



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

1. INSURER NAME AND ADDRESS:				6. 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		STATE		ZIP	
9. TELEPHONE NUMBER:					Hazard		
10. OCCUPATION (Specific job title)					11. SOCIA SECURITY NUMBER: N/A		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.	
		02/12/07			<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	Occupation	
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 checked="" type="checkbox"/> no	
		March 16, 2007			<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	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 has been working for above employer for over a year M-F 8 hours a day. He is a supervisor in the service department where his job duties are to fix treadmills, stationary bikes, fitness equipment etc. Lifting is required such as tilting treadmills etc. On 02/12/07, patient started his shift around 8:00am doing normal activities by fixing step mills. Around 3:00pm he was tilting a step mill to change the levelers when suddenly the step mill tilted toward him. He tried to get away but the machine slammed onto his right hand. He is not sure how heavy the step mill was but says it is extremely heavy. He did not fall to the ground and had immediate severe pain in his right hand. He states his co-workers witnessed his injury. Patient was the boss of his department and went into his office to see if the pain would go away. He was in his office about an hour and noticed his hand was swollen. While working, patient reported the incident to his supervisor Scott the same day. Scott was very upset at patient for getting hurt. Scott told Mr. Leos to wait a couple of days to see if his hand would get better. Later on the day, patient had difficulty sleeping at night due to pain. The next day he went into to work with pain and tried to work with only his left hand. He was given paperwork to see a doctor. Two days after his injury pt went to a doctor that his employer told him to go. Pt does not remember name of doctor, but knows it was located in Vernon Hills, IL. Per patient this doctor diagnosed him with fracture and was given a cast and referred to a specialist Dr. Kacker M.D. Pt continued to work with a cast. Dr. Jacker M.D. told patient he did not have a fracture and the cast was removed. Pt saw Dr. Jacker 4-5 times over 3-4 weeks. Pt has had no form of therapy yet and was only given pain meds from Dr. Jacker. Pt continued to work with restrictions and not using his right hand. Pt states Jennifer from his employer's Human Resources, told Pt that they never filed a worker's comp claim so their insurance premium would not increase. Patient last worked on March 5, 2007 and was told he was suspended and not to come back to work. Patient presents for treatment and evaluation.

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

1) Right hand pain mostly at medial side along 5th digit (pinky) and metacarpal. Pain is sharp on/off throughout the day. Pain radiates from hand to forearm. Worse with movements. Difficulty sleeping at night due to pain. ADL affected due to pain such as taking showers and holding the soap, etc. 2) Numbness from medial side of hand to proximal forearm. 3) Weakness in right hand and hard to grip things.

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

PHYSICAL EXAM: Height 172cm, Weight 130lbs, BP 110/68 seated on left side, Pulse 68 and regular, Respirations 14. Alert, awake, and oriented x 3.

RIGHT HAND:

Range of motion in flexion 80° with pain, extension 70° with pain, ulnar deviation 24° with pain, and radial deviation 15° with pain. Left wrist range of motion within normal limits. **INSPECTION:** Skin normal in appearance. No swelling noted. 5th digit seems to be deformed. **PALPATION:** Severe tenderness with light touch throughout medial side of hand 5th metacarpal area. Severe tenderness in 5th carpalmetacarpal joint. Mild muscle spasm throughout hypothenar muscles. Moderate deformity of the 5th metacarpal bone.

DOCTOR'S FIRST REPORT

DOI:
RE:
CL#:

SPECIAL TESTS: Sharp/dull and vibration test are within normal limits. (+) Tinels. Capillary refill less than 2 seconds. Grip strength 80, 89, and 90 for Left side, and 30, 31, 30 for right side. Circumferential measurements: Biceps 24.5cm left and 25cm right, elbow 25cm left and 24.5cm for right, forearm 24cm left and 23.5cm right, wrist 15.5cm left and 15.5cm right, hand 19.5cm left and 19.0cm right.

RIGHT ELBOW:

Range of motion within normal limits. Inspection, palpation, and orthopedic examination unremarkable.

MUSCLE TESTING:

5th digit of hand (pinky) flexion 5.9/6.0/6.1 for left and 1.3/1.2/1.1 for right, 5th digit of hand extension 4.1/4.0/4.2 for left and 1.3/1.2/1.2 for right, Wrist flexion 16/17/16.5 for left and 7.0/7.1/7.0 for right, wrist extension 14.0/14.5/17.0 for left and 7.6/7.5, and 7.5 for right. Muscle strength of elbow is 5/5 bilaterally.

B. X-ray and laboratory results (State if none or pending.) 3v bilateral hand X-ray taken. Right hand shows deformity of the fifth digit suggesting a fracture. Radiologist report pending.

20. DIAGNOSIS (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? [] Yes [x] No

Table with 2 columns: ICD-9 Code and list of conditions including Late Effect Of Fracture Of Upper Extremities, DISUSE ATROPHY, MUSCLE WEAKNESS, PARESTHESIA, Sprain Of Carpometacarpal (joint) Of Hand, MUSCLE SPASM, Pain in joint of right wrist, STIFFNESS of JOINT, and Other Accident Caused By Striking Against Or Being Struck Accidentally By Objects Or Persons.

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

22. I there any other current conditions that will impede or delay patient's recovery? [x] Yes [] No If "yes," please explain. If the patient is denied proper Physical Therapy, Rehabilitation, 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 to hands bilaterally and scheduled for therapy and rehabilitation.

24. If further treatment required, specify treatment plan / estimated duration. This patient will need additional treatment in the form of Physical Therapy and STS ACU-ELECTRICAL procedures daily for 1-2 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 6-8 week however, request leniency if indeed the time line of care goes beyond these guesstimates due to complications of care. Patient will begin with passive physical therapy modalities such as e-stim, hot packs, ultrasound, manual therapy, and STS procedures. After a few visits, we will attempt to start patient on therapeutic exercises as tolerable and eventually may start work conditioning/hardening. Re-exam will be every 30 days. If patient does not improve on his next re-exam, MRI of hand and/or Electro-diagnostic assistance will be necessary. We do not suspect that this patient will need a medical specialist referral at this time however we certainly will not rule this out if indeed his condition does not improve or other symptomatology begins.

25. If hospitalized as inpatient, give hospital name and location. Admitted date: MO DAY Year Estimated Stay UNKNOWN

26. WORK STATUS-is patient able to perform usual occupation? [] Yes [x] No If "no," Date when patient can return to: Regular Work: Modified Work: Specify restrictions: TTD until 04/23/07. Is permanent residual disability anticipated? [] Yes [] No [x] Unknown If "yes," to what extent:

Doctor's Signature: Dr. Kelly G. Worth, D.C., F.A.F.I.C.C., D.A.C.A.N. IL License Number 038-010349
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