COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 2:37 PM
Time Out: 5:22 PM

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

Date of Injury	01/16/2016	Workers' Comp #	
Injured Worker's Name	Stormy Soltero	Insurer Claim #	
Social Security #	522-77-3355	Insurer Name	GALLAGHER BASSETT
Date of Birth	05/27/1990	Insurer Phone/Fax	(800) 370-0594
Exam Date	01/19/2016	Employer Name	Employer Solutions Staff/CMG
		Employer Phone/Fax	(952) 767-0053 (952) 767-0740

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

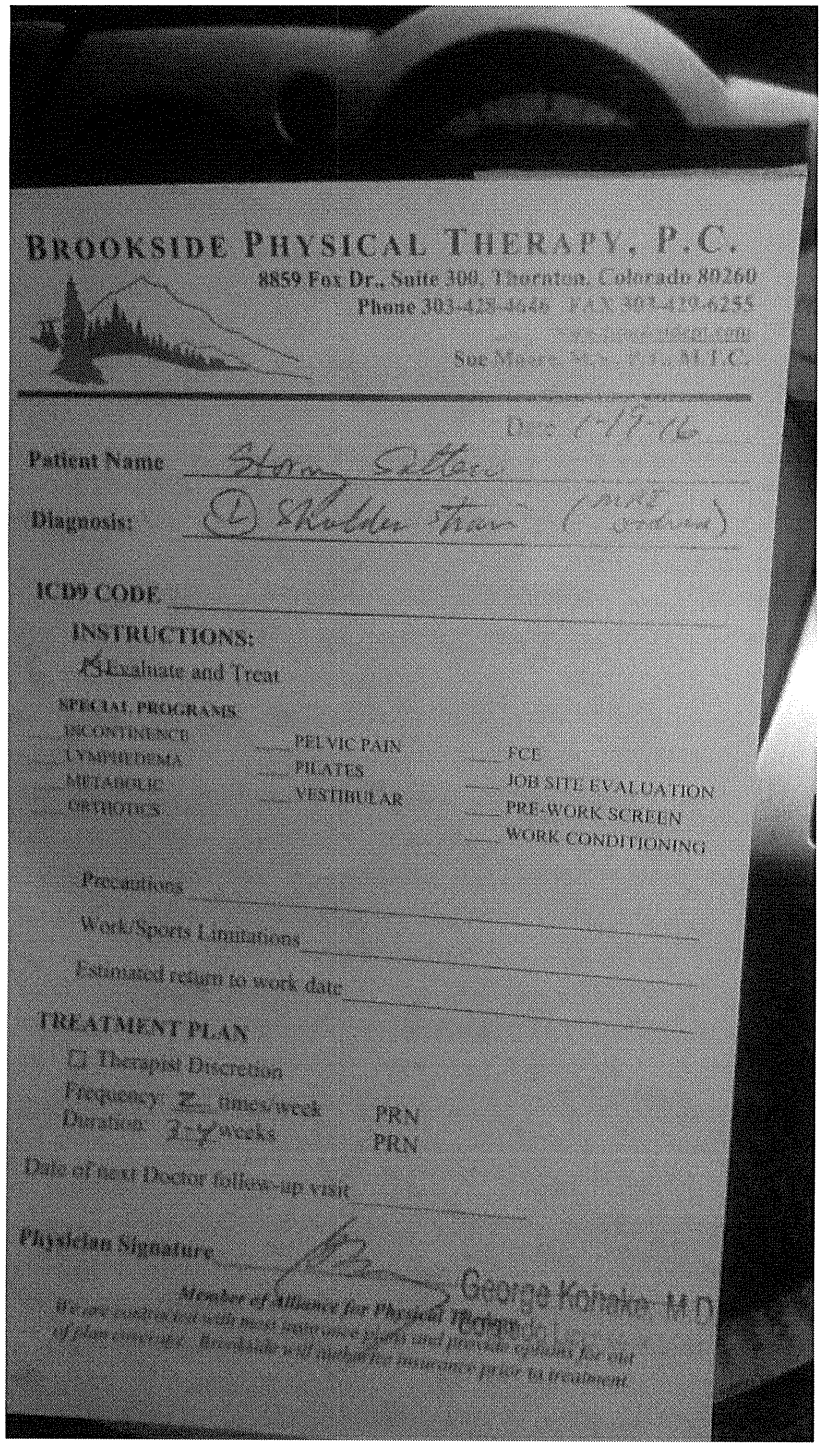
Are your objective findings consistent with history and/or work related mechanism of injury/illness? ☑ Yes ☐ No

4. CURRENT WORK STATUS ☑ Is Working ☐ Not Working
5. WORK RELATED MEDICAL DIAGNOSIS (ES) 1. Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, unspecified arm, initial encounter (S46.919A)
6. PLAN OF CARE
a. TREATMENT PLAN
☑ Diagnostic tools/tests exam MRI L shoulder ordered
☐ Procedures
☑ Therapy PT 2/wk for 3 wks
☑ Medications dispensed 1 bottle Ibu 600mg Rx Vicodin 5/300
☐ Supplies
☑ Other out of sling for gentle ROM exercises
b. WORK STATUS
☐ Able to return to full duty on
☑ Able to return to modified duty from 01/19/2016 to 01/25/2016
☐ 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
☐ Repetitive lifting ______ lbs
☐ Carrying ______ lbs
☐ Pushing / Pulling ______ lbs
☐ Pinching / Gripping
☐ Reaching over head
☐ Reaching away from body
☐ Repetitive Motion Restrictions

Walking ______ hours per day
Standing ______ hours per day
Sitting ______ hours per day
Crawling ______ hours per day
Kneeling ______ hours per day
Squatting ______ hours per day
Climbing ______ hours per day

Other
wear sling NO use L arm

7. FOLLOW UP CARE AND REFERRALS 3-5 days
a. ☑ Return Appointment Date 01/25/2016 7:30 AM
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)
☐ 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 too early
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. PHYSICIAN'S SIGNATURE [signature]
Print Name George A. Kohake, MD Date of Report 01/19/2016
License number 28449
Address 9195 Grant St #100
Thornton, CO 80229
Telephone Number (303) 292-0034



BROOKSIDE PHYSICAL THERAPY, P.C.

8859 Fox Dr., Suite 300, Thornton, Colorado 80260
Phone 303-429-4646 FAX 303-429-6255
Sue Moore, M.S., P.T., M.T.C.

Date 1-19-16

Patient Name Storm Sellers

Diagnosis: (L) Shoulder Strain (Pain Syndrome)

ICD9 CODE _____

INSTRUCTIONS:

Evaluate and Treat

SPECIAL PROGRAMS

___ INCONTINENCE	___ PELVIC PAIN	___ FCE
___ LYMPHEDEMA	___ PILATES	___ JOB SITE EVALUATION
___ METABOLIC	___ VESTIBULAR	___ PRE-WORK SCREEN
___ ORTHOTICS		___ WORK CONDITIONING

Precautions _____

Work/Sports Limitations _____

Estimated return to work date _____

TREATMENT PLAN

☐ Therapist Discretion

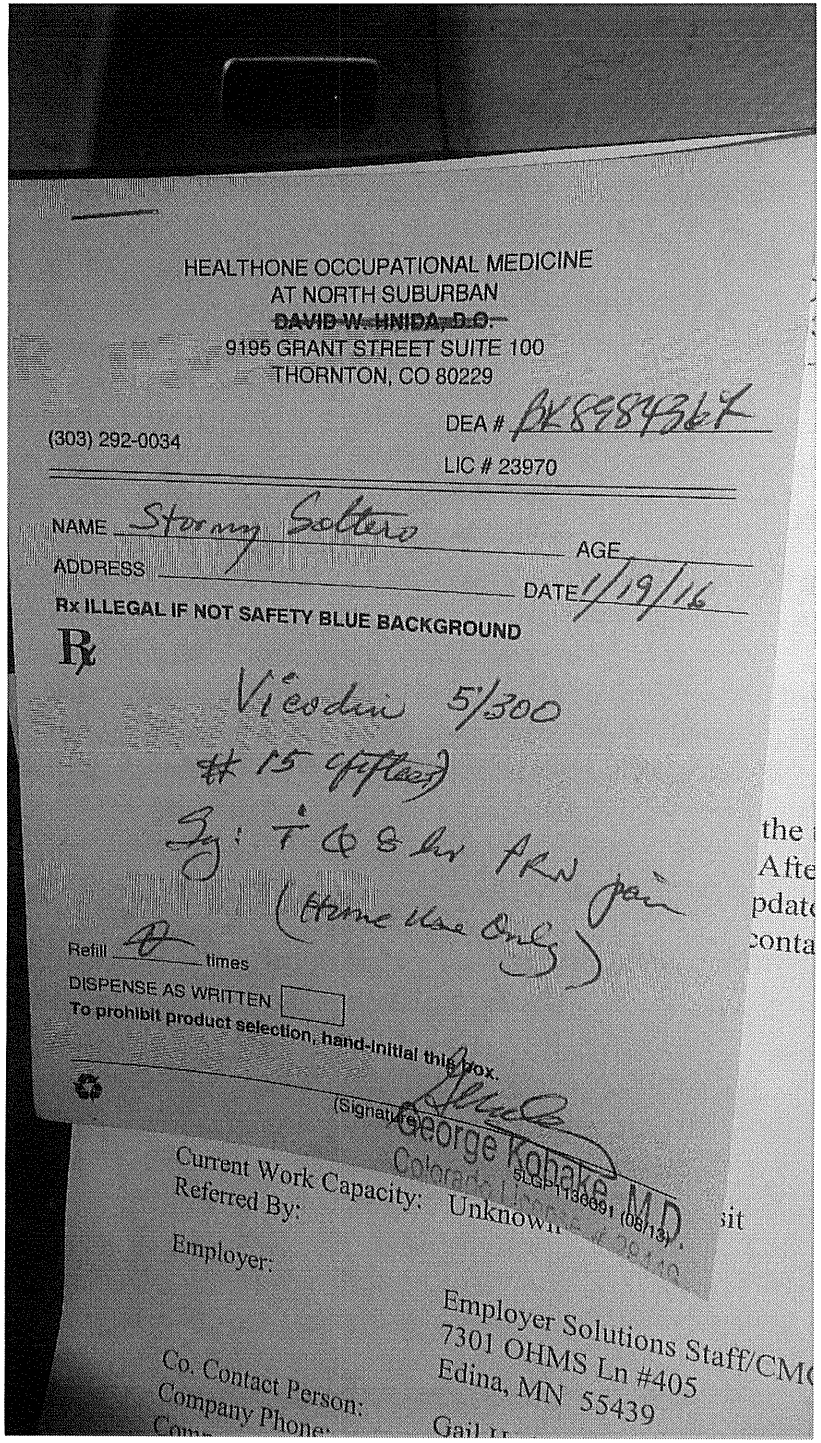
Frequency: 2 times/week PRN
Duration: 2-4 weeks PRN

Date of next Doctor follow-up visit _____

Physician Signature _____ George Kohake, M.D.

Member of Alliance for Physical Therapy Groups

We are contracted with most insurance companies and private agencies for out of plan coverage. Brookside will assist for insurance prior to treatment.



HEALTHONE OCCUPATIONAL MEDICINE
AT NORTH SUBURBAN
~~DAVID W. HINDA, D.O.~~
9195 GRANT STREET SUITE 100
THORNTON, CO 80229

(303) 292-0034

DEA # BK8984367

LIC # 23970

NAME Stormy Soltero AGE

ADDRESS DATE 1/19/16

Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

℞

Vicodin 5/300
#15 (fifteen)
Sig: 1 Q 6 hr PRN pain
(Home Use Only)

Refill 0 times

DISPENSE AS WRITTEN ☐

To prohibit product selection, hand-initial this box.

(Signature) George Kohake M.D.

SLCP1130691 (05/13)

Colorado License # 29140

Current Work Capacity: Unknown

Referred By:

Employer:

Employer Solutions Staff/CM
7301 OHMS Ln #405
Edina, MN 55439

Co. Contact Person:

Company Phone:

Gail

Fax: 303-292-0097

s been referred to you for the treatment of a work-related injury. Thi
injury tracking program. After you have seen the patient, someone fr
office for information to update our case management files. If you hav
claim, please feel free to contact our office.

1/19/2016 15:15
Soltero, Stormy
900-13-6676
5/27/1990
1/16/2016

Work Comp Initial Visit
Unknown

Patient Phone: 720-329-6785
Cell Phone:
Address: 3060 E Bridge St
Brighton, CO 80

Employer Solutions Staff/CMG
7301 OHMS Ln #405
Edina, MN 55439

Gail Hetletvedt
952-767-0053
952-767-0740

GALLAGHER BASSETT
PO BOX 23812
TUCSON AZ 85734-3812

800-370-0594