Midtown Occupational Health Services, P.C. 2424 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 #	
Injured Worker's Name	SHIRLEY BACA	Insurer Name	PINNACOL ASSURANC
Social Security #	522889861	Fax	
Date of Birth	07/11/1957	Guarantor	EMPLOYMENT SOLUTIONS
Exam Date	2/18/2016	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 Will send for hand evaluation and possible injection
☐ Procedures
☐ Therapy
☐ Medications
☐ Supplies
☐ Other

b. WORK STATUS

☐ Able to return to full duty on
☒ Able to return to modified duty from 2/19 to 3.10.16
☐ 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 forceful or repetitive grasping with R hand

7. FOLLOW UP CARE AND REFERRALS

a. ☒ Return Appointment Date 3 week March 10, 2016 @ Time 3:45pm

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 Dr Davis 2.29.16 @ 9:50Am 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 2/18/2016

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
J. Raschbacher, M.D. License 33333 · Kirk Holmboe, D.O. License 34287 · Braden Reiter, D.O. License 28258 · Richard Kraus M.S.,P.A.-C License 3740

(1)

MIDTOWN OCCUPATIONAL HEALTH SERVICES, P.C.
2420 W. 26th Ave. Ste. 200-D, Denver, CO 80211 303-831-9393 fax: 303-831-6335

ACH & Chiro

PATIENT REFERRAL INFORMATION

Appointment Date: 2.29.16 (2) Check In Time: 9:50

Bell | Shirley | | July 11, 1957
Patient Last Name | First Name | MI | DOB

Social Security Number	Home Phone	(720) 429.4620 Cell Phone	Sex: Male or Female

12.12.15 Date of Injury	Claim Number	Authorization Number

Insurance Carrier	Adjustor	Insurance Phone	Fax

Insurance Address

Employment Solutions
Employer | Phone Number

Employer Address

Craig Davis | 303 695-6060
Consultant/Physician | Telephone Number | Fax Number

401 W. Hampden Pl (#220) Englewood, CO 80110
Consulting Address

Notice to Consulting Physicians
Please contact Midtown Occupational Health Services if:

- Your diagnosis indicates additional diagnostic tests or visits
- Referral to another physician is necessary
- Hospitalization and/or surgery is needed
- If you want to change the Work Status

Does Patient need Interpreter? YES or (NO)
If YES name of interpreting company? _____
Interpreting company number _____
Who you spoke with at Interpreting Company? _____

(Treating Physician please circle) Is this an urgent referral? YES or (NO)

DX: Medial epicondylitis R elbow

Referring Physician's Signature: _____

Reason for referral: Orthopedic eval ? injection

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Social Security #	522889861	Fax	
Date of Birth	07/11/1957	Guarantor	EMPLOYMENT SOLUTIONS
Exam Date	2/4/2016	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~~ RE ☒ Not Working
5. WORK RELATED MEDICAL DIAGNOSIS(ES) M77.01 ~~MEDIAL EPICONDY~~LITIS RIGHT ELBOW

6. PLAN OF CARE
a. TREATMENT PLAN
- ☒ Diagnostic tools/tests: EXAM
- ☐ Procedures
- ☒ Therapy: Cont HEP Cont OT 2x week x 2 wks
- ☒ Medications: OTC Tylenol PRN
- ☐ Supplies
- ☒ Other: ICE/Heat PRN

b. WORK STATUS
- ☐ Able to return to full duty on
- ☒ Able to return to modified duty from 2/4/16 to 2/18/16
- ☐ 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: ⓓⓡ hand		☐ Kneeling	hours per day
☐ Reaching over head		☐ Squatting	hours per day
☐ Reaching away from body		☐ Climbing	hours per day

☒ Repetitive Motion Restrictions: Avoid any repetitive motions involving the ® hand, writing; and filing OK.
☐ Other

7. FOLLOW UP CARE AND REFERRALS
a. ☒ Return Appointment Date 2/18/16 with Dr. Holmboe ONLY for MD check/Reviews Time 11:45a
b. ☐ Referral for ☐ Treatment (specify) ☐ Impairment Rating ☐ Evaluation (specify) ☐ 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)
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☐ Needs referral to Level II physician for impairment rating (see 7 b above)

10. PRINT NAME RICHARD KRAUS MS PAC Date of Report 2/4/2016
PHYSICIAN'S SIGNATURE [signature] PA-C PHYSICIAN'S CO-SIGNATURE
LICENSE NUMBER

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