FAXED

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

1300
1455

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** 6/23/2017

2. **CASE INFORMATION**

Date of Injury	6/20/2017	Insurer Claim #	
Injured Worker	Russell Cipponeri	Insurer Name/TPA	Gallagher Bassett
Social Security #		Insurer Phone/Fax	800-370-0594
Date of Birth	12/1/1976	Employer Name	Employer Solutions F 952-767-0740

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)** (R) elbow pain M25.521

6. **PLAN OF CARE**
   a. **TREATMENT PLAN**
   ☐ Diagnostic tools/tests
   ☐ Procedures
   ☐ Therapy
   ☐ Medications
   ☐ Supplies
   ☐ Other

   Exams
   Ortho Referral, Quick, today
   To ER if not improved

   b. **WORK STATUS**
   ☐ Able to return to full duty on
   ☐ Able to return to modified duty from ____ to ____
   ☑ Unable to work from 6/23 to Next
   ☐ 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)	____ 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** - *7c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)
   a. ☐ Return Appointment Date 5d. 6/28/2017 9am
   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** ____ Date of Report 6/23/2017

Print Name Tom Chau PA-C License # 1842 Phone # (303) 292-0034

WC164 Rev. 11/14