

DAVIS, JEREMY W

Scan on 5/10/2016 by User: Lee A Spencer, MA of 5/9/2016 Notes, Medco 14, to Workstar from Dr.



Bureau of Workers' Compensation

Physician's Report of Work Ability

D.O. B 8/3/79

Injured worker name <u>Jeremy Davis</u>	Claim number <u>16-814288</u>	Date of injury <u>4-11-16</u>
Employer name and injured worker's position of employment at time of injury	Date of last exam or treatment <u>5-9-16</u>	Next appointment date

**Injured worker progress**

The injured worker is progressing:  As expected  Better than expected  Slower than expected

1 If a MEDCO-14 was previously completed for this injured worker, are there any changes to the information provided in Section 2 through 7 to report at this time?  Yes  No *If yes, proceed to section 2. If no, proceed to section 8.*

**Work status**

Did you review a description of the injured worker's job duties as they existed on the date of injury (former position of employment)? Check all applicable boxes.

Yes, I was provided a job description (verbal or written) by the  Injured worker  Employer  MCO

No, I have not been provided a job description.

Select one of the three options below.

2  Injured worker is temporarily not released to any work, including the former position of employment from (date): \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ *Please complete required sections 4, 5, 6, 7 and 8.* Surgery to be scheduled.

Injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions. from (date): \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ *Please complete required sections 3, 4, 5, 6, 7 and 8.*

The restrictions are:  Permanent  Temporary if temporary until what date? \_\_\_/\_\_\_/\_\_\_

Injured worker is released to the former position of employment without restrictions as of (date): 5.10.16

Is this date the day the injured worker actually returned to work?  Yes  No  I don't know. *Proceed to section 8 and complete it.*

**Injured worker's capabilities. Employer will use information in this section to evaluate available and appropriate work opportunities**

How many total hours is this injured worker potentially able to work? 8 Hours in a day 40 Hours in a week

**Upper extremities**

The injured worker is able to perform simple grasping with:  Left hand  Right hand  Both

The injured worker is able to perform repetitive wrist motion with:  Left hand  Right hand  Both

The injured worker's dominant hand is:  Left  Right

**Lower extremities**

The injured worker is able to perform repetitive actions to operate foot controls or motor vehicles with:  Left foot  Right foot  Both

**Medications**

The injured worker is able to safely perform work duties which, if applicable, may include operating heavy machinery or driving while taking prescribed medications:  Yes  No

If no, what are the potential side effects:  Dizziness  Drowsiness  Impaired ability  Other, please explain

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously

Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C	Activity	N	O	F	C	Activity	N	O	F	C
0 - 10 lbs.					13 to 25 lbs.					Bend					Reach above shoulder				
11 - 20 lbs.					26 to 40 lbs.					Squat					Type/keyboard				
21 - 40 lbs.					41 to 60 lbs.					Kneel					Driving				
41 - 60 lbs.					61 to 100 lbs.					Twist/tum					Automatic				
61 - 100 lbs.					100 + lbs.					Climb					Standard shift				

3 In an eight-hour workday, how many total hours is the injured worker potentially able to work?

Sit: \_\_\_ hours  Continuously  With break Walk: \_\_\_ hours  Continuously  With break Stand: \_\_\_ hours  Continuously  With break

**Degree of functional impairment based on allowed psychological conditions only, if applicable.**

Activities of daily living: Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities and occupational functioning	None	Mild	Moderate	Marked	Extreme
Social functioning: Capacity to interact and communicate effectively and get along with others	<input type="checkbox"/>				
Concentration, persistence and pace: Ability to sustain focused attention long enough to complete tasks commonly found in the workplace	<input type="checkbox"/>				
Adaptation: Ability to appropriately react to stressful circumstances, including the workplace; includes attendance, making decisions, scheduling or completing tasks and interacting with supervisors and co-workers	<input type="checkbox"/>				

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**Disability period information (all fields required including site/location if applicable)**

Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and ICD code for the conditions being treated due to the work-related injury. Please indicate if the condition is causing temporary total disability (all fields required, including site/location, if applicable).

Narrative description of the work-related condition	Site/Location if applicable	ICD code	Is the condition causing temporary total disability?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

List all other conditions being treated (attach additional sheet if necessary).

**Clinical findings**

Provide your clinical and objective findings supporting your medical opinion outlined on this form. List any barriers to return to work and any reason for the injured worker's delay in recovery.

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**Maximum medical improvement (MMI)**

MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability in spite of continuing medical or rehabilitative procedures. An injured worker may need supportive treatment to maintain this level of function. Note: periodic medical treatment may still be requested and provided.

Has the work-related injury(s) or occupational disease reached MMI based on the definition above?  Yes  No

If yes, give MMI date: \_\_\_/\_\_\_/\_\_\_ If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

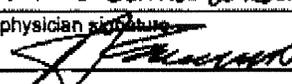
**Vocational rehabilitation**

Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions, and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?

Yes  No If no, please explain why and provide your recommendations to help the injured worker return to employment.

**Treating physician signature - mandatory**

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Treating physician's name (please print legibly) <b>Adam D. Cash M.D.</b>	Physician PEACH number <b>279783015-00</b>
Address <b>1950 Niles-Corland Rd. NE</b>	City <b>Warren</b>
State <b>OH</b>	Nine-digit ZIP code <b>44484</b>
Treating physician signature 	Date <b>5/9/16</b>
	Telephone number <b>330-856-2545</b>
	Fax number <b>330-856-2542</b>