

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Time In: 2:00 PM
Time Out: 2:34 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	<u>09/21/2015</u>	Workers' Comp #	
Injured Worker's Name	<u>Barry Kappius</u>	Insurer Claim #	<u>011260046563WC01</u>
Social Security #	<u>521-73-7016</u>	Insurer Name	<u>GALLAGHER BASSETT</u>
Date of Birth	<u>09/24/1985</u>	Insurer Phone/Fax	<u>(800) 370-0594</u>
Exam Date	<u>11/25/2015</u>	Employer Name	<u>Employer Solutions Staff/CMG</u>
		Employer Phone/Fax	<u>(952) 767-0053</u> <u>(952) 767-0740</u>

3. INITIAL VISIT (only)

Injured worker's description of accident/injury
auulsion en left pinky finger

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. Unspecified open wound of left little finger with damage to nail, subsequent encounter (S61.307D).

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests Evaluation
 Procedures _____
 Therapy _____
 Medications _____
 Supplies _____
 Other Olenick appt Dec 18

b. WORK STATUS

Able to return to full duty on 11/25/2015 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

<input type="checkbox"/> Lifting (maximum weight in pounds) _____ lbs.	Walking _____ hours per day
<input type="checkbox"/> Repetitive lifting _____ lbs.	Standing _____ hours per day
<input type="checkbox"/> Carrying _____ lbs.	Sitting _____ hours per day
<input type="checkbox"/> Pushing / Pulling _____ lbs.	Crawling _____ hours per day
<input type="checkbox"/> Pinching / Gripping _____	Kneeling _____ hours per day
<input type="checkbox"/> Reaching over head _____	Squatting _____ hours per day
<input type="checkbox"/> Reaching away from body _____	Climbing _____ hours per day
<input type="checkbox"/> Repetitive Motion Restrictions _____	

Other _____

7. FOLLOW UP CARE AND REFERRALS

a. Return Appointment Date 12/30/2015 1:00 PM
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 Permanent Impairment (attach required worksheets and narrative)
 Anticipate permanent impairment Needs referral to Level II physician for impairment rating (see 7 b above)

10. PHYSICIAN'S SIGNATURE Pradeep Rai 11/25/2015 2:24:14 PM Date of Report 11/25/2015
Print Name Pradeep Rai, MD License number 0054622
Telephone Number (303) 292-0034
Address 9195 Grant St #100
Thornton, CO 80229