Medical Referral to Employer

Employee Name: Brittany Hoisington **Date of Injury:** 5-8-08

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Health Care Provider who completes this form to release any information to The Suzlon Rotor Corporation which substantiates, clarifies, or elaborates on my fitness for duty.

Employee Signature _____ Date _____

Medical Provider _____ **Date / Time of Appt:** _____

ALL WORKERS' COMPENSATION MEDICAL EXPENSES must include the patient name, date of service, and Medical Provider's "Progress Notes" for treatment. Social Security Number is recommended. Mail all claims for payment directly to:

Berkley Risk
PO BOX 59143
Minneapolis, MN 55459-0413
(612)766-3000

Incomplete billings or those mailed directly to Corporate Management Group may result in slow payment processes.

Diagnosis: _____ ____ **Non-work related**

_____ ____ **Undetermined**

Treatment Plan: _____ ____ **Work related**

RETURN TO WORK: ____ **With No Limitations** **Date:** _____

(Suzlon rotor Corp. has an active return-to-work program. Most temporary restrictions can be accommodated. Please call 507-562-6700 if you have any questions regarding light duty jobs.)

____ **TOTALLY DISABLED:** (Dates) From: _____ To: _____

X **RESTRICTED WORK:** **Duration of Limitations:** 4 days Days/Weeks

____ Restricted Work Hours: May Work ____ hours per day ____ hours per week.
____ Restricted Lifting: Maximum lift: ____10lbs ____20lbs ____30lbs ____40lbs ____50lbs
Weight limit for repetitive lifting or carrying: (more frequent than 2 times per hour)
____ 0-5lbs ____ 5-10lbs ____ 10-20lbs ____ 20-30lbs ____30-40
____ Restricted bending: (Limit in degrees) ____ Bending frequency (# of times per hour): ____
X Restricted use of hand: ___ Right X Left X No Use or ___ Limited repetitive grasping, gripping
____ Standing/Sitting: Standing (hours per day) ____ Sitting (hours per day) ____
____ Other: _____

Next Appt. Date / Time: _____ **Provider's Comments:** _____

Medical Provider Signature: B Kaminski **Date:** 5/8/08

Please fax back to 507.562.6800 – Attn CMG.

Health Care Provider Report

See Instructions on Reverse Side
(WHEN COMPLETED RETURN TO REQUESTER)

HC01

DO NOT USE THIS SPACE

Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
504171167	5-8-08	11-1-89
EMPLOYEE: Brittany Hoisington	EMPLOYER: Suzlon Rotex	
INSURER/SELF-INSURER/TPA	INSURER CLAIM NUMBER	
INSURER ADDRESS		
CITY	STATE ZIP CODE	

REQUESTER must specify all items to be completed by health care provider. ☐ Items: _____ ☐ MMI (#9) ☐ PPD (#10)

HEALTH CARE PROVIDER TO COMPLETE ITEMS REQUESTED ABOVE

1. Date of first examination for this injury by this office: 5-8-08 (date)
2. Diagnosis (include all ICD-9-CM codes): contusion (2) hand
3. History of injury or disease given by employee: got hand caught between rack + bar
4. In your opinion (as substantiated by the history and physical examination) was the injury or disease caused, aggravated or accelerated by the employee's alleged employment activity or environment? ☐ No ☑ Yes
5. Is there evidence of pre-existing or other conditions that affect this disability? ☑ No ☐ Yes If yes, describe:
6. Is further treatment of this injury or referral to another doctor planned? ☑ No ☐ Yes If yes, describe:
7. Has surgery been performed? ☑ No ☐ Yes If yes, date and describe: (date)
8. Attach the most recent Report of Work Ability. Date of report: 5/8/08 (date)
9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) ☑ No ☐ Yes Date reached:
10. Has the employee sustained any permanent partial disability from the injury? ☐ No ☐ Yes ☑ Too early to determine
    The permanent partial disability is % of the whole body. This rating is based on Minn. Rules:

5223.	%	5223.	%
5223.	%	5223.	%

NAME (Type or Print) BRUCE W KOCOUREK, DO	SIGNATURE B-Kocourek		DEGREE
ADDRESS PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164	STATE	LICENSE #/REGISTRATION #	
CITY 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #	DATE SIGNED 5/8/08

MN HC01 (7/01).

Report of Work Ability

See Instructions on Reverse Side

RW01

DO NOT USE THIS SPACE

Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

This form must be provided to the employee.
(Minn. Rules 5221.0410, subp. 6)

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

SOCIAL SECURITY NUMBER	DATE OF INJURY
504 171167	5-8-08
EMPLOYEE: Brittany Hoisington	Date of Birth: 11-1-89
EMPLOYER: Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 5-8-08 (date)

Select the appropriate option(s) below and fill in the applicable dates.

1. ☐ Employee is able to work without restrictions as of _____ (date)

2. ☒ Employee is able to work with restrictions, from 5/8/08 (date) to 5/12/08 (date)

The restrictions are:

no use (L) hand

3. ☐ Employee is unable to work at all, from _____ (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR 5/12/08 (date)

NAME (Type or Print)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO	B. Kocourek	
ADDRES: PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164	STATE	LICENSE #/REGISTRATION #
507-825-5700 FAX 507-825-4744		
CITY: DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE # / DATE SIGNED: 5/5/08

MN RW01 (7/01)