



Spine Institute of Waukegan
WORKERS COMPENSATION PROGRESS REPORT
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR2)
PTP - PROGRESS REPORT UPDATE
OFFICIAL OFFICE FORM

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e. has reached maximum medical improvement), do not use this form. You may use WCPR Form FR3 or WCFR-3 Form 040605.

Form with checkboxes for report reasons: Periodic report (checked), Change in treatment plan, Discharged, Change in Work Status, Need for referral or consultation, Info. Requested by, Change in patient's condition, Need for surgery or hospitalization, Other: PHYSICAL THERAPY CONTINUE (checked)

Patient: *(see below) Treatment Facility: SPINE INSTITUTE of WAUKEGAN, LLC

Form for patient information: Last, First, MI, Sex, D.O.B., Address, City, State, Zip, Occupation, SS#, Phone

Claims Administrator: DOI:

Form for Claims Administrator/DOI: Name, Claim Number, Address, City, State, Zip, Phone, Fax

Attorney: *(If Applicable)

Form for Attorney: Name, Claim Number, Address, City, State, Zip, Phone, Fax

Employer Name: Employer Phone:

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints: (Any and all complaints that pertain to the injury of issue and that are consistent with exam findings.)
Re-exam today. Patient states he is improving in overall pain scale. He states most of his pain is in his left 4th hand digit and extensor muscles currently rating it a 3 out 10 in VAS. Left 4th and 3rd digit pain is worse with movements. He states his hand pain and weakness have also improved. He says exercises and therapies have helped the most. Patient saw Dr. Visotsky M.D. twice and has another appointment on August 01, 2007. Patient also had a diagnostic ultrasound by Dr. Goomar M.D. to his left hand area.

Objective findings: (Include significant physical examination findings or other needed for current update on patients progress.)

LEFT WRIST/HAND:

Range of motion in flexion 60° with pain in lunate bone area, extension 60 with no pain, ulnar deviation 30° with no pain, and radial deviation 20° with no pain. INSPECTION: No erythema. Deformity of the 3rd digit present in flexed position (trigger finger). No swelling noted. PALPATION: No crepitation present. Mild tenderness throughout wrist bones mostly at lunate. Mild tenderness in distal 3rd and 4th distal interphalangeal joints. Trigger points with tenderness throughout wrist flexors and extensors. SPECIAL TESTS: Finkelsteins negative. Allen's circulation test within normal limits. Grip strength 20, 21, and 22 for left side with pain throughout metacarpal bones, and 82, 78, and 81 for right side. There is still much improvement in strength for the left to achieve.

NEURO: Reflexes for upper and lower extremities 2+ bilaterally and symmetrical.

MUSCLE TESTING (via Microfet2 electronic tester): Hand 4th digit flexion 2.5/2.5/2.4 for L and 5.6/5.4/5.4 for R, Hand 4th digit extension 1.8/1.9/1.9 for L and 2.2/2.4/2.3 for R, Hand 3rd digit flexion 2.5/3.5/3.4 for L and 7.5/7.6/8.0 for R, Hand 3rd digit extension 2.5/2.7/2.7 for L and 4.5/4.2/4.0 for R, Wrist flexion 12/15/13 for L and 25/25/24 for R, Wrist extension 12/14/13 for L and 16/15/14 for R, Elbow flexion 24/26/227 for L and 30/34/30 for R, Elbow extension 26/25/24 for L and 27/28/28 for right.

MRI, NCV/EMG or CPT/SEP test results, Digital Motion Fluoroscopy, (DMF), etc.: (laboratory, imaging, or other diagnostic findings that are pertinent to this patient and the injury of question. Discuss findings and how it will alter your treatment plan, if at all.)

No new additions

PTP - PROGRESS REPORT

RE:
DOI:
DOE:

MD EVALUATION and findings: (If applicable, describe all referred Physician findings and what's recommended and/or what's being performed by said Physician Specialist. Is surgery a probability or possibility?)

Co-management with Dr. Visotsky M.D. with continued treatment and Dr. Goomar M.D.

DX-Diagnoses:

1. Late Effect Of Fracture Of Upper Extremities	ICD-9 905.2
2. Closed Fracture Of Shaft Of Metacarpal Bone	ICD-9 815.03
3. Numbness	ICD-9 782.0
4. Disuse Atrophy	ICD-9 728.2
5. Sprain of unspecified site of hand	ICD-9 842.10
6. Sprain of unspecified site of wrist	ICD-9 842.00
6. Muscle weakness	ICD-9 728.87
6. Muscle spasm	ICD-9 728.85
6. Stiffness of joint (digits)	ICD-9 719.54
6. Late effects from accidentally struck by falling object.	ICD-9 E929.8

Treatment Plan: Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation or acupuncture) Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Patient has been receiving treatment 3x's a week since last re-exam 4 weeks ago. He is continuing to improve in range of motion, strength, and subjectively. He had diagnostic ultrasound done by Dr. Goomar M.D. with report pending however noted were remarkable findings according the Physician. Depending on findings, we will alter therapy as needed. The patient is also being co-managed with Dr. Visotsky M.D. Patient will continue now only 2x's a week for 4 more weeks where another re-exam will be performed.

DISABILITY STATUS: (Describe patient's current disability and whether or not they are off work, working with restrictions or back to work completely. Also display the amount of time lost from work since treatment commenced in your office up to the date of the re-exam.)

Work Status: this patient has been instructed to:	
<input checked="" type="checkbox"/>	Remain off work until: 08/25/07 *(Dr. Visotsky placed semi-cast/ splint on finger for extensor/ flexor tendon to strengthen with exercises.)
<input type="checkbox"/>	Return to modified work on: _____ WITH THE FOLLOWING RESTICTIONS: (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):
<input type="checkbox"/>	Return to full duty on _____ with no limitations or restrictions.

Primary Treating Physician: (Original signature, do not stamp)

Date of exam: 07/25/07

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated any Illinois W/C Laws.

IL Lic. #: 038-010349

Signature: _____

Executed at: Lake County, Illinois

Date: 07/25/07

Name: Dr. Kelly G. Worth, D.C., FAFICC, DACAN, DABCI

Specialty: Chiropractic Neurology and Rehabilitation

Address: 2634 Grand Avenue, Suite #100, Waukegan, IL 60085

Phone: (847) 775-0800

WCC Form PR-2 (Rev. 8/29/05)

(Use additional pages, if necessary)