



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, 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: PATIENT IN NEED OF MD EVAL.

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

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

Claims Administrator: DOI:

Form with fields for insurance information: Name of Insurance, Claim Number, Address, City, State, Zip, Phone, Fax.

Attorney: *(If Applicable)

Form with fields for attorney information: 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.)

Patient presents for a follow-up exam. Patient states he continues with pain and tenderness. Pain is constant overall and feels just a little better. Pain is mostly throughout the right hand. Patient has been working in a new job fixing machines. He feels numbness at times in the right hand. Patient is able to sleep at night for the most part without pain. He has been doing home exercises and icing that seems to help temporarily. Patient has not been to Dr. Visotsky M.D. for evaluation due to insurance non-authorization and desires to have his hand evaluated further.

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

RIGHT HAND: RANGE OF MOTION: 50 degrees in flexion with pain at end range, extension 52 degrees with mild pain, ulnar deviation 22 degrees with mild pain, and radial deviation 15 degrees with mild pain at end range. INSPECTION: Skin normal in appearance. Deformity noted in 5th digit with loss of flexion. PALPATION: Mild-moderate tenderness throughout carpal bones, and metacarpal bones mostly at 5th digit dorsally. Moderate tenderness throughout flexors and extensors muscles of wrist, and hypothenar eminence muscles of the right hand with slight atrophy from disuse. SPECIAL TESTS: (-) Tinels Sharp/dull discrimination within normal limits for right upper extremity dermatomes. Grip strength 20, 18, 20 for right and 85, 50, and 85 for left. Patient is right handed.

CIRCUMFERENTIAL MEASUREMENTS (cm): Left Biceps, 25.5, left elbow 24, left forearm 25 and left wrist 15.25, right Biceps 25, elbow 24 and forearm 24.5 and wrist 15.

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

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

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?)

Dr. Vistosky M.D. authorization pending.

PTP - PROGRESS REPORT

RE:
DOI:
DOE:

<p>20. DIAGNOSIS (If occupational illness, specify etiologic agent and duration of exposure.)</p> <p>1) Late Effect Of Fracture Of Upper Extremities 2) DISUSE ATROPHY, right Hypothenar/ Forearm Musculature 3) MUSCLE WEAKNESS, right Hand and Extensor Musculature 4) PARESTHESIA, right Hand 5) Sprain Of Carpometacarpal (joint) Of Hand 6) MUSCLE SPASM, Hand and Forearm, right side 7) Pain in joint of right wrist 8) STIFFNESS of JOINT, Right Hand 9) Other Accident Caused By Striking Against Or Being Struck Accidentally By Objects Or Persons</p>	<p>Chemical or toxic compounds involved? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>ICD-9 Code</p> <p>1) 905.2 2) 728.2 3) 728.87 4) 782.0 5) 842.11 6) 728.85 7) 719.43 8) 719.53 9) E917.9</p>
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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 continues with tenderness in his hand and has failed conservative treatments and is released from our care. He has been referred to Dr. Visotsky M.D. an upper extremity specialist at Illinois Bone and Joint for further evaluation and treatment. Work comp insurance was under a prolonged investigation of the incident and patient was not able to receive MRI of his hand or the recommended evaluation. We will be scheduling him for a Medical Diagnostic Ultrasound of his hand with Dr. Gommar, Pain Specialist, with further work up and evaluation from him. Perhaps this will assist our current problem and we will be able to satisfy all parties. Patient is told to continue home exercises. He is to return in 30 days for a follow-up exam.

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.)

Patient is able to return to work with restrictions, please see below.

<p>Work Status: this patient has been instructed to:</p> <p><input type="checkbox"/> Remain off work until:</p> <p><input checked="" type="checkbox"/> Continue modified work from: <u>06/15/07</u> WITH THE FOLLOWING RESTICTIONS: No lifting >35lbs, No Excessive Gripping, Pushing or Pulling or Grasping with the right hand.</p> <p>(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):</p> <p><input type="checkbox"/> Return to full duty on _____ with no limitations or restrictions.</p>

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

Date of exam: 06/15/07

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 Labor Code 139.3.

IL Lic. #: 038-010349

Signature: _____

Executed at: Lake County, Illinois

Date: 06/15/05

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)