

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 12:50 pm
Time Out: 1:17 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 # 01-263045503WC01
Social Security # [REDACTED] Insurer Name GALLAGHER BASSETT
Date of Birth 09/24/1985 Insurer Phone/Fax (800) 577-0594
Exam Date 12/30/2015 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? Yes No

4. CURRENT WORK STATUS Is Working Not Working

5. WORK RELATED MEDICAL DIAGNOSIS (ES) 1. Unspecified open wound of left distal finger with drainage to nail, subsequent encounter (S61.307D).

6. PLAN OF CARE

a. TREATMENT PLAN

- Diagnostic tools/tests EXAM
- Procedures
- Therapy
- Medications
- Supplies
- Other

b. WORK STATUS

- Able to return to full duty on 12-30-15
- Able to return to modified duty from _____ to _____
- Able to return to part time work at _____ for _____ hrs per day

c. LIMITATIONS/RESTRICTIONS

- No Restrictions
- Temporary Restrictions
- Permanent Restrictions
- Lifting (maximum weight in pounds) _____ lbs. Working _____ hours per day
- Repetitive lifting _____ lbs. Standing _____ hours per day
- Carrying _____ lbs. Sitting _____ hours per day
- Pushing / Pulling _____ lbs. Crawling _____ hours per day
- Pinching / Gripping _____ Reaching _____ hours per day
- Reaching over head _____ Reaching away from body _____ hours per day
- Repetitive Motion Restrictions _____ hours per day

Other _____

7. FOLLOW UP CARE AND REFERRALS

- a. Return Appointment Date _____
- b. Referral for Treatment (specify) _____ Impairment Rating _____
- 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 12-30-2015
- Maintenance care after MMI required? No Yes (if yes, specify) _____

- 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
- Anticipate permanent impairment Permanent impairment (if rating requires worksheets and narrative)
- Anticipate permanent impairment No permanent impairment (if physician has impairment rating (see 7 b above))

10. PHYSICIAN'S SIGNATURE

Print Name RIK SANTAGUIDA MD License number 12-30-2015 22538
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