



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

This communication is intended solely for the use of the person (s) named above or others authorized to receive it. This communication may include privileged and confidential information and any use, dissemination, or reproduction by unauthorized persons is absolutely prohibited. If you have received this communication in error, please notify the sender immediately.

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 10/07/16

2. CASE INFORMATION

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

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) S50.222D CONTUSION OF LEFT HAND, SUBSEQ, S63.92XD SPRAIN OF UNSE PART OF LEFT WR

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests xray reviewed - no fracture

Procedures _____

Therapy _____

Medications Etodolac 1/day - Rx

Supplies splint - into hand

Other _____

b. WORK STATUS

Able to return to full duty on _____

Able to return to modified duty from 10/07/16 to _____

Unable to work from _____ to _____

Able to return to part time work on _____ for _____ hours per day

c. LIMITATIONS/RESTRICTIONS

<input checked="" type="checkbox"/> Lifting (maximum weight in pounds)	<u>2</u> lbs.	<input checked="" type="checkbox"/> Temporary Restrictions	<input type="checkbox"/> Permanent Restrictions
<input checked="" type="checkbox"/> Repetitive lifting	<u>2</u> lbs.	<input type="checkbox"/> Walking	_____ hours per day
<input checked="" type="checkbox"/> Carrying	<u>2</u> lbs.	<input type="checkbox"/> Standing	_____ hours per day
<input checked="" type="checkbox"/> Pushing / Pulling	<u>2</u> lbs.	<input type="checkbox"/> Sitting	_____ hours per day
<input checked="" type="checkbox"/> Pinching / Gripping	<u>no w/4th finger</u>	<input type="checkbox"/> Crawling	_____ hours per day
<input type="checkbox"/> Reaching over head		<input type="checkbox"/> Kneeling	_____ hours per day
<input type="checkbox"/> Reaching away from body		<input type="checkbox"/> Squatting	_____ hours per day
<input type="checkbox"/> Repetitive Motion Restrictions		<input type="checkbox"/> Climbing	_____ hours per day
<input type="checkbox"/> Other			

7. FOLLOW UP CARE AND REFERRALS - *7c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)

a. Return Appointment Date _____

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 4 - 6 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 M.D. Date of Report 10/07/16

Print Name DOWN, DONALD D., P.A. License # 1238 Phone # (303) 682-2473

NOT IN SYSTEM 4016
DOS:10/07/16 DOI:10/06/16 DOB:11/28/55

Patient: GROVES, SHERYL
Case # : 452-001625 Ref # : LEFT HAND