CLIENT: **Robert Gabriel**
DATE OF EVALUATION: **January 17, 2008**
DATE REPORT INITIATED: **March 10, 2008**
REPORT FINALIZED: **March 17, 2008**

Robert Gabriel is a 55-year-old Caucasian male seen for evaluation in my office in Oviedo, Florida accompanied by his son-in-law Jeremy Baxter. Robert was referred for a rehabilitation evaluation by his attorney, Clay Booker. 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: Robert Gabriel; **Social Security #:** XXX-XX-XXXX; **Address:** 3364 Clover Lane Lake Mary, FL 32795; **County:** Seminole; **Closest Metro Area** Orlando; **Phone**: XXX-XXX-XXXX; **Birthdate:** 2/3/52; **Age:** 55; **Sex:** Male; **Race:** Caucasian; **Marital Status:** Widowed 3 months prior to his injury; **Birthplace:** Valdosta, GA; **Citizen:** Yes; **Elementary/Secondary Education:** Elementary school through ninth grade in Lake Mary, FL. No GED.; **Employer at time of injury:** Chuck Regis -Regis Trucking; **Position/Grade**: Long Distance and Local Driving; **Bilingual:** No; **Glasses:** Yes; **Dominant Hand**: Right; **Height:** 5'8" pre-injury; **Weight (present):** 140 pounds; **Weight (pre-injury):** 170 pounds; **Date of Onset:** 10/22/07.

History: Robert indicates he was injured on 10/22/07 when a fork lift driver pushed a concrete road barrier off the back of his flat bed truck onto him. He reports that he never lost consciousness. He does recall being in severe pain, *"I'm surprised all of Orlando did not hear me hollering."* He has full recall of the EMT workers arriving and providing treatment. Once they gave him morphine on the helicopter, he reports losing recall for details regarding the remaining ride into the hospital. Seminole County Fire-Rescue records indicate they responded to an emergency crush injury in which Mr. Gabriel's legs were found underneath a large concrete road barrier. The emergency report noted that Robert expressed complaints of severe pain and denied loss of consciousness. There was, considerable blood loss. He was stabilized at the scene and taken by helicopter to Florida Hospital. Florida Hospital emergency department records indicate he was admitted for bilateral lower extremity crush injuries, dysvascular distal left lower extremity and right bundle-branch block. There was a large amount of degloving to lower

extremities bilaterally. The patient also had vascular compromise of left lower extremity. He also sustained multiple right foot fractures, severely open and comminuted left tibia and fibula fractures and multiple open left foot fractures. He denied any loss of consciousness, remembers the event, and was feeling fine before event. He could not move his feet at all and did not have sensation to the left foot subjectively. He had sustained considerable blood loss and received blood transfusions for anemia at the hospital. Robert notes recalling being taken from the helicopter and being moved to a gurney, but he thinks he passed out at that point.

Loss of Consciousness or Altered State of Consciousness: No.
Length of Unconsciousness or of Altered State: Apparently no loss of consciousnes at the scene.
Independent Recall: Full independent recall for details at the scene. No recall of details regarding ED treatment in the hospital.

Rehabilitation Program(s) [In/Outpatient Since Injury]: Robert was admitted to Florida Hospital on 10/22/07 and remained through 10/27/07. In addition to what was noted above, further examination in the ED found severe degloving injury involving the entire right foot. The bones distal to the talus and calcaneus were completely obliterated and most of them were missing. There was only a flap of skin. He did have dopplerable pulses in the region of the dorsalis pedis and posterior tibial in the region of the ankle but nothing in the foot. His left lower extremity had about a 35 cm open wound, extending from the tibial tuberosity all the way down to the ankle until the entire tibia area was filleted open with severe stripping of the tibia and nearly 300 degrees around. He had fractures on the dorsal aspect of the left foot and no pulses could be detected.

On 10/23/07, he underwent a temporizing left through-knee amputation and a right below-knee amputation (the degloving was noted to the region of the femoral condyle). He was staged for a revision to the left knee amputation on 10/25/07 and tolerated all procedures well. Robert notes that his first recall after the arrival on the helicopter pad was waking up from the first amputation procedure.

On 10/27/07, Robert was transferred to Shands Rehabilitation in Gainesville, FL to begin what was stated to be, *"a lengthy course of rehabilitation"*. On admission, he was complaining of severe pain to the bilateral lower extremities. He had phantom pain, 9/10 upon admission. OT and PT were initiated and continued through the course of his stay. Robert indicates he had PT and OT at Shands Rehab, often twice a day. He was not given any psychological evaluation or assistance. He was discharged on 11/5/07.

He developed a MRSA infection with lower extremity cellulitis in the latter part of his stay at Shands Rehab and was discharged to home under the care of his daughter. The records indicate that Robert was also provided some in home RN services and PT services. Robert and Jeremy indicate that PT never came to his home post-discharge from Shands Rehab, despite what the

record might indicate. The RN came three times only to teach Miriam, his daughter, how to wrap his legs.

There has not been any outpatient PT or OT and no other nursing. He has done his outpatient exercises on his own. He has been using 2.5 lb foam padded dumbbells that "women use for exercise while walking," to exercise his arms. Jeremy notes he rolls him down a ramp in the morning and he will exercise by navigating his wheelchair around a level surface for a brief time. He is not able to negotiate up or down the ramp to the front door independently. He resides with his daughter, son-in-law and granddaughter age nine. He was residing there before the accident as well.

No doctor ever evaluated this patient for a wheelchair and took into consideration his amputations and his wrist fusion. He really requires a power chair and he needs a PM&R evaluation for a wheelchair prescription with a power chair considered. He also needs PT and OT.

Prior Medical History: In 1995 or 1996, he tore the ligaments in his right hand. *"I have four pins in there now."* He reports full use of his right hand now.
In approximately 2005, he injured his left hand. *"I tore the ligaments in my wrist. I slipped while fueling the tractor trailer."* He required three surgeries to repair his left wrist. Eventually they had to fuse the left wrist and this lack of wrist movement makes it difficult to use manual chair.
At age fifteen he had a tonsillectomy.
In his thirties, he had an appendectomy.
In his forties, he had all his teeth removed and went to dentures.
He has never seen a psychologist or psychiatrist and he has no history of taking psychotropic medication.

In school he does not recall being diagnosed with a learning disability, ADD or ADHD, but at his age this would not be a typical diagnosis. He indicates he dropped out to go to work and help his parents.

Chief Complaint(s)

Current Disability

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

Robert, *"I have one below the knee amputation on the right and one above the knee amputation on the left. I received my prosthesis for both legs just yesterday. I walked with them yesterday with a walker at the prosthetist office, but when I got home I did not have a walker, so I could not use them. I have asthma, but I had that before this accident. I still have a lot of pain.*

The left leg only gets an occasional tingling feeling. All of the severe pain is in the right."

Right Leg Pain: Robert reports that he can be pain free in his right leg. He has some level of pain in the right leg every day. He experiences both phantom pain and pain in the residual limb. Both types of pain will occur several times per day. The average residual limb pain he experiences when it does occur is a 7 to 9. He will grab the leg and rub it to, *"help it ease off"*. The pain will usually last about fifteen minutes. He usually will ask for a pain pill when it does occur and this helps also. The pain rarely, if ever, gets worse than a 7 to 9. It can occur up to three to four times per day. He is unable to point to anything in particular that precipitates the pain.

The phantom pain occurs, on average, once to twice per day at the very most. He rates his average level of pain at a 3 to 4. It does not typically require a pain pill. Robert says that there is not much to do to help relieve the phantom pain beyond massaging the residual limb at the base of the stump.

Jeremy notes, *"When he calls for a pain pill and he is grabbing for his leg, I feel the pain is really severe because I have seen him many times when he is rubbing his limb and the pain is mild and he does not complain. He also began showing, 'tremors or spasms' in his residual limb just below the knee. I think it is restless leg syndrome, but it is clear he has no control over what is happening. These tremors or spasms occur two to three times per day and last until he grabs the leg and holds it until it stops."*

Anticipated Treatments: None scheduled.

Psychosocial Issues

Patient: Robert states, *"It is aggravating to be confined to a wheelchair and a house. I was use to going all the time and now I do little but watch TV."* He denies depression but admits to stress, tension and aggravation. *"If I am by myself, I can't use my bathroom, reach high cabinets, or use the stove. I am embarrassed to have to have my daughter dump my commode chair."* Jeremy notes that both he and his wife have vomited while cleaning his commode chair and this is very embarrassing to Robert.

Family, Emotional Impact on Spouse/Children: Robert feels that Jeremy and Miriam are stressed and tense having to wait on him, *"hand and foot"*. Jeremy notes that Robert cannot even change the TV if the remote is missing. With kids around all the time the remote often goes missing and it becomes a crisis. They describe Robert as easy going and kind, but still with a lack of proper space, renovations and equipment things get tense. He does not even have a handicap sticker for the vehicle, so he certainly has fallen through the cracks on a number of fronts.

Physical Limitations

Loss of Tactile Sensation: Tingling at the terminal end of right leg, feels like it has fallen asleep and is awakening but more intense sensation. Some tingling in left residual limb, but not to the degree as the right leg. No numbness reported.

Reach: He has full range of motion with his upper extremities. Reaching is limited to sitting position from wheelchair. He has new prostheses, but he is only learning to use these. He does not have a walker as yet.

Lift: He does have a fused left wrist done in approximately 2005. This limits his ability to lift with left hand. Lifting is limited to sitting only and should be limited to light lifting only.

Prehensile/Grip: Grip strength is normal in the right hand and he feels it has returned to normal in his left hand since fusion surgery.

Sitting: He spends most of his day in the borrowed wheelchair which is not comfortable for him. He shifts constantly because he has pain in his lower back and buttocks. He has pain in his right residual limb because it is supposed to be elevated and the wheelchair does not have any adaptations to elevate his leg. He can transfer to the furniture in his home, but he cannot transfer back to his wheelchair, so he just stays in the chair.

Standing: He just got his prostheses yesterday. Yesterday was the first time he was able to stand.

Walking/Gait: He did take steps using his prostheses yesterday. He does not have a walker yet and his prostheses are just starter prostheses.

Bend/Twist: He can bend and twist from a sitting position with no pain.

Kneel: Nonfunctional.

Stoop/Squat: Nonfunctional.

Climb: Nonfunctional.

Balance: He says he is still very weak and frequently has the *"shakes"*.

Breathing: He has asthma. This is a pre-existing condition. He uses Primatene Mist for treatment.

Headaches: He has occasional headache maybe every other week and he notes it depends on his stress levels.

Vision: Intact, wears glasses. He has not noticed a change in vision post-injury.

Hearing: Intact.

Driving: He cannot drive now and he has not been evaluated for adaptive equipment.

Physical Stamina (average daily need for rest or reclining): Still very weak. Reduced stamina.

Environmental Influences

Problems on exposure to:

Air Conditioning: Yes, chills easily and his leg pain will increase if he gets too cold or cold wind blows on his residual limbs.
Heat: Yes, when in the sun his legs seem to be very sensitive to the sun and they feel like they are burning.
Cold: Yes.
Wet/Humid: No.
Sudden Changes: Yes.
Fumes: No.
Noise: Yes, he has noticed he has less patience with noise.
Stress: No.

Present Medical Treatment

Doctors	Specialty	Phone	Fax	Frequency
F. Parker Loren, M.D. Orlando	Orthopedic Surg.	XXX-XXX-XXXX	XXX-XXX-XXXX	1 X / month
Ernie Clements Orlando	Specialty Prosthetics	XXX-XXX-XXXX	XXX-XXX-XXXX	1 X / week

Therapies/Notes: Robert has not been provided any therapy since his discharge from Shands Rehab.

Medication	Strength	Frequency	Tablets Day	Purpose	Prescribed by
Lyrica	50 mg	q4hours	120	Pain	Loren

Over-the-Counter Medication(s): None reported.
Drugstore and Phone Number: Walgreens Pharmacy XXX-XXX-XXXX
Assistive Devices: One above knee prosthesis, one below knee prosthesis. Borrowed wheelchair-ill fitting, bedside commode.

Medical Summary

ROBERT GABRIEL
D.O.B.: 2/3/52
D.O.O.: 10/22/07
Date of Medical Summary: 12/19/07

Robert Gabriel is a 55-year-old Caucasian male who sustained bilateral crushing leg injuries resulting in a right below the knee amputation and left through knee amputation on 10/23/07.

SEMINOLE COUNTY FIRE-RESCUE DEPARTMENT/EMS: 10/22/07
EMS responded to emergency crush injury in which Mr. Gabriel's legs were found underneath a large concrete road barrier. His right foot was crushed and paramedics could not feel a pedal pulse. Left lower extremity had an open fracture with bone ends exposed. He complained of severe pain, denied loss of consciousness and had considerable blood loss. He was stabilized and transported via flight care to Florida Hospital. He received Morphine IV for pain.

FLORIDA HOSPITAL: 10/22/07 – 10/27/07
Robert was admitted for severe bilateral lower extremities crush injuries, dysvascular distal left lower extremity and right bundle-branch block. He sustained severe crush injury to bilateral lower extremities. There was a large amount of degloving to lower extremities bilaterally. The patient also had vascular compromise of left lower extremity. He also sustained multiple right foot fractures, severely open and comminuted left tibia and fibula fractures and multiple open left foot fractures. He denied any loss of consciousness, remembers the event, and was feeling fine before event. He could not move his feet at all and did not have sensation to the left foot subjectively. He had sustained considerable blood loss and received blood transfusions for anemia at the hospital.

Upon examination he had severe degloving injury involving the entire right foot. The bones distal to the talus and calcaneus were completely obliterated and most of them were missing. There was only a flap of skin. He did have dopplerable pulses in the region of the dorsalis pedis and posterior tibial in the region of the ankle but nothing in the foot. His left lower extremity had about a 35 cm open wound, extending from the tibial tuberosity all the way down to the ankle until the entire tibia area was filleted open with severe stripping of the tibia and nearly 300 degrees around. He had fractures on the dorsal aspect of the left foot and no pulses could be detected.

Impression of CT spine was no acute fracture or acute process with some spondylosis and mild chronic degenerative changes. CT of the abdomen revealed huge hiatal hernia and tiny liver cyst. Chest x-ray showed bilateral pleural thickening fluid, biapical linear opacity suggesting scarring. X-rays of the bilateral lower extremities reveal a severely comminuted fracture involving the proximal half of the tibia and fibula, with severe soft tissue injury by the soft tissue area. X-rays of his feet showed that he had essentially degloving injury of the right foot with obliterated bony structures distal to the talus and calcaneus. He also had a right calcaneus fracture. X-rays of the left foot revealed a calcaneus fracture, as well as fractures of the third metatarsal neck and fractures of the second, third, fourth and fifth distal phalanx.

On 10/23/07, he underwent a temporizing left through-knee amputation and a right below-knee amputation (the degloving was noted to the region of the femoral condyle). He was staged for a revision to the left knee amputation on 10/25/07 and tolerated all procedures well.

Medical Consultants of America was consulted due to several co-morbidities and the fact that a right bundle-branch block was noted. This was managed with telemetry and conservatively and did not require any acute intervention.

He had what was stated to be a lengthy rehabilitation process due to the severity and inclusion of bilateral lower extremities. It was arranged for him to be transferred to Shands Rehab Hospital. He was discharged to Shands with a non-weight-bearing restriction to bilateral lower extremities and continuation of home medications on 10/27/07.

SHANDS REHAB HOSPITAL: 10/27/07 – 11/5/07

Robert was admitted for rehabilitation and complained of severe pain to bilateral lower extremities, phantom pain, 9/10 upon admission. He was able to flex and abduct his hips. He also reported tingling and burning sensations. PT and OT were ordered.

Chest x-rays on 11/2/07 showed the appearance of a large intra-thoracic stomach. Scarring in the right upper lobe suggesting the possibility of previous granulomatous change. He also had an echocardiogram, which showed grossly normal left ventricular size and contractility with normal appearing right ventricular size and contractility.

(PT & OT records were incomplete and difficult to read).

Occupational therapy evaluated him on 10/28/07 and Robert complained of pain to residual limbs bilaterally and indigestion. He was able to complete self-care with minimum assistance. He was able to engage in bed mobility with transfer out of bed with minimum assistance. He was very motivated but concerned regarding bowel movements and indigestion. He had no

complaints on 11/5/07 and was ready to be discharged. Right lower stump had no post-surgical ecchymosis, no redness and no drainage from incision site. Left lower extremity had mild ecchymosis surrounding incision site. Robert was informed to follow-up with OT in two weeks.

Physical Therapy evaluation on 10/28/07 indicated he made good progress and remained in good spirits. Upon discharge, Robert was able to propel wheelchair on outdoor surfaces, use sliding board for transfers into truck and use the positioning board.

At the end of his stay, he acquired methicillin-susceptible staphylococcus aureus (MRSA) and was diagnosed with lower extremity cellulitis. He was given Doxcycline, 100mg 2x/day. Robert was discharged home with assistance from daughter who was available 24-hours/day and was provided with a drop arm commode, Browning's donor wheelchair with elevating leg rest, 30-inch sliding board for transfers and RN/PT home health care.

Records Reviewed:

Seminole Counry Fire Department: 10/22/07
Shands Rehab Hospital: 10/27/07 – 11/5/07
Seminole County Fire-Rescue Department/EMS: 10/22/07
Florida Hospital: 10/22/07 – 10/27/07

Activities Of Daily Living

Sleep Pattern

Arises: 5-6 a.m.
Retires: 10-11 p.m.
Average Hours Sleep/24 Hours: 5-1/2 to 6 hours.
Sleep Difficulties: He has problems going to sleep and staying asleep. He has spasms in his right leg that cause his leg to jump and this will make it hard for him to sleep. Pain will wake him at night.

Independence In

Dressing: He dresses in the bed and it is difficult but he does this independently.
Housework: His daughter does the house work.
Cooking: His kitchen is not accessible. He can make himself a sandwich. Daughter cooks for him.
Laundry: Daughter does his laundry.
Yard Work: Jeremy does the yard work.

Social Activities

Organizations Pre/Post: None pre or post.
Volunteer Work Pre/Post: None pre or post.
Socialization Pre/Post: He socialized with his family and friends. On the weekends, his sons will come and pick him up and take him to their home.
Hobbies (Present): Watch TV.
Hobbies (Previous): Fishing was his favorite thing to do.

Personal Habits

Smoking: No, but he uses dip.
Alcohol: Only once in a while he will have a beer, but not very often.
Drugs: None.
History of Abuse and/or Treatment Programs: None.

Socioeconomic Status

Spouse: Robert's wife died three months prior to his injury.
Children: He has three sons and one daughter, all grown.
Number in Residence: 4, Robert, his daughter, son-in-law Jeremy and their daughter (age 9).
Type of Residence: Manufactured home, double wide, rented. Ramp to one door built.

Income

Disability Policy: None.
W.C.: None.
S.S.D.I.: May 2008 SSDI will start at $1,200.
S.S.I.: Starting Feb 2008 $400 per month.
Wages: None.
Food Stamps: None.
Medicaid: Yes
Medicare: Not at this time, but should qualify two years after SSDI begins.

Other Agency Involvement

State Vocational Rehabilitation: No.
State Employment Services: No.
Rehabilitation Nurse: No.
Other Agency: None.
Felony Convictions? No.

Education & Training

Highest Grade Completed: 9th grade.
Last School Attended: Greenwood Lakes Middle School
Trade/Tech Training: None.
Apprenticeship/OJT: Truck driver training with his brother.
Literacy: Literate.
Licenses/Certifications: He does still have a CDL.

Military Experience

Branch: Not applicable.

Employment History

Released to Return to Work: No.
Work History Since Injury: None.

Robert estimates he made a little over $35,000 in 2007. They are going to try to get income tax records for me. He did not file last years records yet, because of the death of his wife, but he says he has always filed his income tax. Attorney may need to request from IRS, so that economist can assess loss of earning capacity.

He has worked as a truck driver all of his life. He began working in this field at the age of 21. He has never owned his own truck, but has always worked steady driving trucks owned by other people. The only time that he has been off from work for an extended period of time was when he had his wrist surgery in 2005. He was off from work for about a year, and this was covered by Worker's Comp.

Employer: Chuch Regis; **City/State:** Apopka, FL
Position: Truck Driver; **Start Date:** 2005; **End Date:** 10/22/07; **Schedule:** Full-time; **Length:** 2 years; **Wage:** 25%; **Reason for Leaving:** Injured on the job.

Observations

Orientation: Alert and oriented.
Stream of Thought: Clear and rational.
Approach Toward Evaluation: Cooperative.
Attitudes/Insight: Good/Good.
Appearance: Overtly disabled.

Tests Administered

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

On the Beck Depression Inventory-II, Robert's score of eight does not reach clinically significant levels. This is inconsistent with the clinically elevated depression scale he demonstrates on the MMPI-2. The Beck is far more easy to manipulate in those patients in denial than the MMPI-2. Overall clinical interview and test results are consistent with DSM-IV-TR criteria for a finding of Depression-Single Episode-Moderate-296.22.

On the Beck Anxiety Inventory, his score of fifteen does indicate a mild clinical anxiety. This is consistent with findings on his MMPI-2, and clinical interview. Clinical interview and test results do meet DSM-IV-TR criteria for a finding of Anxiety Disorder-Mild 300.02.

On the Beck Hopelessness Scale, his score of two suggests an optimistic outlook on his future. Research indicates scores of nine or more are predictive of eventual suicide in depressed suicidal 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 and the Beck Scale for Suicidal Ideation for more accurate results. His results on this scale are also consistent with his MMPI-2 results. Robert 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, Robert's score of zero demonstrates his lack of suicidal ideation.

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 can invalidate the profile. In Robert'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. A new scale, recently added to the profile is the FBS or Fake Bad Scale similar to the combined "fake bad" profile previously used by examining a combination of several validity scales. Robert does not show elevations on any of the F scales or the FBS. When looking at the FBS the circumstances of the assessment must be taken into

considerations. For example, any significant physical injuries, chronic illnesses or medical findings that could artificially elevate scores on the FBS as a result of the patient truthfully responding to test questions, would effectively reset the normative floor for determining when a patient is "faking bad".

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. Robert'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. There is an indication that Robert tends to use denial and repression in dealing with issues of a psychological nature. This suggests that many of the clinical scales may be muted in relation to what he may be experiencing on a day-to-day basis.

On the clinical scales, Robert demonstrates an elevated triad profile with scale two, depression, at the peak, followed by scale one, somatic focus. This is followed by scale three, hysterical/anxiety response to disability, which approaches but does not quite reach clinical significance. Together this profile represents a classic chronic pain/chronic disability syndrome.

In addition to the triad profile Robert demonstrates clinically significant elevations on scales seven and eight, while closely approaching significance on scale nine. 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. There is also evidence of hypomanic behavior, although at this level, it is not likely to show as much more than a mild nervous energy and perhaps some agitation.

The new Restructured Clinical Scales preserve the valuable descriptive features of the existing Clinical Scales and enhance their distinctiveness. The RC Scales profile constructed a demoralization scale, extracting the general complaint or malaise factor represented to some degree in each of the clinical scales. These scales then go on to identify the major dimensions of eight of the ten clinical scales, except scales 5 and 0. The RC scales are:

- RCd-Demoralization
- RC1-Somatic Complaints
- RC2-Low Positive Emotions
- RC3-Cynicism
- RC4-Antisocial Behavior
- RC6-Ideas of Persecution
- RC7-Dysfunctioal Negative Emotions

- RC8-Aberrant Experiences
- RC9-Hypomanic Activation

In Robert's profile, he demonstrates elevations on RC-1, 3, 6, 8, and 9 essentially refining distinctive features of his clinical scale elevations of somatic focus, cynicism, ideas of persecution, aberrant experiences and hypomanic activation.

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

Axis II: Deferred.

Axis III: Severe bilateral lower extremities crush injuries, dysvascular distal left lower extremity and right bundle-branch block.
S/P temporizing left through-knee amputation and a right below-knee amputation (the degloving was noted to the region of the femoral condyle). He was staged for a revision to the left knee amputation on 10/25/07 and tolerated all procedures well.
Lengthy rehabilitation process due to the severity and inclusion of bilateral lower extremities.
S/P methicillin-susceptible staphylococcus aureus (MRSA) and was diagnosed with lower extremity cellulitis.

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

Robert's older age onset of disability has played an important role in the difficulty he has had in making an effective psychosocial adjustment to disability. As a result, he demonstrates continued psychological response to disability, less effective physical adjustment and a greater role of psychological issues in the chronic pain response to exposure to disability over time.

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 bilateral lower extremity amputations, and attention is paid to the practice guidelines for multiple amputations promulgated by multiple

sources and cited in the Life Care Plan. Correspondence with treating physicians was issued. All of these steps are taken to help in establishing the medical, case management, rehabilitation and psychological foundations for the Life Care Plan.

Robert remains significantly disabled secondary to the 10/22/07 onset of disability resulted in the amputation of both of his lower limbs. Robert is nonfunctional for independent living at this time. In order to enhance his independence, he will require additional therapy, adaptive equipment and an accessible environment. It is often more difficult for older age individuals to make the adjustment to onset of severe disability as compared to much younger individuals who are far more often the victim of such injuries, (65% of spinal cord, brain injured and other catastrophic disabilities occur in males 16-26 at onset). Older age onsets rarely reach similar levels of independence and they decline in function over time as age and disability combine at a much more rapid pace. Declination rates compared between younger age and older age onsets converge rapidly in older years making the rate of decline in older age onsets very rapid, leading to the need for equipment, aids for independent function and support care more rapidly for the older age onset then the younger patient.

The Life Care Plan outlines all of his needs dictated by the onset of disability throughout his life expectancy. In addition to the recommendations specifically for Robert, education and counseling is provided to the family members in order to assist them in adjusting to his disability and assisting him in managing his disability. Robert will require ongoing medical monitoring of his injuries through life expectancy.

A Vocational Worksheet, attached as Appendix B, outlines Robert'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,

Paul M. Deutsch, Ph.D., CRC, CCM, CLCP, FIALCP
Licensed Mental Health Counselor, (FL MH#0000117)
PAUL M. DEUTSCH & ASSOCIATES, P. A.

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