COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In:
Time Out:

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		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 No show. Left message to reschedule appt.
☐ Procedures
☐ Therapy
☐ Medications
☐ Supplies
☐ Other

b. WORK STATUS

☐ Able to return to full duty on ☐ Unable to work from to
☐ Able to return to modified duty 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

7. FOLLOW UP CARE AND REFERRALS

a. ☐ Return Appointment Date
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. PHYSICIAN'S SIGNATURE Date of Report 01/25/2016

Print Name George A. Kohake, MD License number 28449

Telephone Number (303) 292-0034

Address 9195 Grant St #100
Thornton, CO 80229

WC164 05/06