

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

EXAM DATE 12/26/2016

2. CASE INFORMATION

Date of Injury 12/26/2016

Injured Worker Vanessa Alarid

Social Security # 524-91-9137

Date of Birth 3/12/1994

Insurer Claim # \_\_\_\_\_

Insurer Name/TPA \_\_\_\_\_

Insurer Phone/Fax \_\_\_\_\_

Employer Name \_\_\_\_\_

Corp Management Group

3. INITIAL VISIT (only)

a. Injured worker's description of accident/injury

Hand smashed between the moving belt - and metal flap - machinery

b. Are your objective findings consistent with history and/or work-related mechanism of injury/illness?  Yes  No

4. CURRENT WORK STATUS  Working  Not Working

5. WORK-RELATED MEDICAL DIAGNOSIS(ES) Contusion to right hand

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests

Procedures

Therapy

Medications

Supplies

Other

MPE, PE  
x-ray

Ibuprofen, Vicodin - can't use while working  
Hand/wrist splint  
Rest, ice, elevate, compress

b. WORK STATUS

Able to return to full duty on

Able to return to modified duty from

Unable to work from

Able to return to part time work on

12-26-16 to next apt  
to \_\_\_\_\_  
for \_\_\_\_\_ hours per day

c. LIMITATIONS/RESTRICTIONS

Lifting (maximum weight in pounds)

Repetitive lifting

Carrying

Pushing / Pulling

Pinching / Gripping

Reaching over head

Reaching away from body

Repetitive Motion Restrictions

Other

No Restrictions

Temporary Restrictions

Permanent Restrictions

20 lbs.

20 lbs.

20 lbs.

20 lbs.

2 miles

Walking

Standing

Sitting

Crawling

Kneeling

Squatting

Climbing

\_\_\_\_\_ hours per day

7. FOLLOW UP CARE AND REFERRALS - \*7c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)

a.  Return Appointment Date 1-2-17

b.  Referral for  Treatment (specify) \_\_\_\_\_

Impairment Rating \_\_\_\_\_

Referred Provider's Name \_\_\_\_\_

Evaluation (specify) \_\_\_\_\_

Other (specify) \_\_\_\_\_

Phone # \_\_\_\_\_

c.  Discharged for Non-Compliance\*

Discharged from Care for Nonmedical Reasons\*

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)

Injured Worker has reached MMI Date of MMI \_\_\_\_\_

Injured Worker is not at MMI, but is anticipated to be at MMI in/on \_\_\_\_\_

MMI date unknown at this time because \_\_\_\_\_

9. MAINTENANCE CARE AFTER MMI

Yes  No

If yes, specify care: \_\_\_\_\_

10. PERMANENT MEDICAL IMPAIRMENT (REQUIRED)

No permanent impairment

Permanent Impairment (attached required worksheets and narrative)

Anticipate permanent impairment

Needs referral to Level II physician for impairment rating (see 7b above)

11. PHYSICIAN'S SIGNATURE Sheila L. Alarid

Date of Report \_\_\_\_\_

Print Name Sheila L. Alarid

License # 89573

Phone # 303-439-4544