



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: Hazard	
10. OCCUPATION (Specific job title)				11. SOCIA 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		14. Date last worked Mo. Day Yr. Occupation	
		APRIL 06, 2006 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM			
15. Date and hour of first examination or treatment		MO DAY YR HOUR		16. Have you (or your office) previously treated patient? <input type="checkbox"/> yes <input type="checkbox"/> no Return Date/Code	
		NOVEMBER 03. 2006 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM			

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 worked for Dovee for 4 years as a machine operator working with aluminum and metals for 8-10 hours a day Monday through Friday. On or around April 6, 2006, patient was working with a machine where he had to repeatedly place parts in the machine and then into a box. Patient stated this was a constant routine he had to do with one hand by placing objects into the machine and twisting his wrist to take out the object. After about 2-3 hours into his shift after constant repetitive motion, he went to take out a piece from the machine and felt a pop in his right wrist. He immediately felt a sharp pain in his right wrist and continued to work. He told the owner/supervisor Larry that his wrist had popped and that he was in pain. Larry said to patient that maybe it was due to him working on the same machine for at least 15 days. Larry told the patient to go home and rest over the weekend, and have someone massage it. Monday came and patient continued with the same pain, went to work, and notified Larry. Patient was taken to the company clinic where he was given a wrist brace and pain medications, and to return in two weeks. Patient returned in two weeks and still felt the same. The clinic doctor then gave him exercises to do at home for another 2 weeks and to return for a follow up. Patient still felt the same and was referred to orthopedic doctor Sanjay Patari the same day. Dr. Sanjay Patari recommended surgery. Patient did not want surgery thinking his hand would never be the same. Patient was told by his company to go to his primary doctor. Patient went to see Dr. Castro where he ordered an MRI and EMG was told nothing was wrong. And was referred to Dr. Meisles an orthopedic doctor. Dr. Meisles said the MRI findings were not helping him so he referred patient to Dr. Light, another orthopedic doctor. Dr. Light told him there was nothing wrong and referred him to Dr. Bednar where he said the patient didn't have anything and there is nothing he can do. Patient says he never received any therapy to his wrist and was only given restrictions. Patient continues with pain and presents for further evaluation.

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

1) Right wrist pain; 2) Weakness in right wrist; 3) Numbness in right wrist, intermittent.

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

A. Physical examination

Vitals are within normal limits. Right wrist range of motion is decreased in flexion, extension, and ulnar deviation. Right wrist range of motion is painful at end range in all directions, and audible clicks are noted in all directions. Left wrist is unremarkable. Reflexes for upper and lower extremities are within normal limits. Pathological reflexes are negative. Circumferential measurements for upper extremities are within normal limits. Grip strength is significantly decreased for the right side compared to the left. Patient is right handed. Muscle testing for wrist flexion and extension was slightly decreased on the right side. Orthopedic exam: Right wrist: (-) Finkelsteins's, (+) Phalen's, (+) Reverse Phalens. Left wrist unremarkable. Right wrist palpation is tender and painful at the lunate carpal bone area. There is evidence of a small marble sized ganglion cyst noted upon flexion of the wrist. Cysts is seen on the dorsum of the right wrist. Mild swelling is noted in right wrist. According to Dr. Meisles, MD report, MRI results shows a small ganglion cyst and some tenosynovitis.

B. X-ray and laboratory results (State if none or pending.) X-rays of his bilateral wrists taken for comparison. Minor misalignment found or noted within the carpal bones. Radiologist report pending.

Doctors 1st Report

RE:
DOI:
CL#

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
1) Tenosynovitis of Right Wrist 2) Stiffness of wrist joint 3) Ganglion Cyst 4) Crepitus of Right Wrist 5) Arthralgia of Right Wrist 6) Numbness of right wrist and hand.		ICD-9 Code 1) 727.05 2) 719.53 3) 727.49 4) 719.64 5) 719.44 6) 782.0
21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "no," please explain.		
22. I there any other current conditions that will impede or delay patient's recovery? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please explain. If patient's treatment is limited or not authorized, it will delay his recovery. Further, if work restrictions are not honored.		
23. TREATMENT RENDERED (Use reverse side if more space is needed) A complete history and consultation was performed in the beginning, which consisted of a complete history of his injury, past history of injuries, social history, job description and details of his symptomatology. He was then given a complete and thorough examination which consisted of measurements, reflexes, Orthopedic, Range of Motion study and so on. The patient was then referred to our Radiological Department for x-rays of his wrists. He was then referred to our therapy department and scheduled for his therapies.		
24. If further treatment required, specify treatment plan / estimated duration. This patient will need additional treatment in the form of Physical Therapy and possible CMT procedures to the wrist daily for the first week to two weeks, then 3x's per week with a gradual reduction of weekly visits until such time the patient can be released as stable and static. Course of treatment should not be longer than 4-6 weeks however we do not know how the patient will respond since his condition is chronic, and request leniency if indeed we go beyond a few weeks from this guesstimate. Part of his therapy will certainly be Rehabilitation or Work Conditioning to increase his overall functional capacity and strength and to prepare him to go back to work with no or very little restrictions. An NCV/SSEP test for the upper extremities will be necessary for further evaluation of his pain and numbness and the patient will be referred. We would also request that this patient be seen by Dr. Jeffrey L. Visotsky, MD; of "ILLINOIS BONE and JOINT", 900 Westmoreland, Suite LL72, Lake Forest Illinois 60045, to assist us with treatment and for any further possible medical intervention that may be needed. Otherwise, we will be working with the patient aggressively to strengthen his right wrist and to assist in reduction of the pain and to attempt to cure and/or relieve the patient from the effects of his injury. Monthly assessments will be necessary to comply with workers compensation mandates. This patient never received formal physical therapy and proper treatments for his condition, and overall we feel confident that by giving the opportunity to go through rehabilitation and staying consistent with care, will and should improve his condition.		
25. If hospitalized as inpatient, give hospital name and location. NONE		Admitted date: MO DAY Year Estimated Stay
26. WORK STATUS-is patient able to perform usual occupation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "no," Date when patient can return to: Regular Work: Modified Work <u>12/08/06</u> Specify restrictions: <u>Patient to not perform any repetitive gripping or handling of product or metal items, etc.. No Heavy Lifting with the right wrist.</u> Is permanent residual disability anticipated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown If "yes," to what extent:		
Doctor's Signature: _____		IL License Number 038-010349
Doctor's Name and Degree (please type) <u>Dr. Kelly G. Worth, D.C., F.A.F.I.C.C., D.A.C.A.N.</u>		IRS Number 20-2713448
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