MEDICAL BOARD OF CALIFORNIA
CONSUMER COMPLAINT FORM

PERSON REGISTERING THE COMPLAINT

Please Print or Type

( ) Mr. ( ) Ms.
Name: TREPINSKI (Last Name) KATHRYN (First Name) M (M.I.)

Mailing Address: 509 S. BEVERLY DRIVE

BEVERLY HILLS (City) CA (State) 90212 (Zip)

Phone Number: (310) 201-0022 (Daytime Number) ktrepinski@trepinskilaw.com (Evening Number) (Cell phone/E-mail address)

( ) Mr. ( ) Ms.
Patient Name: WALTER (Last Name) TAMARA (First Name) L (M.I.)

Patient Date of Birth: 10-12-58 **Your Relationship to Patient:** Attorney for Surviving family members

NATURE OF COMPLAINT

Please check the box which best describes the nature of your complaint and provide details on the next page

- [x] **Substandard Care** (e.g., Misdiagnosis, Negligent Treatment, Delay in Treatment, etc.)
- [ ] **Prescribing Issues** (e.g., excessive/under prescribing, Internet)
- [x] **Unlicensed Provider or Aiding/Abetting unlicensed practice**
- [ ] **Sexual Misconduct**
- [ ] **Physician/Provider Impairment** (e.g., Drug, Alcohol, Mental, Physical)
- [x] **Unprofessional Conduct** (e.g., Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest or conviction)
- [x] **Office Practice** (e.g., Failure to Provide Medical Records to Patient, Failure to Sign Death Certificate, Patient Abandonment)

Other _____

Notice: The information included on the complaint form is requested per Section 2220 of the Business and Professions Code. Except for the name of the physician, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. Provide as much information as possible in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of State Law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Attorney General's Office.

I wish to complain about the individual named below. I understand that the Medical Board does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

Check one: ☑ Physician (M.D.) ☐ Podiatrist (DPM) ☐ Physician Assistant (PA) ☐ Registered Dispensing Optician (RDO) ☐ Midwife ☐ Unlicensed Provider

COMPLAINT REGISTERED AGAINST Please Print or Type

Name: MADAN (Last Name) ATUL (First Name) K (MI) #C53803

Office/Facility Name: BEVERLY HILLS SURGICAL CTR. **License No.** (If known): C 53803

Street Address: 9001 WILSHIRE BLVD. (Address) BEVERLY HILLS (City) CA (State) 90211 (Zip Code) SUITE #106

Phone Number: (800) GET-SLIM

Has the patient been examined/treated by another professional for this same condition?
☐ No ☐ Yes If yes, provide name and address on the Authorization for Release of Medical Information

Reason for Treatment: LAP BAND PROCEDURE - PATIENT DIED

Date(s) of Treatment: PROCEDURE: 12-23-10 EXPIRED: 12-26-10

DETAILS OF COMPLAINT
(Attach additional sheets if necessary)

Patient Tamara Lynn Walter died following a lap band procedure. Post surgery, in recovery, she extubated herself. Extubation discovered, patient re-intubated. Patient extubated herself a second time. No airway management, patient went into cardiac arrest. When discovered, epi. administered through wrist IV. IV not patent. Medication delivered subcutaneously, not effective. Hand became extremely swollen and cyanotic. Gangrene eventually developed. Patient removed from life support at Family's request. Third death at this clinic. Dr. Madan also had another patient expire post lap-band surgery 2/15/2010.