SPINE INSTITUTE OF WAUKEGAN

Workers Compensation Specialists

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 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 second. Disability issues are discussed at the bottom of this report and will be updated accordingly.

			PLEASE DO NOT USE THIS COLUMN
1. INSURER NAME AND ADDRESS - CLAIM NUMBER: **Adjuster:** **Direct Line:** **Phone#:** **Fax #:** **Employer HR Dept.: PH#:** **WC Inquiries: PH: FX:**			
2. EMPLOYER NAME –			
3. ADDRESS: NO. an d 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. ☑Male ☐Female	7. DATE OF BIRTH: Mo Day Yr.	Age
8. ADDRESS: NO. and STREET CITY STATE ZIP		9. TELEPHONE NUMBER:	Hazard
10. OCCUPATION (Specific job title)		11. SOCIAL SECURITY NUMBER:	Disease
12. INJURED AT: NO. and STREET CITY COUNTY			Hospitalization
13. Date and hour of Injury or onset of illness MO DAY YR	HOUR ☑AM ☐ PM	14. Date last worked Mo. Day Yr.	Occupation
15. Date and hour of first examination or treatment MO DAY YR	HOUR ☑ AM ☐ PM	16. Have you (or your office) previously treated patient? ☐ yes ☑ no	Return Date/Code

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 require)

Patient's job duties are to assist machine operators by taking cardboard rolls out of machines. He has been at this employer for approximately 8 months and usually works Monday-Sunday 12 hours a day. He started his normal shift on 05/04/07 around 5:00p.m. He was working his usual duties taking rolls of cardboard that encased metal weighing approximately 75lbs. Patient did this for several of hours. Around 4:40a.m. (20 minutes prior to finishing his shift), he was pulling roll/tube out of machine when suddenly it became very heavy causing it to drop onto the machine surface. The tube falling caused his whole arm to be pulled and the tube ended up falling on his left hand ring finger area. He started to have immediate severe pain in the left hand. The machine operator told patient to place his finger in cold water for 10-15 minutes. Patient went home with pain and figured pain would go away. He woke up later in the day with continued pain and went in to work to report the accident. He told supervisor Israel what had happened and a report was done. Israel told patient to go to the company doctor Dr. Young Lee M.D at Concentra Medical Center. Patient went to the doctor on 05/04/07 where x-rays were taken and was told he had a fracture in his finger. He was given a finger splint and pain meds. Patient did not work over the weekend and on Monday 05/07/07 he went into work and was placed at a new location at a Hotel to work as a dishwasher. Mr. Cruz had to use his left hand to carry plates and trays and it was difficult due to pain. Patient worked on/off throughout the week since there were no jobs for him. He continues with pain throughout his arm, finger and hand and presents for treatment and evaluation.

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

1) Fourth digit pain of the left hand that is constant, sharp, and worse with movements. 2) Left wrist pain that is constant, sharp, and worse with movements. 3) Left elbow pain that is constant and dull. 4) Left shoulder pain that is constant, dull, and worse with movements. 5) Tingling sensation throughout left upper extremity but mostly at 4th finger. 6) Left Forearm pain throughout the extensors with localized pain in the center that with pressure, refers pain down into the wrist.

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

A. Physical examination

PHYSICAL EXAM: Height 68.5inches, Weight 154lbs, BP 118/70 seated on left side, Pulse 74 and regular, Respirations 16. Alert, awake, and oriented x 3.

LEFT WRIST/HAND:

Range of motion in flexion 70 with pain, extension 70º with pain, ulnar deviation 20º with pain, and radial deviation 10º with pain. INSPECTION: Ecchymosis noted throughout distal 4th finger with mild swelling and finger in a semi-flexed position.

PALPATION: No crepitation present. Tenderness throughout wrist bones mostly in lunate bone. Tenderness with mild spasm in wrist flexors and extensor muscles. Distal phalanx of 4th digit severely tender with mild swelling as well as the PIP joint of the 4th finger or digit. SPECIAL TESTS: Sharp/dull are within normal limits. Vibration test is (+) for fracture, (+) Tinels, (-) Phalen's, and (-) modified phalens. Capillary refill less than 2 seconds.

LEFT ELBOW:
Range of motion in flexion 160º with no pain, extension -5º with no pain, pronation 80º with no pain, and supination 80º with no pain. INSPECTION: Skin normal in appearance. No swelling noted. No deformity noted. No erythema. No ecchymosis. PALPATION: No crepitation present. Tenderness throughout pronator and supinator muscles, biceps, and triceps. SPECIAL TESTS: (-) Valgus stress, (-) varus stress.
LEFT SHOULDER: Range of motion in flexion 160º with pain, extension 60º with pain, abduction 150º with pain, adduction 50º with pain, internal rotation 70º with pain, external rotation 75º with pain. INSPECTION: Skin normal in appearance. No deformity noted. There is no swelling. There is no discoloration. PALPATION: Tenderness throughout deltoid musculature and left supraspinatus muscle. Nontender to palpation of clavicle, coracoid process, AC joint, greater tuberosity, and bicipital groove. SPECIAL TESTS: Speed's test (-), Yergason's test (-), Apprehension (-), (+) Supra-spinatous.

MUSCLE STRENGTH:
Shoulder abduction 7, 9, 7 for left and 20, 21, 22 for right, Shoulder external rotation 8, 9, 7 for left and 10, 11, 11 for right, shoulder internal rotation 9, 9, 10 for left and 12, 13, 15 for right, elbow flexion 20, 20, 21 for left and 33, 30, 31 for right, elbow extension 20, 20, 19 for left and 28, 30, 30 for right, wrist flexion 3, 4, 5 for left and 14, 14, 12 for right, wrist extension 6, 6, 7 for left and 14, 15, 14 for right.

Circumferential measurements (cm): 28.5 for left and 29 for right, 24.5 for left and 26.5 for right, forearm 26 for left and 26.5 for right, wrist 17.5 for left and 18 for right, hand 24 for left and 23 for right.

Grip strength: 05, 03, 02 for left and 80, 60, 80 for right.

B. X-ray and laboratory results (State if none or pending.) Closed Fracture of distal phalanx of 4th digit of left hand. Radiologist report pending.

20. DIAGNOSIS (If occupational illness, specify etiologic agent and duration of exposure.)

1) Closed Fracture Of Distal Phalanx Or Phalanges Of Hand
2) Mallot Finger, 4th Distal Phalange
3) Limb Pain, Brachium, Anti-Brachium, Wrist and Hand/ Fingers
4) Sprain of the Interphalangeal Joint of Hand/ Finger, 3rd and 4th digit.
5) Tingling sensation throughout left upper extremity
6) Wrist sprain/strain
7) Elbow/Forearm Sprain/ Strain
8) Shoulder/Arm Sprain
9) Muscle spasms
10) Muscle weakness
11) Caught Accidentally In Or Between Objects

Chemical or toxic compounds involved? ☐ Yes ☑ No

ICD-9 Code
1) 816.00
2) 736.1
3) 729.5
4) 842.13
5) 782.0
6) 842.00
7) 841.9
8) 840.9
9) 728.85
10) 728.87
11) E918

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☑ Yes ☐ No If "no," please explain.

22. I there any other current conditions that will impede or delay patient's recovery? ☑ Yes ☐ No If "yes," please explain.
If the patient is denied proper Physical Therapy, Rehabilitation, MD Evaluation, or if work restrictions are not honored, it will delay his progress.

23. TREATMENT RENDERED (Use reverse side if more space is needed)
The patient was given a complete and thorough examination consisting of AMA guideline measurements for accurate detail of possible disability and to compare to the opposite side consisting of grip strength, measurements of circumference of the upper extremities, muscle testing of the flexor and extensor muscles and visual palpation. He was further given a comprehensive and detailed consultation and history detailing his past history, history of injuries, symptoms of the injury of issue and job description complete. He received x-rays and then was scheduled for therapy and rehabilitation.

24. If further treatment required, specify treatment plan / estimated duration.
This patient will receive treatment 3-5x's per week for 1-2 weeks then 3x's a week thereafter until MMI. Patient will begin with passive physical therapy modalities such as e-stim, hot packs, ultrasound, manual therapy, and

CMT procedures to assist in healing. After a few visits, we will attempt to start patient on therapeutic exercises and rehabilitation as tolerable that will include range of motion, stretching, and strengthening exercises. If patient does not show adequate progress or improvement in a short amount of time, his treatment plan will be re-evaluated and changed. Re-exam will be every 30 days. If patient does not improve on his next re-exam, an MRI or Electro-diagnostic assistance will be necessary. The patient's care will be co-managed with Dr. Jeffrey Visotsky, MD who specializes with upper extremity conditions and will be scheduled. The patient suffered an avulsion fracture and we are not certain if the distal extensor tendon has completely detached from the distal phalanx and whether or not the patient will be able to heal through standard therapeutic treatment measures. It is our belief that the patient will need an MRI of his phalanx or entire hand and then further follow-up with our Ortho MD for other treatment options or considerations. Until then, we are applying STS Surface Neuro-Stimulation to the patients' upper left extremity for pain control and to assist in the healing of his injury to the hand as well as the stretch injury to the left upper extremity that injured other areas of his left arm. We are also applying other therapeutic adjuncts as stated above and will begin light rehab when he is ready. We will wait to order the MRI after the patient is seen by the MD for his opinion on what else may be necessary for MRI.

25. If hospitalized as inpatient, give hospital name and location. MO DAY Year Estimated Stay
NONE TO DATE Admitted date:

26. WORK STATUS-is patient able to perform usual occupation? ☐ Yes ☑ No Patient TTD until 05/27/07 and most likely will continue until MD Evaluation is authorized.
If "no," Date when patient can return to: Regular Work:
Modified Work ____________________ Specify restrictions:
Is permanent residual disability anticipated? ☐ Yes ☐ No ☑ Unknown
If "yes," to what extent:

Doctor's Signature: ____
IL License Number 038-010349
Doctor's Name and Degree (please type) Dr. Kelly G. Worth, D.C., F.A.F.I.C.C., D.A.C.A.N.
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