COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 11:17 AM
Time Out: 1:17 PM

# 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 | 04/18/2016 | Workers' Comp # | |
| Injured Worker's Name | Jonathan C. Cavalier | Insurer Claim # | 011260-052334-WC-01 |
| Social Security # | | Insurer Name | GALLAGHER BASSETT |
| Date of Birth | 03/21/1994 | Insurer Phone/Fax | (800) 370-0594 |
| Exam Date | 04/28/2016 | 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

Started feeling numbness in left hand and pain

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. Other synovitis and tenosynovitis, left hand (M65.842).
2. Carpal tunnel syndrome, left upper limb (G56.02).

6. PLAN OF CARE

a. TREATMENT PLAN

| | |
|---|---|
| ☑ Diagnostic tools/tests | Exam |
| ☑ Procedures | Reviewed ER records |
| ☑ Therapy | OT 2x/wk for 4 wks |
| ☑ Medications | Rx Naproxsen 1 tablet twice daily with food. |
| ☐ Supplies | |
| ☑ Other | Wear splint at all times except to shower. |

b. WORK STATUS

☐ Able to return to full duty on _____ ☐ Unable to work from _____ to _____
☑ Able to return to modified duty from 04/28/2016 to 05/05/2016 ☐ 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) | _____ lbs. | Walking | _____ hours per day |
| ☐ Repetitive lifting | _____ lbs. | Standing | _____ hours per day |
| ☐ Carrying | _____ lbs. | Sitting | _____ hours per day |
| ☐ Pushing / Pulling | _____ lbs. | Crawling | _____ hours per day |
| ☐ Pinching / Gripping | _____ | Kneeling | _____ hours per day |
| ☐ Reaching over head | | Squatting | _____ hours per day |
| ☐ Reaching away from body | | Climbing | _____ hours per day |

☑ Repetitive Motion Restrictions
Must wear splint at work. For every 30 minutes of repetitive work, must have 15 minutes of no repetitive work.

Other

Do not overuse right hand.

7. FOLLOW UP CARE AND REFERRALS

a. ☑ Return Appointment Date 05/05/2016 9:00 AM 1 wk

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 to be determined
☐ MMI date unknown at this time because _____

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 [signature] 4/28/2016 12:39:21 PM Date of Report 04/28/2016

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