ALLINA
Hospitals & Clinics
Allina Medical Clinic - Cottage Grove
8611 W Point Douglas Rd S
Cottage Grove MN 55016
651-458-1884

CLINIC REPORT OF WORKABILITY

Employee: Matthew Ryan Diamond	Date: 5/27/2010	Arrival time:
SS#: xxx-xx-6991	DOB: 2/24/1990	Time roomed:
Employer: Employer Solutions	Date of Injury: 5/20/10	Time out:
Employer phone: 952-835-1288	Employer fax: 952-223-6109	Contact person:
Employer contacted: yes		

DIAGNOSIS: R Elbow Pain(Lateral Epicondylitis)
Work related injury/illness? yes
Maximum medical improvement? no
Permanent Partial Disability? no
Anticipate permanent restrictions: no

RETURN TO WORK Return to work WITH LIMITATIONS today through 2 weeks.R Arm Limitations.
EMPLOYEE'S CAPABILITIES

Lift/Carry	Push/Pull	Bend: N/A	Avoid the following hand and wrist activities:
0-10 lbs: frequent, 34-66%	**0-25 lbs:** occasional, 1-33%	Not applicable **Twist/turn:** Not applicable	Operate power/vibrating tools: right Coarse manipulation: not applicable
11-20 lbs: occasional, 1-33%	**26-50 lbs:** Not at all	**Kneel:** Not applicable	Torquing/crimping: not applicable Grasping – light: not applicable
21-35 lbs: occasional, 1-33%	**51-75 lbs:** Not at all	**Squat:** Not applicable **Sit:** Not applicable	Grasping – heavy: right Out-stretched arms: not applicable
36-50 lbs: Not at all	**76-100 lbs:** Not at all	**Stand/walk:** Not applicable **Overhead reaching:** Not applicable	One-handed work only: not applicable **Other:** Not applicable.
51-100 lbs: Not at all		**Ladder/stair climb:** Not applicable **Rotate activities/positions:** Not applicable	

TREATMENT/OTHER RESTRICTIONS:
Medication: Naprosyn for 2 weeks
Ice 15 minutes at a time with light cloth on the skin
Heat 15 minutes at a time with light cloth on the skin
Stretching exercises
The above has been discussed with the employee.

RETURN TO CLINIC: Return to clinic in 2 weeks

_____ License Number: _____
Peter A Badroos, MD
5/27/2010

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

Medical Referral to Employer

Employee Name: Matthew Diamond **Date of Injury:** 5/20

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Health Care Provider who completes this form to release any information to The Suzlon Rotor Corporation which substantiates, clarifies, or elaborates on my fitness for duty.

Matthew Diamond
Employee Signature

5/27/2010
Date

Medical Provider Peter Badros, MD MPH **Date / Time of Appt:** 05-27-2010 10:15

ALL WORKERS' COMPENSATION MEDICAL EXPENSES must include the patient name; date of service, and Medical Provider's "Progress Notes" for treatment. Social Security Number is recommended. Mail all claims for payment directly to:

Berkley Risk
PO BOX 59143
Minneapolis, MN 55459-0413
(612)766-3000

Incomplete billings or those mailed directly to Corporate Management Group may result in slow payment processes.

Diagnosis: _____ _____ **Non-work related**

_____ _____ **Undetermined**

Treatment Plan: _____ _____ **Work related**

RETURN TO WORK: _____ **With No Limitations** **Date:** _____
(Suzlon rotor Corp. has an active return-to-work program. Most temporary restrictions can be accommodated. Please call 507-562-6700 if you have any questions regarding light duty jobs.)

_____ **TOTALLY DISABLED: (Dates) From:** _____ **To:** _____

_____ **RESTRICTED WORK: Duration of Limitations:** _____ Days/Weeks

_____ Restricted Work Hours: May Work _____ hours per day _____ hours per week.
_____ Restricted Lifting: Maximum lift: _____10lbs _____20lbs _____30lbs _____40lbs _____50lbs
Weight limit for repetitive lifting or carrying: (more frequent than 2 times per hour)
_____ 0-5lbs _____ 5-10lbs _____ 10-20lbs _____ 20-30lbs _____ 30-40
_____ Restricted bending: (Limit in degrees) _____ Bending frequency (# of times per hour): _____
_____ Restricted use of hand: ___ Right ___ Left ___ No Use or ___ Limited repetitive grasping, gripping
_____ Standing/Sitting: Standing (hours per day) _____ Sitting (hours per day) _____
_____ Other: _____

Next Appt. Date / Time: _____ **Provider's Comments:** _____

_____

Medical Provider Signature: _____ **Date:** _____

Please fax back to 507.562.6800 – Attn CMG.

See our attached workability