

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In:
Time Out:

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	<u>01/16/2016</u>	Workers' Comp #	
Injured Worker's Name	<u>Stormy Soltero</u>	Insurer Claim #	<u>011260-049631-WC-01</u>
Social Security #	<u>522-77-3355</u>	Insurer Name	<u>GALLAGHER BASSETT</u>
Date of Birth	<u>05/27/1990</u>	Insurer Phone/Fax	<u>(800) 370-0594</u>
Exam Date		Employer Name	<u>Employer Solutions Staff/CMG</u>
		Employer Phone/Fax	<u>(952) 767-0053 (952) 767-0740</u>

3. INITIAL VISIT (only)

Injured worker's description of accident/injury

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 Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, unspecified arm. initial encounter (S16.919A).

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests No show, left message for patient to call and reschedule appt.

Procedures _____

Therapy _____

Medications _____

Supplies _____

Other _____

b. WORK STATUS

Able to return to full duty on _____ 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 _____

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 _____

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

Date of Report 02/08/2016

Print Name George A. Kohake, MD License number 28449

Address 9195 Grant St #100 Telephone Number (303) 292-0034

Thornton, CO 80229