Medical Referral to Employer

Employee Name: Dustin Ruble **Date of Injury:** 2-22-08

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.

Dustin Ruble
Employee Signature

2-22-08
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: FB @ eye

Treatment Plan: Ab. eyedrops

____ **Non-work related**

____ **Undetermined**

____ **Work related**

RETURN TO WORK: X **With No Limitations** **Date:** 2/22/08

(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: prn **Provider's Comments:** _____

Medical Provider Signature: B. Ramundo **Date:** 2/22/08

Please fax back to 507.562.6800 – Attn CMG.

EYE SYMPTOMS

ircle or √ = Present or Yes, ☐ Absent or No, ut = Not Done

Date: 02 / 22 / 08 Time: AM PM

Name: Dustin Ruble (M) F

Birth Date: 0_ / 1_ / 82 Race: C B L A O

VITAL SIGNS

Age 25 WT 153 HT. TEMP O2 Sat

BP (L) 130/80 (R) / PULSE RR

HPI - SUBJECTIVE

4

Chief Complaint: eye: ☐ pain ☐ discharge ☐ vision problem ☐ irritation L (R) both ☐ trauma

other:

Symptoms began: # today D W M Ago

☐ trauma Hx ☒ object in eye

Assoc symptom(s): ☐ fever ☐ headache ☐ N / V ☐ malaise ☐ achiness ☐ drainage / pain ☐ sinus / nasal ☐ earache ☐ sore throat ☐ cough

☐ blurred vision ☐ photophobia ☐ vision loss ☐ scotoma

☐ diplopia ☐ weakness

☐ recently treated elsewhere:

☐ treatment tried: irrigate eye @ work

☐ response: eye felt scratchy, like being

☐ similar symptoms previous: Poked

was grinding hand rail at. got some in (R) eye.

∅ vision changes

REVIEW OF SYSTEMS

9/2

GENERAL / CONST

☐ fatigue ☐ appetite ☐ wt loss

☐ sleep (L) eye 20/20

☐ fever (R) eye 20/25

RESPIRATORY

☐ asthma ☐ smoker

☐ cough

☐ bronchitis ☐ pneumonia

☐ second hand smoke ☐ TB

∅

EYES

☒ vision: OK ☐ correction

☐ allergic symptoms

☐ cataracts ☐ glaucoma

☐ surgery

∅

ENT

☐ nasal allergies ☐ hayfever

☐ frequent URI's

☐ tinnitus ☐ HOH

∅

NEURO

HA: ☐ uni lateral ☐ holocranial ☐ facial/sinus ☐ post cervical ☐ sharp ☐ dull ☐ throbbing ☐ aching ☐ vision SX ☐ aura ☐ N/V ☐ stress ☐ light sens

___ times per D W M Y

last ___ min hrs days

☐ burning pain ☐ numbness

☐ vision trouble ☐ dizzyness

☐ unilateral N T W

☐ memory ☐ tremor ☐ strength

PAST HISTORY

1

☐ History of problem

Family Hx

Physician Signature

☐ Face Sheet Reviewed

Allergies ☐
Problem List ☐
Medications ☐
PMFH ☐
Lab Results ☐

Eye Management Flow Sheet

Pipestone Medical Group Avera 920 - 4th Ave. SW, Pipestone, MN 5616_ 507-825-5700 or 800-322-11__

Bruce W. Kocourek, DO

OBJECTIVE

12/2

Appearance ☒ alert ☐ tired ☐ NAD ☐ neat ☐ anxious ☐ ill

Distress ☒ mild ☐ mod ☐ severe

Build ☐ obese ☒ average ☐ slender

HEENT:

Eyes

R L conjunctival injection
R L scleral injection / hemorrhage
R L exudate
R L ciliary flush (L) eye: WNL
R L hordeolum
R L foreign body
R L irreg / unequal pupil
R L abnl reflex
R L abnl fundus (R) eye: NO
R L anesthetic object present in
R L fluorescein eye.

Neck ☐ goiter ☐ lymphadenopathy ☐ tenderness

CHEST: ☐ abnl breath sounds ☐ murmur ☐ PMI abnl

ASSESSMENT

3

☐ Conjunctivitis, acute 372.00		☐ Sinusitis acute	461.9
☐ Allergic conj, acute 372.05		☐ Influenza	487.1
☐ Corneal abrasion	918.1	☐ Bronchitis acute	466.0
☐ Vision loss acute, one eye	369.8	☐ Common Cold	460
☐ Amaurosis fugax	362.34	☐ Opthalmoplegic Migraine	346.8*
☐ Hordeolum	373.1*	☐ Classic Migraine	346.0*
☐ Blepharitis, unspc	373.00	☐ Diabetic retinopathy	250.5*
☐ URI	465.9	☐ Diplopia	368.2
☐ Viral Syndrome, acute	079.99	☐ Scotoma	368.4*
☐ Rhinitis / Sinusitis Allergic	477.9	☐ Blurred vision, NOS	368.8
☐ Keratoconjunctivitis sicca	370.33	☐ Eye injury, unspc	918.9
☐ Pterygium	372.4	☐ Pain in / around eye	379.91
☒ FB (R) eye		☐	

PLAN

Labs, Imaging & Treatments Ordered:

Instructions:

☐ eye patch with ___ for ___ hrs
☐ eye care sheet given ☐ Strap precautions discussed
☒ instructed to call if SX worsen or if new SX develop
☐ call if pain, decreased vision, or discharge present when patch is removed

- Fluro stain to (R) eye. NO Cornea abrassion present.

Handouts: - Return to normal activities.

MEDICATIONS

1

Over the Counter: ☒ ibuprofen or Tylenol PRN pain.

Prescriptions: Garamycin opth. gtts sig: 2gtts OU QID

FOLLOW UP

F / U or call if not better / well in (PRN) D W M

☐ Add dictation to note

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: Dustin Ruble Date: 2/22/08

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: 2/22/08

(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.)

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____ 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: _____

Employee Signature: Dustin Ruble

Physician or Practitioner Signature: B. Ramaker

Type of Practice: (Field of Specialization) FP

Please fax back to 507.562.6800 – Attn CMG.

Health Care Provider Report

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

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

HC01

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
472 98 5037	2-22-08	7-15-82
EMPLOYEE: Dustin Ruble	EMPLOYER: Suzlon	
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: 2-22-08 (date)
2. Diagnosis (Include all ~~ICD-9~~-CM codes):
   FB (R) eye
3. History of injury or disease given by employee:
   got something in eye grinding sort of blob
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: 2/22/08 (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)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONECOUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	B Kocourek	
ADDRESS / CITY	STATE / LICENSE #/REGISTRATION #	
	AREA CODE / TELEPHONE #	DATE SIGNED 2/22/08

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
472985037	2-22-08
EMPLOYEE: Dustin Ruble	Date of Birth: 7-15-82
EMPLOYER: Sutton	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 2-22-08 (date)

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

1. [X] Employee is able to work without restrictions as of 2/22/08 (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 ADDRES PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 CITY DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	B. Kocourek	
	STATE	LICENSE #/REGISTRATION #
	AREA CODE / TELEPHONE #	DATE SIGNED: 2/22/08

MN RW01 (7/01)