/28/04, Nathan was independent with all aspects of mobility with exception of use of assistive device to walk alone or negotiate stairs/steps or uneven surfaces. He was independent with all ADL's.

Eastfork Home Health: 8/18/04 - 8/26/04
Nathan participated in PT 1-3X/week S/P left total hip arthroplasty. Therapy consisted of gait and transfer training, strengthening exercises, and education in home exercise program and hip precautions. At discharge, he was independent with ADL's and transfers. He required use of assistive device to walk alone and supervision or assistance to negotiate stairs or steps or uneven surfaces. Nathan requested discharge as he felt he no longer needed therapy. He was doing his exercises and felt great.

MARTIN, LOREN M.D.: 4/12/04 - 9/28/05

Martin, Loren M.D.: 4/12/04
Orthopedic follow-up S/P ORIF of left hip and isolated posterior cruciate ligament injury to right knee. Nathan was ambulating with a cane. Left hip wound was healed and swelling was minimal. Hip flexion was 90 degrees. Internal and external rotation was 10 degrees. Abduction was 45

degrees. Right knee had mild effusion and positive posterior drawer at 90 degrees greater than +1.

Conservative treatment to right knee continued. Therapy and medication continued for left hip.

Martin, Loren M.D.: 4/20/04
Nathan continued to ambulate with a cane. He had moderate discomfort that was well controlled with Percocet. Home PT was continued along with Percocet. He was cautioned against performing any high impact activities. Cane use continued.

Martin, Loren M.D.: 5/12/04
Nathan was ambulating without a cane or crutch. He had mild effusion of right knee. Passive flexion to left hip was 90 degrees, abduction was to 45 degrees and internal and external rotation was 10 degrees. Weightbearing as tolerated was recommended. He was having some problems with his right knee and continuation with activities as tolerated was recommended. He would possibly need to address the posterior cruciate ligament instability to right knee at later date.

Martin, Loren M.D.: 6/2/04
Pain to bilateral knees and left hip was reported but was controlled with Percocet. Nathan was advised to continue weightbearing activities as tolerated. He was started on Bextra, an anti-inflammatory to improve signs and symptoms of traumatic arthritis.

Martin, Loren M.D.: 6/25/04
Nathan still complained of some left hip pain with limited function. He had tenderness in the anterior aspect of the left groin, as well as the lateral aspect of the left hip. Right knee showed mild effusion, which was improved from last visit. He had some medial compartment discomfort consistent with his posterior cruciate ligament injury.
Impression:

- S/P ORIF of left acetabulum fracture with continued discomfort at 12 weeks
- Continued synovitis of right knee consistent with posterior cruciate ligament injury.

Nathan was allowed to continue ambulating. Anti-inflammatory and pain mediation continued.

Martin, Loren M.D.: 7/14/04
Nathan complained of increasing pain and limp to left hip with limited motion and limited motion to right knee. X-rays of the pelvis and lateral left hip showed what looked like avascular necrosis to the femoral head secondary to the significant trauma with joint space collapse.

CT of the pelvis was ordered. Medication renewed. Nathan would possibly need further surgical intervention to handle the traumatic arthritic change in left hip.

Martin, Loren M.D.: 7/26/04
Pre-operative visit. Nathan was scheduled to undergo total hip replacement because of severe collapse and arthritic changes in left hip. Plan was to proceed with surgery in August.

Martin, Loren M.D.: 8/23/04
Nathan was S/P left total hip replacement. Pain and anti-inflammatory medication continued.

Martin, Loren M.D.: 9/7/04
Nathan was doing well but continued to have occasional moderate discomfort with increased activities. Otherwise, he was ambulating without the assistance of a crutch or cane. ROM was improving. He was continued on full weightbearing activities as tolerated.

Martin, Loren M.D.: 10/11/04
Ambulation continued to improve. Occasional hip discomfort was reported. Nathan was taking Percocet for pain and Celebrex. He described some persistent anxiety.

Examination revealed blood pressure of 184/123. He had improving ROM of right hip. Nathan was counseled regarding the need to seek medical attention in the near future for his hypertension and the need to speak to his primary care physician about managing his anxiety. Medications and weightbearing as tolerated continued.

Martin, Loren M.D.: 11/10/04
Nathan was doing well. He continued to improve his ADL's. He had mild discomfort that was controlled with Percocet. Weightbearing activities as tolerated continued.

Martin, Loren M.D.: 1/22/05
Letter to attorney summarizing treatment. Nathan was 5-1/2 months S/P left total hip replacement. The right posterior cruciate ligament injury had been treated conservatively.

The right knee definitely showed signs of instability, as well as limited motion, which would make it difficult for him to squat, kneel or stoop. The left total hip also would negate stooping, crawling, climbing ladders or heights. Because it was uncemented, it would take approximately six months to a year for it to heal and incorporate, which would leave him with some discomfort and limited motion.

As of last clinic visit on 11/10/04, he was weight bearing as tolerated with both LE's. He had some mild discomfort to his hip, as well as his knee that was well controlled with

Percocet. He was independent with ambulation. The possibility of surgery was discussed, especially to the right knee for stability in regards to his posterior cruciate ligament. It was recommended that he wait a satisfactory amount of time to allow his total hip to heal.

As far as his left knee, due to the nature of the mechanism of injury for the fracture dislocation to his left hip, he was experiencing discomfort to his left knee at present, which would possibly prompt work-up, as well as possible arthroscopy and debridement of that knee. At this point, no ligamentous instability to that knee had been documented.

It was felt that Nathan had sustained significant severe injury involving his left hip, as well as severe and significant injury involving the right knee. Both were felt to be permanent and would require continued medical management and follow-up, as well as continued treatment with medications, as well as limited function.

Martin, Loren M.D.: 8/22/05
Nathan complained of left hip symptoms including pain with activities of twisting, walking a distance and weight bearing. He had right knee pain with activity, twisting, squatting, range of motion, walking a distance and weightbearing.

Examination of left hip revealed extension of 10 degrees, flexion of 100 degrees. Abduction was 30 degrees, internal rotation 15 degrees, external rotation 15 degrees and abduction was 10 degrees. He had mild pain with ROM.

Examination of right knee revealed grade 2 posterior drawer and active/passive flexion greater than 120 degrees. Impression: Chronic right knee posterior cruciate ligament instability and S/P left total hip arthroplasty, uncemented, for traumatic avascular necrosis.

Nathan was given prescriptions for Celebrex, Percocet and sleep aids. No activity restrictions were imposed.

Martin, Loren M.D.: 9/28/05
No change in symptoms or examination. Medications continued. There were no activity restrictions. Plan was to follow up in one month.

SEMINOLE RADIOLOGY CENTER: 7/22/04
CT of the left hip revealed:

- Flattening of the left femoral head identified, consistent with avascular necrosis
- Evidence of prior surgery with some fragmentation posteriorly in the inferior pubic ramus in the posterior margin of the acetabulum which was probably related to

post-surgical changes, however, those fragments were not fused at this time.

- Joint effusion
- Degenerative changes identified along the acetabular margin with the femoral head coming in contact with the acetabulum.

HANFORD, ANTHONY D.O.: 11/22/04; 1/21/05

Hanford, Anthony D.O.: 11/22/04
One month follow up of blood pressure and anxiety. Nathan reported doing better with blood pressure. He was tolerating Lisinopril. He still had some anxiety, kind of lax in the wings, as far as that goes. He was taking Paxiva, the generic for Paxil at 20 mg a day and plan was to increase that dosage and return in six weeks for follow up. Assessment: (1) Anxiety (2) Hypertension.

Hanford, Anthony D.O.: 1/21/05
Visit for fasting lab work and follow up of anxiety. Nathan stopped taking his medication and was trying to beat his anxiety himself. Plan was to obtain blood work and hold off on any changes in anxiety medication. If he wanted, he could try Zoloft.

DEPOSITION OF NATHAN BRETT: 11/22/05
Graduated high school. Has no additional schooling (Pg. 6). Currently buys and sells cars. Works for his father and he has for his whole life. He also works for two other dealerships. Business is Eastfork Truck Sales. He is independent contractor (Pg. 7). Also buys for Eagle Ford and Grayson Ford. Has three sources of income (Pg. 8). Does business wholesaling (Pg. 9).

He was not rendered unconscious in the accident (Pg. 76). Following the impact, he had pain in both his knees and his left side. It was his lower back and hip area (Pg. 83). He was taken initially to Orlando Regional Medical Center where he was x-rayed and advised he needed surgery immediately. He requested transfer to Eastfork Hospital to be treated by Dr. Martin, whom he knew. (Pg. 92).

He has to have additional treatment to his knees but has not as of yet. Dr. Martin told him he had to get both knees replaced (Pg. 97). In the very near future is what he made it sound like. They were waiting as long as possible as Dr. Martin advised that once you replace them, you have to get them done every so many years (Pg. 98).

Following hip replacement, he still had pain. Some days it hurts like it did pre-replacement (Pg. 98). He receives treatment for anxiety by general practitioner. He was placed on Zoloft. The anxiety started after the accident

(Pg. 99). He describes the anxiety as *''feeling like something's sitting on you and choking you and you're sweating--—I've got anxiety now. You just-—you never know when it's coming and when it's going.''* After the accident, he went to his doctor for blood pressure and anxiety, panic attacks to try to figure out what was wrong with him (Pg. 100).

All his stress revolves around the accident. *''You know, I hurt every single day. It's just everything-—I don't make the money I used to make, so therefore, I don't have the money that I had and-—just a bunch of things involved.''* He hurts all the time, sometimes worse than others. It hurts from his belly button down (Pg. 101). His left leg. He started having lower back problems he assumes from the collision, from the impact. He remembers feeling pain in low back shortly after the accident. He has mentioned pain to Dr. Martin but like Dr. Martin says, *''Well, with your impact, I'm surprised you're walking. In other words, they're saying my back is my least concern right now, basically''* (Pg. 102).

His left hip aches and hurts all the time. It hurts if he steps on it wrong, if it's cold, if it rains. Dr. Martin told him with his injury, *''You'll hurt every day, forever''* (Pg. 103).

His right knee gave out on him once already. He can not squat or kneel. It hurts 24 hours/day, 365 days a year. *''More of a mild, spur, type of thing''* (Pg. 104). Same with the left knee, it feels the same. He has not had MRI of left knee. Dr. Martin has advised that he will need both knees replaced in the near future, but to put it off as long as he can stand it (Pg. 105).

If he steps on his left leg wrong or on uneven pavement or something, it gives a shocking feel. That is because when they replace the hip, they drive a metal rod down in your leg. It hurts most of the time. He is able to walk without an assistive device. Since the accident, the longest he has walked has been probably 1/2 mile (Pg. 106). He can not exercise. He can't run or jog. Walking on uneven ground is tough (Pg. 107).

He believes he has lost income since this accident (Pg. 108). This year he made approximately $35,000. The decrease is *''Because I hurt every day. I don't feel like beating up the pavement out there at the auctions like I need to and get in and out of the car. It's just when you don't feel good, you don't feel good. I hurt''* (Pg. 113). He is sure he has lost customers over the last year. He has not bought a car for Eagle Ford since his hip replacement (Pg. 114).

He tries to work every day. It may be for just a couple of hours. He has worked eight-hour days since the accident but has to sit down and rest often (Pg. 115).

Golf is primary activity he can no longer engage in. He played at least 2-3 times/week or four (Pg. 118). Handicap was probably 18-20 and he shot around 90. He is not able to play golf now (Pg. 119). Time will tell if he can ever play again, but if able to it is not going to be the same (Pg. 119). Dr. Martin did not tell him he could not play golf. He was told he could not ski, jump or run (Pg. 120) anything that jarred his body; play tennis, play basketball, play softball, none of that. It depends as far as golf, ''*I mean I can't twist or turn. In the future, I doubt it, but I don't know*'' (Pg. 121). He can't throw a football or do any running. He used to power-walk all the time (Pg. 123).

He feels he can not get around well enough to do his job (Pg. 125). Dr. Martin told him his hip might last around 15 years (Pg. 126). He believes his lack of mobility is causing him to earn less money. He is unable to walk up and down the building at the auctions or look underneath cars to inspect (Pg. 127). The only other way to obtain cars is through trade-ins. But you still have to get out and walk around them. He can't look under them because he can't squat down to do that. He has not talked to his Dad about working in some other capacity, as that is not what he is interested in (Pg. 128).

He has been fishing a few times since the accident. He can fish for only a little bit, because he has to take Percocet when he gets out there and gets sick as a dog. He thinks his fishing days offshore are about done (Pg. 130). He used to love riding a wave-runner but has not done that since the accident (Pg. 136).

He can climb steps if there is a handrail to help offset some of his weight. He can operate a motor vehicle and has handicap sticker. He can perform ADL's but sex is a little tough (Pg. 137).

He is on blood pressure medication, Percocet, Zoloft and Ambien (Pg. 147). He takes Ambien to sleep, as he was waking up every night with the accident flashing in his head. He has not considered seeing a professional for that. The Ambien does help him sleep (Pg. 149).

Records Reviewed:

Seminole Radiology Center: 7/22/04
Seminole County Emergency Services: 3/29/04
Income Tax Returns and W-2's: 1998 - 2004
Medical Bills
Martin, Loren M.D.: 4/12/04 - 9/28/05

Eastfork Home Health: 4/6/04 - 4/28/04; 8/18/04 - 8/26/04
Eastfork General Hospital: 3/29/04 - 4/5/04; 8/13/04 - 8/17/04
Hanford, Anthony D.O.: 11/22/04; 1/21/05

Depositions Reviewed:

Brett, Nathan: 11/22/05

Activities Of Daily Living

Sleep Pattern

Arises: 8:00 a.m.
Retires: 12:00 a.m.
Average Hours Sleep/24 Hours: 5 to 6 hours even with medication.
Sleep Difficulties: He has to take Ambien to sleep. He usually takes this medication every night. He has recently had to increase to two Ambien, because one was not helping anymore. He has been on some type of sleep medications since his injury. He says without the medication he does not sleep at all. He notes that he did not take the medication last night for fear he would miss this appointment and he only slept about one hour last night.

Independence In

Dressing: He has difficulty washing and dressing his lower body, but he has learned to compensate and do these tasks.
Housework: He can do light chores like vacuum and wash dishes, but heavy cleaning he has to hire someone to do.
Cooking: He does not do much cooking, and when he does, he will sit on a stool.
Laundry: He can do this independently.
Yard Work: He has a friend that does his yard work for him.

Social Activities

Organizations Pre/Post: Elks pre and post.
Volunteer Work Pre/Post: Helped friends and neighbors, but nothing organized.
Socialization Pre/Post: He feels he is able to socialize the same as he did before. Socializing is part of his business.
Hobbies (Present): No new hobbies.
Hobbies (Previous): Golf, speed walking, any physical or athletic activities. He can not play football or basketball with his nephews. He can no longer do running activities.

Personal Habits

Smoking: No.
Alcohol: Social basis only.
Drugs: No.
History of Abuse and/or Treatment Programs: No history of abuse.

Socioeconomic Status

Number in Residence: One, lives alone, but he is in the process of moving in with his grandmother to help her.
Type of Residence: Single story home. Only one step.

Income

Disability Policy: No.
W.C.: No.
S.S.D.I.: No.
Wages: Yes.

Current Financial Situation: He had no health insurance at the time of injury. In fact, he notes that he has never had health insurance. He indicates that he has managed to pay all of his medical bills except the hospital and he is making payments on that account.

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: Clermont High School
Apprenticeship/OJT: Wholesale used car dealer.
Literacy: Yes.
Licenses/Certifications: No.

Military Experience

Branch: Not applicable.

Employment History

Released to Return to Work: Yes.
Work History Since Injury: He did miss work, but he was able to do business on the phone. He works with his father, so the business continued while he recovered. He buys used vehicle trade-ins or at auto auction, and most sales are dealer to dealer, but the family business does have a used car lot also. He now can not get around like he use to and this has directly impacted his business. Also his physical ability to get the trucks ready for sale has changed. Getting around at the auto auction has become very limited. He use to walk 5 miles every Tuesday at the auction, now he is using a golf cart, but the auction is going to prevent this due to liability. Just his ability to get under the cars and look in them, is more difficult. He use to buy for three other dealers for a flat rate and he can no longer do this, which impacts his income.

He earns 50% of what he sells, and the company earns the other 50%. In 2003 he earned approximately $100,000, which means the company made $100,000. In 2004, he estimates that he earned about $60,000. In 2005, he estimates that he earned in the mid to upper $30,000. He does have his 1099s that will help to quantify the financial impact on his business.

Employer: Eastfork Truck Sales; **City/State:** Orlando, FL; **Position:** Sales; **Start Date:** 1988; **End Date:** Present; **Schedule:** Full-time; **Length:** 18 Years; **Wage:** Averages $80,000/year; **Duties:** Buying and selling cars/trucks

Observations

Orientation: Alert and oriented times three.
Stream of Thought: Clear and rational.
Approach Toward Evaluation: Positive.
Attitudes/Insight: Good.
Appearance: Good.

Tests Administered

As part of this evaluation, Nathan is asked to complete the Slosson Intelligence Test, (SIT-R3); the Beck Depression Inventory-II; the Beck Anxiety Inventory; the Beck

Hopelessness Scale; the Beck Scale for Suicide Ideation and the Minnesota Multiphasic Personality Inventory-2, (MMPI-2).

On the Slosson Intelligence Test-Revised-3, Nathan demonstrated a raw score of 140 with a mean age equivalent of 17.8, a T-score of 51, and a percentile rank of 52%. His total standard score, (IQ) is 101 with a confidence interval of (95%). This places him in the average range of intellectual function.

On the Beck Depression Inventory-II, Nathan's score of twenty-three reaches clinically significant levels. These results are consistent with the depression scale of his MMPI-2. The combination of clinical interview and test results are consistent with DSM-IV-TR criteria for a finding of Major Depression-Single Episode-moderate, (296.22).

On the Beck Anxiety Inventory, his score of twenty-one does indicate a clinically significant level of anxiety. This is consistent with findings on his MMPI-2. These findings, along with results of his clinical interview, meet DSM-IV-TR criteria for a diagnosis of General Anxiety Disorder, (300.02). He demonstrates features of physiologic anxiety, worry, oversensitivity, tension and irritability.

On the Beck Hopelessness Scale, his score of seven 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 the Beck Scale for Suicide Ideation along with clinical interview for more accurate results. His results on this scale are also consistent with his MMPI-2 results. Nathan 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 Beck Scale for Suicide Ideation, Nathan's score of zero does not suggest significant suicidal ideation or risk factors for suicide.

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 use 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 Nathan'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. Nathan'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. Nathan'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.

Nathan does demonstrate a significantly elevated triad profile, with scale three hysterical/anxiety response to disability, and scale one elevated somatic focus, elevated above clinically significant levels. These two scales of the triad are followed closely by scale two, depression, which although at the valley still remains well above clinically significant levels. This profile represents a classic chronic disability/chronic pain profile consistent with exposure to severe disability and pain over time. Nathan also demonstrates a clinically significant elevation on scales seven and eight. This profile suggests feelings of inadequacy, inferiority, lowered self-esteem, poor self-concept and a lack of self-confidence. The profile also reveals anxiety, guardedness, anger and resentment over his situation, as well as feelings of depression, sadness and withdrawal.

Although it is clear from testing and clinical interview that depression and anxiety are present as a component of his overall disability, it is also apparent that at least a part of the underlying etiology for these problems is situational in nature. That is, they stem from exposure to his underlying medical condition and exposure to pain and disability over time. Based on this, he has a further diagnosis of Adjustment Disorder with Depressed Mood and Anxiety.

Axis I: Generalized Anxiety Disorder-300.02.
Major Depressive Disorder-Single Episode-Moderate-296.22.
Chronic Disability/Chronic Pain Disorder due to general medical condition and psychological factors-307.89.
Adjustment Disorder with depressed mood and anxiety-309.0.

Axis II: Deferred.

Axis III: Two separate fractures of the articular surface of the tibia. The posterior fracture undermined the attachment of the posterior cruciate ligament, rendering that ligament unstable.
Tear of the deep portion of the posterior limb of the medial meniscus.
Hemarthrosis.
Some soft tissue contusion posterior to the femur.
Displaced fracture at the left acetabulum.
Pars intra-articularis defect.
S/P ORIF.
S/P Total left hip arthroplasty.
Continued synovitis of right knee consistent with posterior cruciate ligament injury.

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

Axis V: Current GAF - 70.
Highest GAF in past year

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 orthopedic injuries, joint replacement, as well as chronic pain, and attention is paid to the clinical practice guidelines for the treatment of these diagnoses promulgated by multiple sources and cited in the Life Care Plan. Correspondence with treating physicians was issued and a response was received from Dr. Loren Martin, Nathan' treating orthopedic surgeon. He outlined some of Nathan's future care needs, but noted that some uncertainties remain and will have to be addressed in the future. As more information is received from Dr. Martin, Nathan's life care plan will be amended. 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.

Nathan remains severely impaired secondary to the March 29, 2004 onset of disability. He continues to experience significant physical limitations that effect his ability to fully participate in activities of daily living and his chosen vocation. He will continue to require medical

management of his injuries through life expectancy. Nathan will also require home care support in the way of housecleaning for heavier chores, along with home and lawn maintenance. Based on reports by his orthopedic surgeon, Dr. Martin, Nathan will require additional surgery to both of his knees and his left hip. After each surgical procedure, he will require home health care, physical therapy and appropriate equipment for a period of follow-up recovery.

The Life Care Plan outlines all of Nathan's needs dictated by the onset of disability throughout his life expectancy. Nathan is experiencing a significant level of depression, anxiety and adjustment disorder. I feel he could benefit from evaluation by a psychiatrist for medication management of these conditions. In addition to medical management, he should also be provided individual counseling to address these problems. An inpatient chronic pain management program would be beneficial to help him learn to better manage his chronic pain, anxiety and depression. All of these recommendations, along with additional considerations, will be outlined in the attached Life Care Plan.

A Vocational Worksheet, attached as Appendix B, outlines Nathan'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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Licensed Mental Health Counselor, (FL MH#0000117)
PAUL M. DEUTSCH & ASSOCIATES, P.A.

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