# ESSG Medical Referral to Employer

**Employee Name:** Debbie Schars **Date of Injury:** _____

**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:

**ESSG**
**7300 Metro Blvd**
**Ste. 635**
**Edina, MN 55439**
**(952)835-1288**
**Fx: (952)835-1255**

Diagnosis: contusion (R) elbow + hip & fall

Treatment Plan: NSAID, Ice

____ **Non-work related**

____ **Undetermined**

__—__ **Work related**

**RETURN TO WORK:** X **With No Limitations** **Date:** 6/12/08

**(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: _____

____ **RESTRICTED WORK:** **Duration of Limitations:** _____ 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): _____
____ Restricted use of hand: ___ Right ___Left ___ 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-Rasmussen **Date:** 6/12/08

*Please fax back form to 507.562.6800 – Attn CMG/ESSG*

# 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 |
|---|---|
| 476900266 | 6-10-08 |
| EMPLOYEE Debbie Schons | Date of Birth 7-29-60 |
| EMPLOYER CMG | |
| INSURER/SELF-INSURER/TPA | |
| INSURER CLAIM NUMBER | |

Date of most recent examination by this office 6-12-08 (date)

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

1. ☐ Employee is able to work without restrictions as of 6/12/08 (date)

2. ☐ Employee is able to work with restrictions, from (date) to (date)

The restrictions are:

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

The next scheduled visit is: ☐ as needed OR (date)

| NAME (Type or Print) | SIGNATURE | DEGREE |
|---|---|---|
| BRUCE W KOCOUREK, DO<br>PIPESTONE COUNTY MEDICAL CENTER<br>ADDRESS 920 4TH AVE SW PIPESTONE MN 56164<br>507-825-5700 FAX 507-825-4744<br>DEA BK0472477 MN LIC 34116<br>CITY UPIN D25406 NPI 1699738559 | B. Kocourek | |
| | STATE | LICENSE #/REGISTRATION # |
| | AREA CODE / TELEPHONE # | DATE SIGNED 6/12/08 |

MN RW01 (7/01)

# Health Care Provider Report

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

HCO1

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 |
|---|---|---|
| 476 00 2166 | 6-10-08 | 7-29-60 |
| EMPLOYEE: Debbie Schons | EMPLOYER: CMG | |
| 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: 6-12-08 (date)

2. Diagnosis (include all ICD-9-CM codes):
contusion @ elbow + hip & fall

3. History of injury or disease given by employee:
tripped over a metal bar @ work et injured Rt elbow et wrist et Rt hip.

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: 6/12/08 (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 | | 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 6/12/08 |

MN HCO1 (7/01).

# FITNESS FOR DUTY

Employees who are absent due to illness or injury (either work-related or non-occupational) may be required to have their physician or other qualified health provider complete a Fitness for Duty Certification before returning to work. The completed form should be returned to Human Resources will make a determination as to his/her ability to return to work. No employee will be allowed to return to work without a satisfactory Fitness for Duty Certification on file.

Employee Name: Debbie Schons Date: 6/12/08

Is employee able to perform the functions of his/her position? X Yes ___ No

Any restrictions? ___ Yes X No If yes, please describe restriction(s) and duration below:

RETURN TO WORK: X With No Limitations Date: 6/12/08

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_____ Restricted bending: (Limit in degrees) _____ Bending frequency (# of times per hour): _____

_____ Restricted use of hand: ___ Right ___Left ___ 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: _____

Employee Signature: B. Kennedy

Physician or Practitioner Signature: B. Kennedy

Type of Practice: (Field of Specialization) FP