Comments
Important
Radiology/Procedure

THE MEDICAL RECORD

The following excerpts from the medical record are representative of the information contained therein and are pertinent to the issues being addressed.

DATE	PROVIDER	OCCURRENCE	PDF Ref
07/16/2019	Memorial MRI & Diagnostic Reza Malek, M.D.	**MRI of the Lumbar Spine** **Clinical Indication:** Back pain status post motor vehicle accident (MVA). **Findings**: The vertebral body heights and alignments were satisfactory, no fracture or subluxation, the cord had normal signal, conus was intact and the discs appeared to be well maintained, the paravertebral soft tissues were unremarkable, at L1-L2, no evidence of focal disc herniation, foraminal or central canal stenosis, at L2-L3, no evidence of focal disc herniation, foraminal or central canal stenosis, at L3-L4, no evidence of focal disc herniation, foraminal or central canal stenosis, at L4-L5, 7 mm right paracentral/foraminal sub ligamentous disc herniation with 2 mm radial tear causing ventral lateral mass effect and mild spinal canal stenosis, at L5-S1, no evidence of focal disc herniation, foraminal or central canal stenosis. **Impression**: L4-L5, 7 mm right paracentral/foraminal sub ligamentous disc herniation with 2 mm radial tear causing ventral lateral mass effect and mild spinal canal stenosis.	Jane Doe-page 27-28
08/26/2019	Golden Triangle Emergency Center Robert Brown,	**X-rays of the Lumbar Spine** **Clinical Indications:** Low back pain after her crutches and falling earlier today.	Jane Doe-page 29

	M.D.	**Findings**: Vertebrae: Partial sacralization on the right of the L5 vertebral body, narrowing of the L5-S1 disc space, remaining disc spaces were maintained, no acute fracture, normal alignment, SI joints were normal, soft tissues normal. **Impression**: Congenital partial sacralization on the right at L5, otherwise normal exam.	
10/28/2019	Orange County Physical Therapy, L.L.C. Cody Trahan Tant, P.T.	**Physical Therapy Initial Examination Note** **CC**: Constant left knee and ankle pain. Patient stated that she slipped out of a trailer at work when she injured her left ankle and landed on her left knee and stated pain aggravated by standing, walking, stairs up, stairs down, sit to stand, and bending. **Diagnoses**: Contusion of left knee, sprain of unspecified ligament of left ankle, abnormalities of gait and mobility, pain in left knee, and pain in left ankle and joints of left foot. **Plan**: Physical therapy (PT) 2-3 times a week x 8 weeks. **Short Term Goals to be achieved in 2 weeks**: Patient to recall 85% of home exercise program (HEP) in order to progress to independent HEP compliance to further progress strengthening, patient to increase AROM of the left knee extension to 0 degrees (terminal knee extension) in order to demonstrate appropriate ROM and decrease gait deviation, to increase AROM of the left knee to 120 degrees in order to restore functional transfer and mobility. **Long Term Goals to be achieved in 8 weeks**: At least 40% but less than 60% impaired, limited or restricted with mobility, walking & moving around, patient to decrease pain reports to <4/10 at worst in order to demonstrate increased activity tolerance, patient to	Jane Doe-page 113-119

		demonstrate decreased gait deviations to improve foot clearance and safety with ambulation, patient to increase AROM of the left ankle to 20 degrees of DF in order to restore appropriate heel off and heel strike during ambulation, patient to increase strength of bilateral lower extremity (BLE) to 5/5 in order to increase safety with ambulation, increased stability and restoration of premorbid state. **Rehab potential**: Good.	
10/28/2019 – 11/25/2019	Orange County Physical Therapy, L.L.C. Cody Trahan Tant, P.T., Edward Frenzel, P.T., Brandi Ballard, P.T.	Patient underwent physical therapy from 10/28/2019 and was last seen on 11/25/2019.	Jane Doe-page 120-131
11/01/2019	Orthopaedic Institute for Spinal Disorders Jose Rodriguez, M.D.	**Progress Note** **CC**: Low back and left leg pain. Patient developed left leg pain about 6 months ago, which began initially as a numbness and tingling sensation to the left leg sometimes going to the big toe. In September, her symptoms got worse after bowling activities. Since then, she had constant left leg pain with numbness and tingling sensation to the big toe, which she described as 7/10 VAS constant, and 9/10 VAS during standing or walking activities, in her right leg she felt tingling to the toe, intermittently. She received extensive physical therapy and 3 epidural steroid injections with no improvement of her symptoms. 10 years ago, she had a low back pain episode that improved with core exercises. MRI of the lumbar spine was performed on 07/16/2019. She was referred from evaluation by Dr. Joel Rodriguez. **Current Medications**: Adderall, Aldactone, Alprazolam, Diclofenac Sodium, Hydroxyzine HCl,	Jane Doe-page 31-33

		Metformin, Norethindrone (contraceptive), Oxybutynin Chloride, Plaquenil, Trintellix. **Exam**: Patient was in mild distress. Lumbar spine: The inspection of the lumbar spine showed abnormalities, decreased lordosis of lumbar spine noted. Anterior flexion of lumbar spine was noted to be 30 degrees, anterior lumbar flexion caused pain, left leg pain extension of lumbar spine was noted to be 10 degrees, pain noted with lumbar extension, left leg pain left lateral flexion of the lumbar spine was noted to be 15 degrees, left lateral flexion caused pain, left leg pain right lateral flexion of the lumbar spine was noted to be full at 25 degrees, pain noted with right lateral flexion. Positive slump, Laseque's, Valsalva, sitting root and straight leg raise, left antalgic. Motor exam of the left side demonstrated 3/5 (L5) extensor hallucis longus, motor exam of the left side demonstrated 4/5 (S1/S2) hamstring. Decreased sensation noted in the bilateral L5. Deep tendon reflexes: Left Achilles (DTR) 1. **Assessment**: 1. Herniated nucleus pulposus, L4-L5 right. 2. Lumbosacral radiculopathy at L5. **Plan**: Bilateral laminotomies at L4-L5 with discectomy right L4-L5 and advised to follow up in 2 weeks postop.	
11/07/2019	Houston Surgery Center Jose Rodriguez, M.D.	**Operative Report** **Pre/Post-Operative Diagnosis**: Lumbar radicular syndrome secondary to herniated disc at L4-L5. **Operation performed**: Bilateral laminotomies and foraminotomies, L4-L5, discectomy right side L4-L5 without complications.	Jane Doe-page 34-35
11/14/2019	Golden Triangle Emergency Center	**CT of the Lumbar Spine** **Clinical Indications:** Low back pain (LBP), history of	Jane Doe-page 36-37

	Amit Mittal, M.D.	back surgery. **Findings**: Vertebrae: Normal vertebral body height and alignment, no acute lumbar spine fracture, partial right facetectomy and laminectomy on the right at L4-L5 also noted, discs/spinal canal/neural foramina transitional lumbosacral anatomy was noted with pseudoarthrosis on the right at L5-S1, congenital narrowing of the L5-S1 disc space with otherwise preserved disc space height, mild disc bulge with a superimposed broad-based right paracentral/foraminal disc protrusion at L4-L5, no high-grade spinal canal or foraminal stenosis appreciated by CT. other bones/joints: No aggressive osseous lesions, gallbladder, and bile ducts: Cholecystectomy clips, kidneys, and ureters: Bilateral nephrolithiasis incidentally noted and soft tissues were unremarkable. **Impression**: 1. Transitional lumbosacral anatomy. 2. Post-surgical change at L4-L5. 3. Mild disc bulge with superimposed broad-based disc protrusion at L4-L5, no evidence for high-grade spinal canal or foraminal stenosis; findings would be better assessed by MRI or CT lumbar myelogram if the patient was unable to have an MRI. 4. Bilateral nephrolithiasis.	
11/19/2019	Orthopaedic Institute for Spinal Disorders Jose Rodriguez, M.D.	**Post-Procedure Follow-up Visit** Patient was here for post procedure follow up visit. Patient was feeling better, radicular symptoms resolved, continued with intermittent LBP, went to a local ER last week because of LBP, she was treated and released, currently, the pain intensity was 6/10. **Exam**: Deep tendon reflexes: Right Achilles (DTR) 1, left Achilles (DTR) 1. **Procedure**: Steri strips removed and she tolerated the procedure well.	Jane Doe-page 38-39

		Assessment: 1. Herniated nucleus pulposus, L4-L5 right 2. Lumbosacral radiculopathy at L5. **Plan**: Prescribed Naproxen 500 mg, and recommended Williams and walking exercises, and advised no lifting and follow up in 1 month.	
01/06/2020	Orange County Physical Therapy, L.L.C. Cody Trahan Tant, P.T.	**Physical Therapy Discharge Note** Patient was discharged from physical therapy for the following reasons: Patient did not return for follow up appointments and attempts to reschedule were unsuccessful.	Jane Doe-page 132
02/01/2020	Golden Triangle Emergency Center Kenneth Lutschg, M.D.	**CT of the Abdomen and Pelvis** **Clinical Indications:** Bilateral flank pain and lower back pain and history of kidney stones. **Findings**: Assessment of the viscera and vasculature might be limited by the lack of intravenous contrast, which was standard for urinary calculus CT, the lung bases were clear, liver normal, no mass, gallbladder and bile ducts, there had been a cholecystectomy, pancreas normal, no ductal dilation, spleen normal, no splenomegaly, adrenals normal, no mass, kidneys and ureters had bilateral small collecting system calcifications, no ureteral calculi, no hydronephrosis or perinephric edema, the renal contours were normal, stomach and bowel unremarkable, no obstruction, no mucosal thickening, appendix had no evidence of appendicitis, intraperitoneal space unremarkable, no free air, no significant fluid collection, vasculature unremarkable, no abdominal aortic aneurysm, lymph nodes unremarkable, no enlarged lymph nodes, bladder unremarkable as visualized, reproductive unremarkable as visualized, bones/joints the lumbar spine demonstrated mild degenerative changes at multiple levels and soft tissues were unremarkable.	Jane Doe-page 89-90

		Impression: Bilateral nonobstructing nephrolithiasis.	
02/16/2020	Katy Emergency Center Muhammad Javaid, M.D., Joseph Caruso, M.D.	**ED Provider Note** **CC**: Right shoulder, lower back, right knee, and right ankle pain 3/10, onset occurred 12 hours ago Patient stated slipped and tripped, had a fall onto concrete surface while walking occurred at a restaurant. Pain was described as moderate in degree and in the area of the lower lumbar spine, and the quality was noted to be sharp. Onset was the previous day, also shoulder and knee pain after fall and it was still present. Pain was worsened by rotation or bending over. **Exam**: Pain level 9/10. Tachycardic. Back: Muscle spasm of the back, moderate vertebral point tenderness over the lower lumbar spine. (Right shoulder pain with movements) **Clinical Impression**: 1. Acute traumatic pain in the lower back and right upper extremity (shoulder) 2. Acute lumbar strain 3. Fall on the same level by tripping 4. Nausea (Acute) **Plan**: Prescribed Zofran 4 mg, Orphenadrine 100 mg, and recommended CT of lumbar spine and lab studies. Patient was discharged to home in stable condition.	Jane Doe-page 5-10/ 11-13/ 18-19
02/16/2020	Katy Emergency Center	**Lab Report** Urinalysis was performed.	Jane Doe-page 14
02/16/2020	Village Emergency Centers Ravi Bikkina,	**CT of the Lumbar Spine** **Clinical Indications:** Fall previous day, low back pain. Previous history of laminectomy and discectomy.	Jane Doe-page 15-16

	M.D.	**Findings**: Lumbar vertebral bodies appear satisfactory in height, assessment for disc herniations, spinal and neural foraminal stenosis was limited without intrathecal contrast, at T12-L1 through L3-L4, no significant osseous spinal canal or neural foraminal stenosis was appreciated, at L4-L5, subtle defect in the right lamina likely related to previous surgery, in addition, a linear other fracture postop defect in the L4 lamina running transversely to the right L4-L5 facet joint that was best seen on the axial image 141 and the images above and below it, that was also seen on the sagittal image 19 and 20, that likely represented postop changes, possibility of a subtle fracture of the inferior articular process of L4 could not be entirely excluded, please correlate with exam findings and previous surgical history, at L5-S1, sacralization of L5 with S1 and small rudimentary facet joints noted, no additional fractures were seen throughout the lumbar spine, no paraspinal abnormality was noted, 6 mm stone was noted in the lower pole region of the right kidney posteriorly in formalin for stone anteriorly. **Impression**: 1. Subtle linear defect in the right L4 lamina and inferior articular process extending to the right facet joint likely represent postop changes from previous laminectomy, possibility of a subtle fracture could not be entirely excluded by imaging alone. 2. No additional fractures of the lumbar spine was detected 3. Right renal calculi	
02/20/2020	Athletic Orthopedics and Knee Center Pawan Grover, M.D.	**Office Visit** *(Handwritten/partially illegible – only what could be read is reported)* Patient was seen in the office for a follow up visit. Patient had a fall on Saturday went to ER and had an MRI. Patient had an injection and reported a reduction in pain of 70% for 20% with increased activity. Patient saw Dr. Rodriguez and was put on a brace for possible fracture.	Jane Doe-page 74-77

		Diagnosis: Contusion. **Plan**: Prescribed Hydrocodone 5/325 mg, Zanaflex 2 mg, got approval and scheduled right/left lumbar facet at L3-L4, L4-L5, and L5-S1.	
02/25/2020	Athletic Orthopedics and Knee Center Jack E. Jensen, M.D.	**Office Visit** **CC**: Right shoulder, right knee, and right ankle pain. Patient presented with right shoulder, right knee, and right ankle pain. She stated she had a fall on 02/15/2020 where she slipped in a restaurant and fell onto the front of her right knee. She was holding her son and her right arm and pulled back to protect him and felt like she strained her shoulder. She also twisted her right ankle in an inversion type injury during the fall. Since then, she had been treating with pain medication that she got for her back issues (Hydrocodone) and a muscle relaxer. She stated she had decreased range of motion (ROM) on her right shoulder and her right knee. She reported that there was some locking in her right knee and instability. **Exam**: ROM: 90 degrees flexion with pain, motor function abnormal, Positive Neer. Right knee: Swelling. Right ankle: Full ROM +1 swelling lateral. **Diagnostic Studies:** X-rays of right knee revealed negative for fracture or dislocation. X-rays of right shoulder revealed negative for fracture or dislocation. X-rays of right ankle revealed negative for fracture or dislocation. **Treatment**: Subacromial corticosteroid injection (5:1) 5cc of 1% Lidocaine mixed with 1cc Kenalog 40 mg/cc performed that day; the patient tolerated the procedure well. **Impression**:	Jane Doe-page 93-97

		1. Sprain of unspecified ligament of right ankle 2. Contusion of right knee 3. Right shoulder pain **Plan**: Ordered major joint injection, Lidocaine, Kenalog, Topical Diclofenac and recommended rest, ice, compression and elevation (R.I.C.E.), x-rays of knee, ankle, and shoulder, corticosteroid injection (CSI) 5:1 with ultrasound, lace up brace, and advised to follow up in 2 weeks.	
03/24/2020	Athletic Orthopedics and Knee Center Jack E. Jensen, M.D.	**Procedure Note** **Procedure performed**: Right shoulder cortisone injection (CSI) 6:2 ratio. Patient tolerated the procedure well without complications.	Jane Doe-page 98
03/24/2020	Athletic Orthopedics and Knee Center Jack E. Jensen, M.D.	**Follow-Up Visit** **CC:** Right shoulder pain. Patient was here for follow up on right shoulder pain. She was also being treated for right ankle sprain. She received a corticosteroid injection 1 month ago, which helped her symptoms significantly. The symptoms started to return on her right shoulder after 2 weeks ago. She had been working on home exercise program that she had developed with PT. She had completed 10-12 physical therapy visits. She reported that she still got aggravated when doing overhead activities with the right shoulder. She was taking Tizanidine and Hydrocodone as needed. She was still seeing Dr. Jose Rodriguez for her back. **Exam**: Right shoulder: Tenderness to palpation (TTP) over the anterior lateral shoulder, ROM was in abduction 130 degrees, flexion 110 degrees, extension 40 degrees, internal and external rotation of 45 degrees, positive Hawkins, Neer's, and O'Brien's. **Assessment**:	Jane Doe-page 99-103

		1. Impingement syndrome of right shoulder 2. Sprain of unspecified ligament of right ankle **Plan**: Recommended to continue Aleve, Tizanidine, and Hydrocodone, continue home exercise program (HEP) for ankle rehab and right shoulder ROM but decrease frequency to every other day, ice as needed, topical Diclofenac as needed, and advised to follow up in 1 month to review symptoms.	
03/24/2020	Orthopaedic Institute for Spinal Disorders Jose Rodriguez, M.D.	**Post-Procedure Follow-up Visit** Patient stated that her pain had neither improved nor worsened since her last visit. Fell again a few days ago from her son's truck. Lower back pain (LBP) increased, twisted her right ankle and left knee. Wearing lumbar brace as instructed. On an average rate now, her pain on a 1-10 scale was 7 and she was not working. **Exam**: Patient was in mild distress. Lumbar spine: The inspection of the lumbar spine showed abnormalities, decreased lordosis of lumbar spine noted. Anterior flexion of lumbar spine was noted to be 60 degrees, extension of lumbar spine was noted to be 20 degrees, pain noted with lumbar extension, motor strength: motor exam of the left side demonstrated 3/5 (L5) extensor hallucis longus, motor exam of the left side demonstrated 4/5 (S1-S2) hamstring. Diagnostic studies were reviewed. **Assessment**: 1. Herniated nucleus pulposus, L4-L5 right 2. Fracture of lamina of lumbar vertebra 3. Lumbosacral radiculopathy at L5 **Plan**: Recommended x-rays of lumbar spine, continue walking and Williams exercises and lumbar brace during activities, and no lifting up to 20 lbs.	Jane Doe-page 40-42

03/24/2020	Orthopaedic Institute for Spinal Disorders Jose Rodriguez, M.D.	**X-rays of the Lumbar Spine** **Impression:** No instability and questionable fracture lamina L4.	Jane Doe-page 43
03/30/2020	Memorial MRI & Diagnostic Robert Loeb, M.D.	**MRI of the Left Knee** **Clinical Indication:** Knee pain. **Findings**: Extensor mechanism: A small joint effusion. The patellofemoral joint was normal in appearance. Quadriceps tendon and patellar ligament were normal in appearance. Medial and lateral retinacular structures were intact. Cruciate ligaments: Anterior and posterior cruciate ligaments were intact. Collateral ligaments: Medial and lateral collateral ligaments were intact. Menisci: Medial and lateral menisci were normal in size shape and configuration. No evidence for meniscal tear. Bone marrow: Bone marrow signal intensity was normal. Articular cartilage and bone marrow in the medial and lateral compartments was maintained. No evidence for fracture or contusion. Miscellaneous: The iliotibial band and biceps femoris tendon were normal in appearance. No fluid collections or baker's cyst demonstrated. **Impression**: Unremarkable knee. No evidence for internal derangement.	Jane Doe-page 54
03/30/2020	Memorial MRI & Diagnostic Robert Loeb, M.D.	**MRI of the Left Ankle** **Clinical Indication:** Ankle pain, injury. **Findings**: Ligaments: The anterior talofibular, the posterior talofibular, the calcaneofibular, and the syndesmotic ligaments were intact. The deltoid ligament was unremarkable. Tendons: The posterior tibial, the flexor digitorum longus, and the flexor hallucis longus tendons were intact. Note was made of minimal reactive posterior tibial tenosynovitis. The	Jane Doe-page 55

		peroneal and extensor tendons were unremarkable. Intact Achilles tendon. Bones/cartilage: Intact distal tibia and fibula. No fracture or significant osseous abnormality. No cartilage lesions of the talar dome. The subtalar joint and the sinus tarsus were unremarkable. General: Small ankle joint effusion. The tarsal tunnel and the plantar fascia were normal. **Impression**: Slight reactive posterior tibial tenosynovitis otherwise unremarkable MRI of the ankle. No evidence for internal derangement.	
04/28/2020	Orthopaedic Institute for Spinal Disorders Jose Rodriguez, M.D.	**X-rays of the Lumbar Spine** **Impression**: Lordosis improving, no fractures.	Jane Doe-page 30
04/28/2020	Orthopaedic Institute for Spinal Disorders Jose Rodriguez, M.D.	**Follow-up Visit** Patient stated that her pain had neither improved nor worsened since her last visit. She fell again last week due to “walking imbalance”. Re-visited the ER after that fall, wearing the lumbar brace during activities, and on average rated her pain at 4/10. **Exam**: Patient was in mild distress. Lumbar spine: The inspection of the lumbar spine showed abnormalities, decreased lordosis of lumbar spine noted, anterior flexion of lumbar spine was noted to be 60 degrees, extension of lumbar spine was noted to be 20 degrees, pain noted with lumbar extension. Motor exam of the left side demonstrated 3/5 (L5) extensor hallucis longus, motor exam of the left side demonstrated 4/5 (S1-S2) hamstring. **Assessment**: 1. Herniated nucleus pulposus, L4-L5 right 2. Fracture of lamina of lumbar vertebra 3. Lumbosacral radiculopathy at L5	Jane Doe-page 44-45

		Plan: Recommended to continue walking and Williams exercises, start brace wear weaning x 2 weeks, no maximum lifting up to 20 lbs. and also recommended neurology evaluation and x-rays of lumbar spine.	
07/23/2020	Athletic Orthopedics and Knee Center Pawan Grover, M.D.	**Follow-up Visit** *(Handwritten/partially illegible – only what could be read is reported)* Patient had an injection and reported a reduction in pain of 80% for 1 week with increased activity. When block wore off patient reported an overall reduction in 20% and reported pain level 4-5/10. **Plan**: Prescribed Hydrocodone 10/325 mg, Zanaflex 2 mg, and get an MRI scan.	Jane Doe-page 70-73
10/15/2020	Athletic Orthopedics and Knee Center Jack E. Jensen, M.D.	**Office Visit** **CC**: Back pain. Patient presented with back pain rated at 4/10. *Patient was 76 severe pain in her right shoulder the last 2 days*, she had to go to the ER, now she had very little motion and was taking considerable medications described by Dr. Grover and Dr. Rodriguez for her low back issues. **Exam**: Right shoulder: Tenderness to palpation over the anterior lateral shoulder, range of motion in abduction 130 degrees, flexion 110 degrees, extension 40 degrees, internal and external rotation of 45 degrees, positive Hawkins, Neer's, and O'Brien's. **Impression**: 1. Left shoulder impingement syndrome 2. Rule out right rotator cuff tear bursitis adhesive capsulitis **Plan**: Recommended surgery with decompression, TENS unit, and cryo cuff for shoulder sling.	Jane Doe-page 104-107

10/16/2020	Athletic Orthopedics and Knee Center Joel Rodriguez, M.D.	**Phone Note** Patient was here for follow up call to discuss lab or test results. Discussed MRI right shoulder results in detail, last CSI she received lasted about 1 month (03/24/2020), she had done physical therapy and was currently working on a home exercise program, she continued to have pain and also for her back pain she was taking Hydrocodone and Tizanidine as needed and worse at night and with activities. MRI of right shoulder performed on 10/15/2020 revealed trace fluid within the subacromial sub-deltoid bursa, trace glenohumeral joint effusion, negative for rotator cuff tear, labrum, and biceps tendon appear intact and minimal acromioclavicular arthrosis. **Impression**: Impingement syndrome of right shoulder. **Plan**: Recommended to try one more CSI, but if not helping would like to proceed with arthroscopic decompression and debridement and advised to follow up next week for CSI and further discussion, continue NSAIDs, and ice as needed.	Jane Doe-page 108-109
11/02/2020	Athletic Orthopedics and Knee Center Joel Rodriguez, M.D.	**Office Visit** Patient was here for follow up on right shoulder. She previously received an injection in March, which helped for a few months. She was recently in the hospital for gastroparesis in September 2020, so she was trying to avoid anti-inflammatories; she had taken Promethazine with Codeine from her gastroenterologist. **Treatment**: CSI's (6:2) ultrasound-guided to the subacromial space of the right shoulder performed. **Assessment**: Right shoulder impingement syndrome **Plan**: Recommended conservative management	Jane Doe-page 110-111

		including exercise to avoid frozen shoulder, avoid anti-inflammatories secondary to GI issues, avoid overhead activity and work on rotator cuff strengthening and advised to follow up in 1 month.	
12/17/2020	Athletic Orthopedics and Knee Center Signature Illegible.	**Follow-up Visit** *(Handwritten/partially illegible – only what could be read is reported)* Patient was seen for follow up visit and continued with lower back pain rated at 4-5/10 and was working with Dr. Rodriguez.	Jane Doe-page 86-88

<< Back to jane doe.pdf-page 5

<< Back to jane doe.pdf-page 10

<< Back to jane doe.pdf-page 11

<< Back to jane doe.pdf-page 13

<< Back to jane doe.pdf-page 14

<< Back to jane doe.pdf-page 15

<< Back to jane doe.pdf-page 16

<< Back to jane doe.pdf-page 18

<< Back to jane doe.pdf-page 19

<< Back to jane doe.pdf-page 27

<< Back to jane doe.pdf-page 28

<< Back to jane doe.pdf-page 29

<< Back to jane doe.pdf-page 30

<< Back to jane doe.pdf-page 31

<< Back to jane doe.pdf-page 33

<< Back to jane doe.pdf-page 34

<< Back to jane doe.pdf-page 35

<< Back to jane doe.pdf-page 36

<< Back to jane doe.pdf-page 37

<< Back to jane doe.pdf-page 38

<< Back to jane doe.pdf-page 39

<< Back to jane doe.pdf-page 40

<< Back to jane doe.pdf-page 42

<< Back to jane doe.pdf-page 43

<< Back to jane doe.pdf-page 44

<< Back to jane doe.pdf-page 45

<< Back to jane doe.pdf-page 54

<< Back to jane doe.pdf-page 55

<< Back to jane doe.pdf-page 70

<< Back to jane doe.pdf-page 73

<< Back to jane doe.pdf-page 74

<< Back to jane doe.pdf-page 77

<< Back to jane doe.pdf-page 86

<< Back to jane doe.pdf-page 88

<< Back to jane doe.pdf-page 89

<< Back to jane doe.pdf-page 90

<< Back to jane doe.pdf-page 93

<< Back to jane doe.pdf-page 97

<< Back to jane doe.pdf-page 98

<< Back to jane doe.pdf-page 99

<< Back to jane doe.pdf-page 103

<< Back to jane doe.pdf-page 104

<< Back to jane doe.pdf-page 107

<< Back to jane doe.pdf-page 108

<< Back to jane doe.pdf-page 109

<< Back to jane doe.pdf-page 110

<< Back to jane doe.pdf-page 111

<< Back to jane doe.pdf-page 113

<< Back to jane doe.pdf-page 119

<< Back to jane doe.pdf-page 120

<< Back to jane doe.pdf-page 131

<< Back to jane doe.pdf-page 132