Midtown Occupational Health Services, P.C. 242 26th Ave. Ste 200-D, Denver CO 80211 Phone: 303-831-9393 Fax: 303-831-6335

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

2. CASE INFORMATION Chart # EMPS004U

Date of Injury	12/12/2015	Insurer Claim #	011260049309WC01
Injured Worker's Name	SHIRLEY BACA	Insurer Name	GALLAGHER BASSETT INS. SERVICE
Social Security #	522889861	Fax	
Date of Birth	07/11/1957	Guarantor	EMPLOYMENT SOLUTIONS
Exam Date	4/6/2016	Employer Name	EMPLOYMENT SOLUTIONS
Authorization:		Employer Phone/Fax	(970)672-1043/(303)455-4434

3. INITIAL VISIT (only)
Injured worker's description of accident/injury

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) M77.01 MEDIAL EPICONDYLITIS RIGHT ELBOW

6. PLAN OF CARE
a. TREATMENT PLAN
☐ Diagnostic tools/tests
☐ Procedures
☐ Therapy
☐ Medications
☐ Supplies
☐ Other

Hand specialist Recommendation injury
I feel her condition is the result of her work activity

b. WORK STATUS
☐ Able to return to full duty on ____
☒ Able to return to modified duty from 4/6 to ____
☐ 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) ____ 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 No formation or repetitive gripping with RUE

7. FOLLOW UP CARE AND REFERRALS
a. ☒ Return Appointment Date 4 weeks 5-4-16 Time @ 7:20
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 ?
☐ MMI date unknown at this time because ____

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

10. PRINT NAME KIRK HOLMBOE DO Date of Report 4/6/2016
PHYSICIAN'S SIGNATURE PHYSICIAN'S CO-SIGNATURE
LICENSE NUMBER

Lawrence Cedillo, D.O. License 32302 | Lon Noel, M.D. License 18393 | Marc Steinmetz, M.D., M.P.H. License 25727 | Craig Anderson, M.D. License 23416
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