



State of Illinois  
Workers' Compensation Commission  
**PRIMARY TREATING PHYSICIAN'S FINAL REPORT (FR3)**  
**FINAL REPORT UPDATE**

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 WCC Form PR-3 or IMC Form 81556.

|   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> Periodic report (required 30-45 days after last report) | <input type="checkbox"/> Change in treatment plan                     | <input checked="" type="checkbox"/> Patient Discharged                                |
| <input type="checkbox"/> Change in Work Status  | <input checked="" type="checkbox"/> Need for referral or consultation | <input type="checkbox"/> Info. Requested by: _____                                    |
| <input type="checkbox"/> Change in patient's condition                                      | <input type="checkbox"/> Need for surgery or hospitalization          | <input checked="" type="checkbox"/> Other: <b>PATIENT RELEASED P&amp;S - 09/08/06</b> |

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

|             |        |       |           |        |
|-------------|--------|-------|-----------|--------|
| Last:       | First: | MI:   | Sex:      | D.O.B: |
| Address:    |        | City: | State: IL | Zip    |
| Occupation: |        | SS#:  | Phone:    |        |

|                              |  |               |        |      |
|------------------------------|--|---------------|--------|------|
| <b>Claims Administrator:</b> |  | <b>DOI:</b>   |        |      |
| 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:**

Patient is in for his possible last visit. Patient is working with restrictions. He still gets pain, but is very little now. The pain comes and goes usually. In the AM he will feel stiffness and some pain but as he gets going, he will be okay. Also, at the end of the day, after working all day, he will feel pain. Long distances are not good while driving and he cannot sit for a prolonged length of time. The patient still wears his brace when he feels his pain coming on. He wears it probably 50% of the day. His leg numbness and radiating pain is only occasional and seems to have improved from the traction and CMT procedures along with work conditioning. He doesn't have any other complaints other than his lower back.

**Objective findings:** (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Patient still exhibits positive compression test to the lower lumbar region, specifically L4 and L5. This pain is vocalized. The patient still exhibits positive SLR at 65-70 degrees bilaterally. Digital pressure to the spine reveals no more spasmed musculature. Pelvic misalignment is not noted any longer. The thoracic spine appears to be within normal limits. The paravertebral muscles were slightly hypertonic, otherwise, within normal limits. The patient's range of motion is still limited 20% from normal due to increased pain, particularly in flexion and extension and rotation's. His gait appears to be within normal limits and patient exhibits better posture and sitting down and standing up performance. There are no other remarkable findings as found or noted. The patient shows still some positive neuromuscular readings with the sEMG but overall appears to be improving. There are no other remarkable findings as found or noted.

**FINAL Diagnoses:**

- |  |                                     |
|--|-------------------------------------|
| 1. L5/S1 Central and Right Paracentral 5mm Lumbar Disc Injury/ Bulge w/ Extrusion of Discal Material | ICD-9 722.10 - Permanent            |
| 2. L4/L5 3mm Central Disc Protrusion   | ICD-9 722.10 - Permanent            |
| 3. Lumbar Radiculopathy, right lower extremity, Intermitt.   | ICD-9 724.4 - Static and Stationary |
| 4. Lumbar sprain/strain  | ICD-9 847.2 - RESOLVED              |
| 5. Lower Extremity Paresthesia, Occasional   | ICD-9 782.0 - Resolving             |

**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?

The patient is to be referred to a Licensed P/T with Condell Medical, for a functional capacity evaluation. This will assist me with my final thoughts as to his permanent disability. The patient would do well with a series of injections and will be referred accordingly. He has reached permanent and stationary status with regard to P/T and CMT but I still believe that he can improve or at least sustain his level of health with the injections. I would recommend Dr. Sue Harsoor, MD whom specializes in pain management and chronic conditions. This patient will also be given an active treatment protocol for in home such as exercise, stretching and so forth and will be recommended to continue this on a regular basis for at least 6-12 months with or without the injections. He is also to purchase an in home traction device that he can continue giving himself traction care to alleviate the pressure on the permanent injured discs.

**PROGRESS REPORT**

DOI:  
RE:  
CL#:

Work Status: this patient has been instructed to:

- Remain off work until: \_\_\_\_\_
- Continue modified work on: 09/08/06 **WITH THE FOLLOWING RESTRICTIONS:** (List all specific restrictions re: standing, sitting, bending, use of hands, etc.): **No Excessive Bending, stooping or prolonged sitting; No Heavy Lifting >25lbs., No Excessive Twisting at the waist. Patient should wear lumbar support brace while working as needed.**
- Return to full duty on \_\_\_\_\_ with no limitations or restrictions.

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

Date of exam: 09/08/06

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 WCC laws.

IL Lic. #: 038-010349

Signature: \_\_\_\_\_

Executed at: Lake County, Illinois

Date: 09/08/06

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)**

**\*\*( FOLLOW-UP REPORT WILL FOLLOW WHEN FUNCTIONAL CAPACITY REPORT IS RECIEVED. )**