

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 10:25 AM

Time Out: 10:51 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 | <u>09/29/2016</u> | Workers' Comp # | |
| Injured Worker's Name | <u>Laniel Laird</u> | Insurer Claim # | <u>011260056903WC01</u> |
| Social Security # | | Insurer Name | <u>GALLAGHER BASSETT</u> |
| Date of Birth | <u>01/09/1966</u> | Insurer Phone/Fax | <u>(800) 370-0594</u> |
| Exam Date | <u>10/27/2016</u> | Employer Name | <u>Employer Solutions Staff/CMG</u> |
| | | Employer Phone/Fax | <u>(952) 767-0053</u> <u>(952) 767-0740</u> |

3. INITIAL VISIT (only)

Injured worker's description of accident/injury
repetitive motion

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

4. CURRENT WORK STATUS Is Working Not Working

5. WORK RELATED MEDICAL DIAGNOSIS (ES) 1. Pain in right hand (M79.641).
2. Pain in left hand (M79.642).

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests
 Procedures
 Therapy OT W/ BABETTE
 Medications
 Supplies
 Other AWAIT ERGONOMIC JOB SITE EVAL REFER FOR EMG/NCS 10/27/2016

b. WORK STATUS

Able to return to full duty on _____ Unable to work from _____ to _____
 Able to return to modified duty from 10/27/2016 to _____ Able to return to part time work on _____ for _____ hrs per day

c. LIMITATIONS/RESTRICTIONS No Restrictions Temporary Restrictions Permanent Restrictions

| | | | | |
|--|---------------|-----------|-------|---------------|
| <input checked="" type="checkbox"/> Lifting (maximum weight in pounds) | <u>5</u> lbs. | Walking | _____ | hours per day |
| <input type="checkbox"/> Repetitive lifting | <u>0</u> lbs. | Standing | _____ | hours per day |
| <input checked="" type="checkbox"/> Carrying | <u>5</u> lbs. | Sitting | _____ | hours per day |
| <input checked="" type="checkbox"/> Pushing / Pulling | <u>5</u> lbs. | Crawling | _____ | hours per day |
| <input checked="" type="checkbox"/> Pinching / Gripping | <u>LIMIT</u> | Kneeling | _____ | hours per day |
| <input type="checkbox"/> Reaching over head | | Squatting | _____ | hours per day |
| <input type="checkbox"/> Reaching away from body | | Climbing | _____ | hours per day |
| <input type="checkbox"/> Repetitive Motion Restrictions | | | | |
| NO W/ BOTH HANDS | | | | |
| Other _____ | | | | |

7. FOLLOW UP CARE AND REFERRALS

a. Return Appointment Date 11/03/2016 11:30 AM HR
b. 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 _____
c. Discharged for non compliance Discharged from care (explain) _____

8. 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 IN TXT

9. PERMANENT MEDICAL IMPAIRMENT

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

10. PHYSICIAN'S SIGNATURE Hiep L. Ritzer 10/27/2016 10:47:13 AM Date of Report 10/27/2016
Print Name Hiep L. Ritzer, MD License number 38239
Telephone Number (303) 218-4250
Address 14000 E. Arapahoe Road #160
Centennial, CO 80112-4043