COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 9:11 AM
Time Out: 9:30 AM

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: 04/18/2016
Injured Worker's Name: Jonathan C. Cavalier
Social Security #:
Date of Birth: 03/21/1994
Exam Date: 05/05/2016

Workers' Comp #:
Insurer Claim #: 011260-052334-WC-01
Insurer Name: GALLAGHER BASSETT
Insurer Phone/Fax: (800) 370-0594
Employer Name: Employer Solutions Staff/CMG
Employer Phone/Fax: (952) 767-0053 (952) 767-0740

INITIAL VISIT (only)

Injured worker's description of accident/injury

Started feeling numbness in left hand and pain

Are your objective findings consistent with history and/or work related mechanism of injury/illness? ☑ Yes ☐ No

CURRENT WORK STATUS ☑ Is Working ☐ Not Working

WORK RELATED MEDICAL DIAGNOSIS (ES)
1. Other synovitis and tenosynovitis, left hand (M65.842).
2. Carpal tunnel syndrome, left upper limb (G56.02).

PLAN OF CARE

a. TREATMENT PLAN

☑ Diagnostic tools/tests: Exam
☐ Procedures:
☑ Therapy: OT 2x/wk for 4 wks
☑ Medications: Rx Naproxsen 1 tablet twice daily with food.
☐ Supplies:
☑ Other: Wear splint at all times except to shower. referral to ortho hand

b. WORK STATUS

☐ Able to return to full duty on ____ ☐ Unable to work from ____ to ____
☑ Able to return to modified duty from 05/05/2016 to 05/26/2016 ☐ Able to return to part time work on ____ for ____ hrs per day

LIMITATIONS/RESTRICTIONS ☐ No Restrictions ☑ Temporary Restrictions ☐ Permanent Restrictions

☐ Lifting (maximum weight in pounds)	____ lbs.	Walking	____ 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		Kneeling	____ hours per day
☐ Reaching over head		Squatting	____ hours per day
☐ Reaching away from body		Climbing	____ hours per day

☑ Repetitive Motion Restrictions
Must wear splint at work. For every 30 minutes of repetitive work, must have 15 minutes of no repetitive work.

Other
Do not overuse right hand.

FOLLOW UP CARE AND REFERRALS

☑ Return Appointment Date 05/26/2016 9:30 AM
☐ 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 ____
☐ Discharged for non compliance ☐ Discharged from care (explain) ____

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 ____

PERMANENT MEDICAL IMPAIRMENT

☑ No permanent impairment
☐ Anticipate permanent impairment
☐ Permanent Impairment (attach required worksheets and narrative)
☐ Needs referral to Level II physician for impairment rating (see 7 b above)

PHYSICIAN'S SIGNATURE [signature] 5/5/2016 9:32:47 AM Date of Report 05/05/2016
Print Name Pradeep Rai, MD License number 0054622
Address 125 E Hampden Avenue Englewood CO 80113 Telephone Number (303) 788-9292

05/06