COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 8:10 AM
Time Out: 9:23

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 #	
Social Security #		Insurer Name	GALLAGHER BASSETT
Date of Birth	01/09/1966	Insurer Phone/Fax	(800) 370-0594
Exam Date	09/30/2016	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) Bilateral Tenosynovitis

6. PLAN OF CARE

a. TREATMENT PLAN

- ☐ Diagnostic tools/tests
- ☐ Procedures
- ☐ Therapy
- ☐ Medications
- ☐ Supplies
- ☐ Other

EXAM / MEDROL / BRACE / ERGO

b. WORK STATUS

- ☐ Able to return to full duty on
- ☑ Able to return to modified duty from 9/30 to Next
- ☐ 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.
- ☐ Repetitive lifting ↓ lbs.
- ☐ Carrying ↓ lbs.
- ☐ Pushing / Pulling ↓ lbs.
- ☑ Pinching / Gripping LIMIT R-L
- ☐ Reaching over head
- ☐ Reaching away from body
- ☐ Repetitive Motion Restrictions

Walking	_____	hours per day
Standing	_____	hours per day
Sitting	_____	hours per day
Crawling	_____	hours per day
Kneeling	_____	hours per day
Squatting	_____	hours per day
Climbing	_____	hours per day

Other

7. FOLLOW UP CARE AND REFERRALS

a. ☑ Return Appointment Date 1-2 wks. 10-7-16 @ 9:15

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 _____

☑ MMI date unknown at this time because ACTIVE

9. PERMANENT MEDICAL IMPAIRMENT

☐ No permanent impairment
☐ Anticipate permanent impairment NO

☐ Permanent Impairment (attach required worksheets and narrative)
☐ Needs referral to Level II physician for impairment rating (see 7 b above)

10. PHYSICIAN'S SIGNATURE _____ Date of Report 9/30/16

Print Name Robert Broghammer, MD License number 54410

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Telephone Number (303) 218-4250

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