

Midtown Occupational Health Services, P.C. 247 26th Ave. Ste 200-D, Denver CO 80211

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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

2. CASE INFORMATION

Chart # EMPS004U

|                       |              |                    |                             |
|-----------------------|--------------|--------------------|-----------------------------|
| Date of Injury        | 12/12/2015   | Insurer Claim #    |                             |
| Injured Worker's Name | SHIRLEY BACA | Insurer Name       | PINNACOL ASSURANC           |
| Social Security #     | 522889861    | Fax                |                             |
| Date of Birth         | 07/11/1957   | Guarantor          | EMPLOYMENT SOLUTIONS        |
| Exam Date             | 2/4/2016     | Employer Name      | EMPLOYMENT SOLUTIONS        |
| Authorization:        |              | Employer Phone/Fax | (970)672-1043/(303)455-4434 |

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) M77.01 MEDIAL EPICONDYLITIS RIGHT ELBOW

6. PLAN OF CARE

a. TREATMENT PLAN

Diagnostic tools/tests Exam

Procedures

Therapy Cont. HEP Cont. OT 2x week x 2 wks

Medications OTC Tylenol PRN

Supplies

Other ICE/Heat PRN

b. WORK STATUS

Able to return to full duty on \_\_\_\_\_ to \_\_\_\_\_  
 Able to return to modified duty from 2/4/16 to 2/18/16  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 DR hand

Reaching over head \_\_\_\_\_

Reaching away from body \_\_\_\_\_

Repetitive Motion Restrictions Avoid any repetitive motions involving the DR hand, writing; and filing OK.

Other \_\_\_\_\_

7. FOLLOW UP CARE AND REFERRALS

a.  Return Appointment Date 2/18/16 with Dr. Holmboe ONLY for MD check/Review

b.  Referral for  Treatment (specify) \_\_\_\_\_  Evaluation (specify) \_\_\_\_\_  
 Impairment Rating \_\_\_\_\_  Other (specify) H/S

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. PRINT NAME

RICHARD KRAUS MS PAC

Date of Report 2/4/2016

PHYSICIAN'S SIGNATURE

Richard Kraus MS PAC

PHYSICIAN'S CO-SIGNATURE

[Signature]

LICENSE NUMBER

Lawrence Cedillo, D.O. License 32302

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