ESSG Medical Referral to Employer

Employee Name: Stacy Orchard **Date of Injury:** 4/2/08

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Health Care Provider who completes this form to release any information to The Suzlon Rotor Corporation which substantiates, clarifies, or elaborates on my fitness for duty.

Employee Signature _____ Date _____

Medical Provider H. Thoreson PA-C **Date / Time of Appt:** 4/4/08 9:00am

ALL WORKERS' COMPENSATION MEDICAL EXPENSES must include the patient name, date of service, and Medical Provider's "Progress Notes" for treatment. Social Security Number is recommended. Mail all claims for payment directly to:

ESSG
7300 Metro Blvd
Ste. 635
Edina, MN 55439
(952)835-1288
Fx: (952)835-1255

Diagnosis: (L) Knee Contusion ____ **Non-work related**

_____ ____ **Undetermined**

Treatment Plan: Wrap, Ice, Elevation X **Work related**

RETURN TO WORK: X **With No Limitations** **Date:** 4/4/08

(Suzlon rotor Corp. has an active return-to-work program. Most temporary restrictions can be accommodated. Please call 507-562-6700 if you have any questions regarding light duty jobs.)

____ **TOTALLY DISABLED:** (Dates) From: _____ To: _____

____ **RESTRICTED WORK:** **Duration of Limitations:** _____ Days/Weeks

____ Restricted Work Hours: May Work _____ hours per day _____ hours per week.
____ Restricted Lifting: Maximum lift: _____10lbs _____20lbs _____30lbs _____40lbs _____50lbs
Weight limit for repetitive lifting or carrying: (more frequent than 2 times per hour)
_____ 0-5lbs _____ 5-10lbs _____ 10-20lbs _____ 20-30lbs _____30-40
____ Restricted bending: (Limit in degrees) _____ Bending frequency (# of times per hour): _____
____ Restricted use of hand: ___ Right ___Left ___ No Use or ___ Limited repetitive grasping, gripping
____ Standing/Sitting: Standing (hours per day) _____ Sitting (hours per day) _____
____ Other: _____

Next Appt. Date / Time: prn **Provider's Comments:** _____

_____

Medical Provider Signature: Heidi Thoreson **Date:** 4/4/08

Please fax back form to 507.562.6800 – Attn CMG/ESSG

FITNESS FOR DUTY

Employees who are absent due to illness or injury (either work-related or non-occupational) may be required to have their physician or other qualified health provider complete a Fitness for Duty Certification before returning to work. The completed form should be returned to Human Resources will make a determination as to his/her ability to return to work. No employee will be allowed to return to work without a satisfactory Fitness for Duty Certification on file.

Employee Name: Stacey Orchard Date: _____

Is employee able to perform the functions of his/her position? X Yes ___ No

Any restrictions? ___ Yes X No If yes, please describe restriction(s) and duration below:

RETURN TO WORK: X With No Limitations Date: _____

(Suzlon rotor Corp. has an active return-to-work program. Most temporary restrictions can be accommodated. Please call 507-562-6700 if you have any questions regarding light duty jobs.)

_____ TOTALLY DISABLED: (Dates) From: _____ To: _____

_____ RESTRICTED WORK: Duration of Limitations: _____ Days/Weeks

_____ Restricted Work Hours: May Work _____ hours per day _____ hours per week.

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Weight limit for repetitive lifting or carrying: (more frequent than 2 times per hour)
_____ 0-5lbs _____ 5-10lbs _____ 10-20lbs _____ 20-30lbs _____30-40

_____ Restricted bending: (Limit in degrees) _____ Bending frequency (# of times per hour): _____

_____ Restricted use of hand: ___ Right ___Left ___ No Use or ___ Limited repetitive grasping, gripping

_____ Standing/Sitting: Standing (hours per day) _____ Sitting (hours per day) _____

_____Other: _____

Next Appt. Date / Time: _____ Provider's Comments: _____

Employee Signature: _____

Physician or Practitioner Signature: Heidi Thoreson PA-C

Type of Practice: (Field of Specialization) FP

Report of Work Ability

See Instructions on Reverse Side

Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

This form must be provided to the employee.
(Minn. Rules 5221.0410, subp. 6)

RW01

DO NOT USE THIS SPACE

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

SOCIAL SECURITY NUMBER	DATE OF INJURY
476064278	4-208
EMPLOYEE: Stacy Orchard	Date of Birth: 2-17-70
EMPLOYER: Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 4/4/08 (date)

Select the appropriate option(s) below and fill in the applicable dates.

1. [X] Employee is able to work without restrictions as of 4/4/08 (date)

2. [ ] Employee is able to work with restrictions, from (date) to (date)

The restrictions are:

3. [ ] Employee is unable to work at all, from (date) to (date)

The next scheduled visit is: [ ] as needed OR (date)

NAME (Type or Print)	SIGNATURE	DEGREE
HEIDI M. THORESON, PA	Heidi Thoreson	PA-C
ADDRESS: PIPESTONE FAMILY CLINIC, 920 4TH AVE SW, PIPESTONE, MN 56164, 507-825-5700 FAX 507-825-5895, DEA- MT1547833 MN LISC-10239	STATE	LICENSE #/REGISTRATION #
CITY: UPIN Q75758 NPI - 1689722027	AREA CODE / TELEPHONE #	DATE SIGNED: 4/4/08

MN RW01 (7/01)

Health Care Provider Report

See Instructions on Reverse Side
(WHEN COMPLETED RETURN TO REQUESTER)

HC01

Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
476064278	4-2-08	2-17-70
EMPLOYEE: Stacy Orchard	EMPLOYER	
INSURER/SELF-INSURER/TPA	INSURER CLAIM NUMBER	
INSURER ADDRESS		
CITY	STATE ZIP CODE	

REQUESTER must specify all items to be completed by health care provider. ☐ Items: _____ ☐ MMI (#9) ☐ PPD (#10)

HEALTH CARE PROVIDER TO COMPLETE ITEMS REQUESTED ABOVE

1. Date of first examination for this injury by this office: 4/4/08 (date)

2. Diagnosis (include all ICD-9-CM codes):
Knee Contusion

3. History of injury or disease given by employee:
Tripped over bar at work

4. In your opinion (as substantiated by the history and physical examination) was the injury or disease caused, aggravated or accelerated by the employee's alleged employment activity or environment? ☐ No ☒ Yes

5. Is there evidence of pre-existing or other conditions that affect this disability? ☒ No ☐ Yes If yes, describe:

6. Is further treatment of this injury or referral to another doctor planned? ☒ No ☐ Yes If yes, describe:

7. Has surgery been performed? ☒ No ☐ Yes If yes, date and describe: (date)

8. Attach the most recent Report of Work Ability. Date of report: 4/4/08 (date)

9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) ☒ No ☐ Yes Date reached:

10. Has the employee sustained any permanent partial disability from the injury? ☒ No ☐ Yes ☐ Too early to determine
The permanent partial disability is % of the whole body. This rating is based on Minn. Rules:

5223.	%	5223.	%
5223.	%	5223.	%

NAME (Type or Print)	SIGNATURE		DEGREE
HEIDI M. THORESON, PA PIPESTONE MEDICAL GROUP	Heidi Thoreson		PA-C
ADDRESS 920 4TH AVE SW, PIPESTONE, MN 56164 507-825-5700 FAX 507-825-5895 DEA- MT1547833 MN LISC-10239 UPIN Q75758 NPI - 1689722027	STATE	LICENSE #/REGISTRATION #	
CITY	AREA CODE	TELEPHONE #	DATE SIGNED 4/4/08

MN HC01 (7/01).

3 PART DRUGS OF ABUSE TEST REQUEST

MEDTOX® LABORATORIES, INC.

SPECIMEN ID V8868875

Employer:
SUZLON ROTOR CORPORATION
1711 S HWY 75
PIPESTONE, MN 56164

Account #

MRO:

Account # 93470

STEP 1 To be completed by **COLLECTOR / DONOR**

Social Security No, Employee No. or other Identification No.

Donor I.D. 476064278

Specimen Type: ☐ Blood ☑ Urine ☐ Oral Fluid

Donor Name (last, first) or SSN: Orchard, Stacy

Donor Daytime Phone: 5076620432

Referring Phys. / Company: Suzlon

DONOR CONSENT *I certify that I provided my specimen to the collector, that the specimen container was sealed with a tamper-proof seal in my presence; and that the information provided on this form and on the label affixed to the specimen bottle is correct. I authorize MEDTOX to release the results of the tests to my employer, prospective employer, employer representative and/or their authorized healthcare professionals.*

Signature: X Stacy Orchard

DATE Month Day Year: 04-04-2008

Test(s) Ordered: ☒ 86343 7 PANEL

STEP 2 To be Completed by **COLLECTOR**

Indicate Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion ☐ Other (specify): ☐ Return to Duty ☐ Follow-up ☒ Post Accident ☐ Periodic Medical

STEP 3 To be Completed by **COLLECTOR**

Specimen temperature must be read within 4 minutes of collection

Specimen Temperature within range: (90°-100°F/32°-38°C) ☑ YES ☐ No, Remark Required

81605

STEP 4 To be Completed by **COLLECTOR**

Collection Site Location: *Facility and Address* 461
PIPESTONE COUNTY MED CENTER
PIPESTONE, MN 56164

Collection Site Phone No.: (507)825-5811

Fax No.: (507)825-5081

Remarks Concerning Collection: none

Date and Time of Collection: Month 04 Day 04 Year 2008 (DATE); Hour 9 Minutes 10 (TIME) ☒ am ☐ pm

I, the collector, by signing below certify that the specimen identified on this form is the specimen given to me by the donor identified above and that it has been collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X Michelle Vanderwal
Signature of Collector

Michelle VanderWal
(PRINT) Collector's Name (First, MI, Last)

SPECIMEN BOTTLE(S) RELEASED TO:
Name of Delivery Service Transferring Specimen to Lab

☑ DHL ☐ Local Courier ☐ Other

STEP 5

COPY 3 - GIVE TO SUBJECT