U.S. HealthWorks

Fax

Date: 10/11/16

To: Kaitlyn Company:

From: USHW - Longmont

Pages: Fax Number: 303-736-7707

Re:

● Comments:

☐Urgent ☐ For Review ☐ Please Comment ☐ Please Reply

1860 Industrial Circle, Suite D ♦ Longmont, CO 80501
Phone: (303) 682-2473 ♦ Fax: (303) 682-0229

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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 **EXAM DATE** 10/12/16

2. **CASE INFORMATION**

Date of Injury	10/06/16	Insurer Claim #	3863334
Injured Worker	GROVES, SHERYL	Insurer Name/TPA	NOT IN SYSTEM
Social Security #	XXX-XX-0509	Insurer Phone/Fax	(999)999-9999 (000)
Date of Birth	11/28/55	Employer Name	NOT IN SYSTEM

3. **INITIAL VISIT (only)**
   a. Injured worker's description of accident/injury _____
   b. Are your objective findings consistent with history and/or work-related mechanism of injury/illness? ☐ Yes ☐ No

4. **CURRENT WORK STATUS** ☐ Working ☒ Not Working

5. **WORK-RELATED MEDICAL DIAGNOSIS(ES)** S60.222D CONTUSION OF LEFT HAND, SUBSEQ

6. **PLAN OF CARE**
   a. **TREATMENT PLAN**
   ☒ Diagnostic tools/tests eval
   ☐ Procedures
   ☐ Therapy
   ☐ Medications
   ☐ Supplies
   ☒ Other wean off splint
   b. **WORK STATUS**
   ☐ Able to return to full duty on _____
   ☐ Able to return to modified duty from _____ to _____
   ☐ Unable to work from _____ to _____
   ☐ Able to return to part time work on _____ for _____ hours 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 _____
   ☒ Other use splint if and as needed

7. **FOLLOW UP CARE AND REFERRALS** - W/c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)
   a. ☐ Return Appointment Date 10/19/16 @ 4:20
   b. ☐ Referral for ☐ Treatment (specify) _____ ☐ Evaluation (specify) _____
   ☐ Impairment Rating ☐ Other (specify) _____
   Referred Provider's Name _____ Phone # _____
   c. ☐ Discharged for Non-Compliance* ☐ Discharged from Care for Nonmedical Reasons*

8. **MAXIMUM MEDICAL IMPROVEMENT (MMI)**
   ☐ Injured Worker has reached MMI Date of MMI _____
   ☒ Injured Worker is not at MMI, but is anticipated to be at MMI in/on 1-2 weeks
   ☐ MMI date unknown at this time because _____

9. **MAINTENANCE CARE AFTER MMI** ☐ Yes ☐ No
   If yes, specify care: _____

10. **PERMANENT MEDICAL IMPAIRMENT (REQUIRED)**
    ☐ No permanent impairment ☐ Permanent Impairment (attached required worksheets and narrative)
    ☐ Anticipate permanent impairment ☐ Needs referral to Level II physician for impairment rating (see 7b above)

11. **PHYSICIAN'S SIGNATURE** Donald D Downs PAC Date of Report 10/12/16

Print Name DOWNS, DONALD D., P.A. License # 1338 Phone # (303)692-2473

WC164 Rev. 11/14

Daniel W Reuter MD

NOT IN SYSTEM 4016
DOS:10/12/16 DOI:10/06/16 DOB:11/28/55
Claim # 3863334
Patient: GROVES, SHERYL
Case # : 452-001635 Ref. # : LEFT HAND