



17710 Old Excelsior Blvd.
Minnetonka, MN 55345
800-4STUBBE (800-478-8223)
Fax: 952-474-6508
www.stubbe.com

TELEFAX TRANSMITTAL

DATE: 2-7-2008

TO: Eileen Stephenson 612-677-3043

FROM: Jane Fest, R.N.,BSN, MS

Number of pages to follow: 1

If you do not receive all pages, please call me at (507) 793-2273 or fax me at (507) 793-2274.

NOTES/COMMENTS: re: Kathy Topete

Return to work slip received today.

Thank you,
Jane Fest @

1-877-241-4512

CONFIDENTIAL & PRIVILEGED

THE INFORMATION CONTAINED IN THIS FACSIMILE IS PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED FOR THE SOLE USE OF THE ADDRESSEE

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CENTER FOR SPECIALTY CARE

717 South State Street, Suite 900 ♦ Fairmont, MN 56031

(507) 238-4949 ♦ FAX (507) 238-3370

REPORT OF WORK ABILITY

Date Faxed: _____

EXAM DATE: 2-7-08

NAME: Kathy Topate DOB: _____ MR#: 61552

EMPLOYER: Suzlon JOB TITLE: _____

INJURY/ONSET DATE: _____ WORK RELATED: Yes NO UNDETERMINED

IS INJURY CONSISTENT WITH REPORTED CAUSE: YES NO If not, why? _____

APPARENT DIAGNOSIS: _____

PATIENT DESCRIPTION OF PROBLEM: Lower back pain 5/12/07
while lifting an object

- ABOVE INFORMATION UNCHANGED FROM LAST ORDER
- NO RESTRICTIONS, full work duties (continue with) (starting on) _____ NO WORK -TOTALLY DISABLED
- RESTRICTED WORK (continues) (starting on) _____ May work regular shift hours

WORK/HOME RESTRICTIONS RESTRICTION IN FORCE CURRENT RESTRICTIONS UNCHANGED FROM LAST VISIT

- (No) (Avoid) use of _____ (No) (Avoid) overhead work
- (No) (Avoid) weight bearing on _____ foot (No) (Avoid) working at heights
- Work limited to _____ hours per day (No) (Avoid) repetitive use of _____
- (Should) (Must) rotate on frequent basis

Expanded from the U.S. Department of Labor's Dictionary of Occupational Titles

- VERY HEAVY** Standing & walking: stretch or rest every 2-3 hours. Carry & lift: up to 100 lbs. occasionally, 50 lbs. frequently.
Bending & lifting: 50 lbs. with back straight and no twisting frequently. Pushing & pulling: 100 lbs. without bending or 200 lbs. on wheels.
- HEAVY** Standing & walking: stretch or rest every 2-3 hours. Carry & lift: up to 50 lbs. occasionally, 20 lbs. frequently.
Bending & lifting: 20 lbs. with back straight and no twisting frequently. Pushing & pulling: 50 lbs. without bending or 100 lbs. on wheels.
- MEDIUM** Standing & walking: stretch or rest every 2-3 hours. Carry & lift: up to 35 lbs. occasionally, 15 lbs. frequently.
Bending & lifting: 15 lbs. with back straight and no twisting frequently. Pushing & pulling: 35 lbs. without bending or 50 lbs. on wheels.
- LIGHT** Primarily standing & walking: stretch or rest every hour. Carry & lift: up to 20 lbs. occasionally.
Bending & lifting: 10 lbs. with back straight and no twisting frequently. Pushing & pulling: 20 lbs. without bending or 35 lbs. on wheels.
- SEDENTARY** Primarily sitting: stretch or rest every hour. Stand and walk as tolerated. Pushing & pulling: 10 lbs. occasionally.
Bending & lifting: none. Carry & lift: up to 10 lbs. without bending or 25 lbs. frequently.
- VERY SEDENTARY** Primarily sitting: stretch and postural change as needed. Standing & walking: as tolerated.
Carry & level lift: a negligible amount occasionally. Bending & lifting: pushing & pulling: none

DEFINITION: Occasional: 0-33% of work shift Frequent: 34-66% of work shift Continuously during work shift

HANDS	Avoid OR No (Circle One)			HANDS	Avoid OR No (Circle One)		
	Right	Left	Both		Right	Left	Both
<input type="checkbox"/> Fine Manipulation				<input type="checkbox"/> Firm Grasping			
<input type="checkbox"/> Gross Manipulation				<input type="checkbox"/> One-handed work only			
<input type="checkbox"/> Forceful turning				<input type="checkbox"/> Other:			

TREATMENT: Physician Examination Manipulative Therapy Given

Medication Prescription Given Medications to be continued _____

X-Ray obtained: Area: _____ Results: Pending Normal Abnormal

Splint/Appliance: Area: _____ To Be Used Cont. Only at Work As Needed At Night

Patient Referred To: _____

Patient Referred To: Physical Therapy Occupational Therapy: Date _____

(Dis) Continue with P.T. O.T. Frequency: Daily: _____ Times per week per month

Exercises Given

Keep Wound Clean and Dry Change Dressing Every Day MRI 3 ml voltaren

Return to clinic for recheck _____ Day(s) _____ Week(s) after consultation Date: _____ Time: 12:00

Discharged from clinic - Follow-up only if needed

Additional comments: No clutch, pedal, gear
no wrist, knee brace PT for no

Patient's condition: Much Improved Improved Slightly Improved Unchanged Worsening Much Worse

Patient: Has not reached Maximum Medical Improvement Nearing MMI Has reached MMI

Permanent disability rating: Has not been assigned Pending Has been assigned No PDR indicated

PHYSICIAN: _____

Employee Signature _____

COVER SHEET

DATE : FEB-07-2008 THU 12:22 PM

TO :

FAX # : 916126773043

FROM : PCMC PHYSICAL THERAPY

FAX # : 507 825 0000

3 PAGES WERE SENT
(INCLUDING THIS COVER SHEET)