COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 11:27 AM
Time Out: 11:56 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	09/29/2016	Workers' Comp #	
Injured Worker's Name	Laniel Laird	Insurer Claim #	011260056903WC01
Social Security #		Insurer Name	GALLAGHER BASSETT
Date of Birth	01/09/1966	Insurer Phone/Fax	(800) 370-0594
Exam Date	11/03/2016	Employer Name	Employer Solutions Staff/CMG
		Employer Phone/Fax	(952) 767-0053 (952) 767-0740

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 EMG/NCS COMPLETED. REFER FOR HSA

b. WORK STATUS

- ☐ Able to return to full duty on _____
- ☑ Able to return to modified duty from 11/03/2016 to _____
- ☐ Unable to work from _____ to _____
- ☐ Able to return to part time work on _____ for _____ hrs per day

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

☑ Lifting (maximum weight in pounds)	5 lbs.	Walking	_____	hours per day
☐ Repetitive lifting	0 lbs.	Standing	_____	hours per day
☑ Carrying	5 lbs.	Sitting	_____	hours per day
☑ Pushing / Pulling	5 lbs.	Crawling	_____	hours per day
☑ Pinching / Gripping	LIMIT	Kneeling	_____	hours per day
☐ Reaching over head		Squatting	_____	hours per day
☐ Reaching away from body		Climbing	_____	hours per day

☐ Repetitive Motion Restrictions
NO W/ BOTH HANDS

Other

7. FOLLOW UP CARE AND REFERRALS

a. ☑ Return Appointment Date 11/17/2016 11:15 AM 2 WKS 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
☑ Anticipate permanent impairment
☐ Permanent Impairment (attach required worksheets and narrative)
☐ Needs referral to Level II physician for impairment rating (see 7 b above)

10. PHYSICIAN'S SIGNATURE _____ 11/3/2016 11:50:36 AM Date of Report 11/03/2016

Print Name Hiep L. Ritzer, MD License number 38239

Telephone Number (303) 218-4250

Address 14000 E. Arapahoe Road #160
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WC164 05/06