



**STATE OF ILLINOIS**

Workers Compensation Commission

# DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

This report is being prepared under the guidance and direction of the IL workers compensation commission formally known as the IL industrial relations commission. Although it is not mandatory, we at the Spine Institute require proper reporting on every injured worker. This report is an initial report of findings and personal patient information which is current and for the sole purpose of the insurance co and claims examiners records. This report will also serve as an initial report that will include working diagnosis, recommended beginning treatment protocol and overall outline of the patients condition at this time and what we expect to accomplish in a reasonable time period through proven and proper treatment methods that have been tested and tried over many years. Regular written reports or progress reports will be submitted every thirty to 45 days or 10 to 12 visits of care, which ever comes first.

1. INSURER NAME AND ADDRESS -			CLAIM NUMBER:			PLEASE DO NOT USE THIS COLUMN		
2. EMPLOYER NAME -								
3. ADDRESS: NO. and STREET			CITY			STATE ZIP		
4. NATURE OF BUSINESS (e.g., food manufacturing, building construction, retailer of women's clothes)								County
5. PATIENT NAME (First name, middle initial, last)				6. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		7. DATE OF BIRTH: Mo Day Yr.		Age
8. ADDRESS: NO. and STREET			CITY			9. TELEPHONE NUMBER:		
10. OCCUPATION (Specific job title)						11. SOCIAL SECURITY NUMBER: N/A		Disease
12. INJURED AT: NO. and STREET			CITY			COUNTY		
13. Date and hour of Injury or onset of illness		MO DAY YR	HOUR 11:00		14. Date last worked		Mo Day Yr.	Occupation
		11/29/06	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		11/29/06			
15. Date and hour of first examination or treatment		MO DAY YR	HOUR		16. Have you (or your office) previously treated patient?			Return Date/Code
		12/20/06	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		<input type="checkbox"/> yes <input checked="" type="checkbox"/> no			

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to work comp under Illinois WC act.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required)

Patient works for Great Lakes construction for the last 7 months Monday through Saturday around 8 hours a day. His job duties are construction work, carrying shingles to roofs, etc. On or around 11/29/06 he started work around 9:00am going up and down the ladder. It was a rainy day and the ground was muddy. Around 11:00am while going up the ladder carrying scaffolds, his shoes were muddy and he slipped off the scaffold and fell over 10 feet to the ground. He landed with most of his weight on his left leg, foot and hip and was unable to walk due to the severe pain in his foot. He was immediately taken to the hospital (Kenosha, WI) by his co-workers. He was given pain medications. His supervisor Umberto was notified the same day. Patient saw Dr. Gershtenson, M.D. and was diagnosed with left calcaneus fracture, left leg strain, and left hip contusion. He was taken off work and given a leg boot/cast. Patient continued to see Dr. Gershtenson for follow-up medication and evaluations but was not getting physical therapy and was referred here for rehabilitation/physical therapy.

18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required)

1) Left foot pain that is severe and is worse with movement. Patient is unable to walk without crutches. His pain is sharp, feels hotness, and numbness in right foot. Has hard time falling asleep due to left foot pain. 2) Left hip pain that is dull; 3) Left Leg pain and numbness/ paresthesia.

19. OBJECTIVE FINDINGS (use reverse side if more space is required)

A. Physical examination

Postural observation shows a right head tilt, right head rotation, right elevated shoulder, and a right elevated iliac crest. Patient is unable to perform heel and toe walk due to left foot pain. Lumbar range of motion 60 degrees in flexion and painful, extension 30 degrees and painful, right lateral flexion 30 degrees, and left lateral flexion 30 degrees, rotation 45 degrees bilaterally. Left ankle range of motion: plantar flexion 25 degrees and painful, dorsiflexion 0 degrees and painful, inversion 0 degrees active and passive, eversion 0 degrees active and passive. Right ankle range of motion within normal limits. Reflexes within normal limits for lower extremities except (+1) for left patellar and (+1) for left achilles. Pathological reflexes negative. Orthopedic examination: Patient's left ankle tender in all directions and unable to do accurate orthopedic tests. Hip ortho shows (+) faber on left and (-) on the right, gaenslen's (+) on left and (-) on the right. Lumbar ortho unremarkable. Circumferential measurements: Left knee 32cm, right knee 33cm, left calf 34cm, right calf 36.5, left ankle 23.5cm, right ankle 22cm, left foot 27.5cm, and right foot 27cm. Muscle strength: Hip flexors 4/5 for left and 5/5 for right, knee extensors 3/5 for left and 5/5 for right, knee flexors 3/5 for left and 5/5 for right, foot inversion 1/5 for left and 5/5 for right. Palpation to left foot shows tenderness throughout ankle, mild swelling with pitting edema throughout, with capillary refill less than 2 seconds. Tenderness also noted in lumbar paraspinal muscles mostly on left side, left sacroiliac joint tenderness. Tenderness and spasm in left gluteus medius and left piriformis muscles. Sharp/dull test to left foot shows good discrimination but decreased sensation on plantar side throughout. Right foot is unremarkable.

B. X-ray and laboratory results (State if none or pending.) NO X-rays taken at this time. Patient will be scheduled for x-rays if we are not successful in receiving MD Ortho reports and x-rays taken. X-rays will be sent out for reading from the radiologist. This patient will also be scheduled for a Digital Motion Fluoroscope of the left ankle and foot. Results will be forwarded.

20. DIAGNOSIS (If occupational illness, specify etiologic agent and duration of exposure.)	Chemical or toxic compounds involved? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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