

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 1:42 PM

Time Out: 2:11 PM

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	09/21/2015	Workers' Comp #	
Injured Worker's Name	Barry Kappius	Insurer Claim #	011260046563WC01
Social Security #	[REDACTED]	Insurer Name	GALLAGHER BASSETT
Date of Birth	09/24/1985	Insurer Phone/Fax	(800) 370-0594
Exam Date	10/22/2015	Employer Name	Employer Solutions Staff/CMG
		Employer Phone/Fax	(952) 767-0053 (952) 767-0740

3. INITIAL VISIT (only)

Injured worker's description of accident/injury
auulsion en left pinky finger

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. Unspecified open wound of left little finger with damage to nail, subsequent encounter (S61.307D).

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests Evaluation _____
 Procedures _____
 Therapy _____
 Medications _____
 Supplies _____
 Other F/u with Dr. Olenick Nov 20

b. WORK STATUS

Able to return to full duty on 10/22/2015 Unable to work from _____ to _____
 Able to return to modified duty from _____ to _____ Able to return to part time work on _____ for _____ hrs per day

c. LIMITATIONS/RESTRICTIONS No Restrictions Temporary Restrictions Permanent Restrictions

<input type="checkbox"/> Lifting (maximum weight in pounds) _____ lbs.	<input type="checkbox"/> Walking _____ hours per day
<input type="checkbox"/> Repetitive lifting _____ lbs.	<input type="checkbox"/> Standing _____ hours per day
<input type="checkbox"/> Carrying _____ lbs.	<input type="checkbox"/> Sitting _____ hours per day
<input type="checkbox"/> Pushing / Pulling _____ lbs.	<input type="checkbox"/> Crawling _____ hours per day
<input type="checkbox"/> Pinching / Gripping _____	<input type="checkbox"/> Kneeling _____ hours per day
<input type="checkbox"/> Reaching over head _____	<input type="checkbox"/> Squatting _____ hours per day
<input type="checkbox"/> Reaching away from body _____	<input type="checkbox"/> Climbing _____ hours per day
<input type="checkbox"/> Repetitive Motion Restrictions _____	

Other _____

7. FOLLOW UP CARE AND REFERRALS

a. Return Appointment Date 11/25/2015 2:00 PM

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) _____

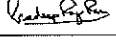
8. MAXIMUM MEDICAL IMPROVEMENT (MMI)

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 evaluation pending by specialist

9. PERMANENT MEDICAL IMPAIRMENT

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

10. PHYSICIAN'S SIGNATURE  10/22/2015 2:01:01 PM Date of Report 10/22/2015
Print Name Pradeep Rai, MD License number 0054622
Telephone Number (303) 292-0034
Address 9195 Grant St #100
Thornton, CO 80229