

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 1/4/2017

2. CASE INFORMATION

Date of Injury 12/26/2016 Insurer Claim # _____
Injured Worker Vanessa Alarid Insurer Name/TPA _____
Social Security # 524-91-9137 Insurer Phone/Fax _____
Date of Birth 3/12/1994 Employer Name Corp Management Group

3. INITIAL VISIT (only)

a. Injured worker's description of accident/injury

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) _____

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests HPT & PE
 Procedures _____
 Therapy _____
 Medications Ibuprofen
 Supplies Wrist Splint & continue to wear
 Other Rest, ice, elevate, compress

b. WORK STATUS

Able to return to full duty on _____
 Able to return to modified duty from 01/04/16 to 1 week
 Unable to work from _____ to _____
 Able to return to part time work on _____ for _____ hours per day

c. LIMITATIONS/RESTRICTIONS

No Restrictions Temporary Restrictions Permanent Restrictions
 Lifting (maximum weight in pounds) less than 5 lbs. Walking _____ hours per day
 Repetitive lifting 0 lbs. Standing _____ hours per day
 Carrying less than 5 lbs. Sitting _____ hours per day
 Pushing / Pulling 0 lbs. Crawling 0 hours per day
 Pinching / Gripping 0 lbs. Kneeling 0 hours per day
 Reaching over head 0 Squatting 0 hours per day
 Reaching away from body 0 Climbing 0 hours per day
 Repetitive Motion Restrictions No repetitive Hand movement

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 week

b. Referral for Treatment (specify) _____ Evaluation (specify) _____
 Impairment Rating _____ Other (specify) _____
Referred Provider's Name _____ 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 [Signature] Date of Report 01/04/16

Print Name Robin Sider License # AP10099-2016 Phone # 303-439-4544