COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 7:49 AM
Time Out: 8:11 AM

PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY

A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER AND THE INSURER.

1. REPORT TYPE ☐ Initial ☑ Progress ☐ Closing

2. CASE INFORMATION

Date of Injury	06/24/2015	Workers' Comp #	
Injured Worker's Name	Barry Kappius	Insurer Claim #	
Social Security #	521-73-7016	Insurer Name	GALLAGHER BASSETT
Date of Birth	09/24/1985	Insurer Phone/Fax	(800) 370-0594
Exam Date	06/30/2015	Employer Name	
		Employer Phone/Fax	

3. INITIAL VISIT (only)

Injured worker's description of accident/injury

"Picked up a parking lot pole, took a few steps back, and pain hit"

Are your objective findings consistent with history and/or work related mechanism of injury/illness? ☑ Yes ☐ No

4. CURRENT WORK STATUS ☐ Is Working ☑ Not Working

5. WORK RELATED MEDICAL DIAGNOSIS (ES)
1. Sprains/strains; lumbosacral (joint) (ligament) (846.0).
2. Sprains/strains; sacrum (847 3).
3. Sciatica; Neuralgia or neuritis of sciatic nerve (724.3).

6. PLAN OF CARE

a. TREATMENT PLAN

- ☐ Diagnostic tools/tests: exam-> better
- ☐ Procedures: stretches
- ☐ Therapy: pt
- ☐ Medications
- ☐ Supplies
- ☐ Other

b. WORK STATUS

- ☐ Able to return to full duty on
- ☑ Able to return to modified duty from 06/30/2015 to 07/07/2015
- ☐ Unable to work from to
- ☐ Able to return to part time work on for hrs per day

c. LIMITATIONS/RESTRICTIONS ☐ No Restrictions ☑ Temporary Restrictions ☐ Permanent Restrictions

☐ Lifting (maximum weight in pounds)	5-10 lbs.	Walking	hours per day
☐ Repetitive lifting	lbs.	Standing	hours per day
☐ Carrying	lbs.	Sitting	hours per day
☐ Pushing / Pulling	5-10 lbs.	Crawling	0 hours per day
☐ Pinching / Gripping		Kneeling	0 hours per day
☐ Reaching over head		Squatting	0 hours per day
☐ Reaching away from body		Climbing	0 hours per day
☐ Repetitive Motion Restrictions			

Other

rech next week

7. FOLLOW UP CARE AND REFERRALS

a. ☑ Return Appointment Date 07/07/2015 7:45 AM

b. ☐ Referral for ☐ Treatment (specify) ☐ Evaluation (specify)
☐ Impairment Rating ☐ Other (specify)

Referral Appointment to be made by ☐ Injured Worker ☐ Referring physician's office

Referred Provider's Name and Address Phone Number

c. ☐ Discharged for non compliance ☐ Discharged from care (explain)

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)

☐ Injured Worker has reached MMI Date

Maintenance care after MMI required? ☐ No ☐ Yes If yes, specify care

☐ Injured Worker is not at MMI, but is anticipated to be at MMI in/on

☑ MMI date unknown at this time because pending rech

9. PERMANENT MEDICAL IMPAIRMENT

☑ No permanent impairment
☐ Anticipate permanent impairment
☐ Permanent Impairment (attach required worksheets and narrative)
☐ Needs referral to Level II physician for impairment rating (see 7 b above)

10. PHYSICIAN'S SIGNATURE Martin Kalevik 6/30/2015 8:06:01 AM Date of Report 06/30/2015

Print Name Martin C. Kalevik, DO License number 32024

Telephone Number (303) 534-9550

Address 1515 Wazee St #D
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