

7-8-08

Dameron Hospital Occupational Health Services

420 W. Acacia Street , Stockton, CA 95203 209-461-3196 FAX 209-461-3123

WORK STATUS REPORT

Employee:	Tiffany Anderson	Exam Date:	07/08/2008
Employee ID:	549-23-5133	Time In:	10:10 AM Time Out: 10:50 AM
Employer:	SJ Mosquito & Vector Control	Guarantor:	AIMS-SACTO 8049
Date of Injury:	6/19/2008	Claim No:	

Work Status: MODIFIED WORK DUTIES
Effective 07/08/2008 to 07/15/2008

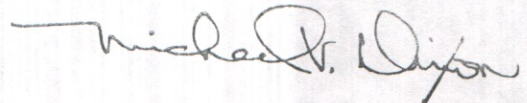
Work Restrictions: WORK RESTRICTIONS: No squatting, kneeling or crawling. No climbing ladders. Wear splint/brace as directed. No prolonged standing or walking.

Diagnosis: Knee effusion, Right
Sprain/strain knee, cruciate ligament

Evaluating Clinician: Mike Dixon PA-C
Donald Rossman M.D.

***Medical Services:** TENS Unit - Application

*This is a general overview of the visit, it is not a complete list of billable services



Next Scheduled Appointment:

<u>Date</u>	<u>Time</u>	<u>Provider</u>	<u>Specialty</u>
7/15/2008	11:20 AM	Dixon, Mike	Occupational Health Services

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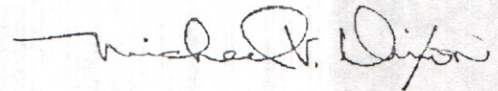
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— intermittent @ knee effusion

— may need MRI later

~~*~~ Darnest

— brace for
— Total hip

Script for Tens unit

7/8/08
ARE REHAB
and Orthopaedic Products, Inc.

Letter of Medical Necessity & Prescription

07

Please Fax to:
Tracy Cook
800-611-5733

The following information is required by your patients insurance company. Please complete this entire form.

Patient Information		Modality	
Name: <u>Tiffany Anderson</u>		<input checked="" type="checkbox"/> Care TENS _®	<input type="checkbox"/> Starr Cervical Traction _®
SS #: _____		<input type="checkbox"/> Care Stim _®	<input type="checkbox"/> Care Lumbar Traction _®
DOB: <u>6/19/08</u>		<input type="checkbox"/> Care Select Stim _®	<input type="checkbox"/> Acustim Adapter _®
Phone: (____) _____		<input type="checkbox"/> Care Select Stim Plus _®	<input type="checkbox"/> Hand Switch
Referring Clinic Clinic: _____ Phone: (____) _____ Physical Therapist: _____		<input type="checkbox"/> Care IFC Sport _®	<input checked="" type="checkbox"/> Electrodes & Supplies
		<input type="checkbox"/> Care IFC Plus _®	<input type="checkbox"/> Other: _____
		<input type="checkbox"/> Care EMG _®	Serial #: <u>CTNS 148214</u>
		<input type="checkbox"/> Care ETS _®	
		<input type="checkbox"/> Care High Volt _®	
		- DO NOT ISSUE E-STIM DEVICES TO FACEMAKER PATIENTS -	
Physician		Diagnosis and Device Duration	
Prescribing Physician: _____		Diagnosis: _____	ICD-9-CM: _____
NPI #: _____		Primary: _____	
Phone: (____) _____ Ext: _____		Secondary: _____	
		Recommended Device Duration: <input type="checkbox"/> 6-9 Months <input type="checkbox"/> Long Term	<input type="checkbox"/> Purchase <input type="checkbox"/> Other _____ Months

Please provide the following information.

Is the above device prescribed to this patient for their physical therapy due to injuries sustained in either an automobile or work related accident? Yes No

Was surgery performed on the patient? (If "Yes", give dates and details.) Yes No

Are these services to be rendered while patient remains under your care? Yes No

Is there a reasonable expectation that the prescribed device will result in significant improvement for the patient? (Please explain). Yes No

Statement of Medical Necessity

Care Rehab and Orthopaedic Products, Inc. has supplied this modality as per the above prescription. I recommend this particular device for home use as part of this patient's physical therapy treatment.

- DO NOT SUBSTITUTE -

Physician's Signature: _____

D. Rimmer

Date: 7/8/08

Rev. 6/2007

718108



Patient Information Form

07

Please Fax to: Tracy Cook 800-611-5733

Patient Information

Name: Tiffany Anderson SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Relationship to Policy Holder:

Self Spouse Child Other

Birth Date: _____ / _____ / _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Ext: _____

Health Insurance Policy Effective Date: _____ / _____ / _____

Insured Name: _____

Insurer: _____

Policy #: _____

Group #: _____

Phone: (_____) _____ - _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Self-Pay Patients

Amount: \$ _____

Visa MasterCard Amex Diner's Club

Card #: _____

Expiration Date: _____ / _____

Payment by Check Check #: _____ Payment by Cash

Worker's Comp / Auto Insurance

Work Comp Auto Carrier

Claim #: _____

Adjuster's Name: _____

Phone: (_____) _____ - _____ Ext: _____

Employer: _____

Date of Injury: _____ / _____ / _____

Insurer: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

WORKERS COMPENSATION: RIGHT TO CHOOSE

The equipment I received is the equipment ordered by my authorized physician. I choose to use this particular equipment supplied by Care Rehab, Inc. I choose Care Rehab, Inc. as my provider and understand that I have the right if applicable under the worker's compensation law in the state of my residence. My insurance carrier may NOT CHANGE the equipment or provider without my prior knowledge and written approval. I choose Care Rehab, Inc. as the provider of any future supplies and accessories.

Modality

Care TENS_® Start Cervical Traction_®

Care Stim_® Care Lumbar Traction_®

Care Select Stim_® Acustim Adapter_®

Care Select Stim Plus_® Hand Switch

Care IFC Sport_® Electrodes & Supplies

Care IFC Plus_® Other: _____

Care EMG_® Other: _____

Care ETS_® Other: _____

Care High Volt_® Other: _____

Serial #: CTNS 148214

- DO NOT ISSUE E-STIM DEVICES TO PACEMAKER PATIENTS -

Attorney

Attorney Name: _____

Law Firm: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: (_____) _____ - _____ Ext: _____

Physician

Prescribing Physician: _____

NPI #: _____

Phone: (_____) _____ - _____ Ext: _____

Diagnosis: _____

ICD-9-CM: _____

Clinician

Clinic: _____

Phone: (_____) _____ - _____

Physical Therapist: _____

I have been instructed in the proper application, use and care of the above described unit. I may rent or purchase the system. I understand that I am responsible for the Care Rehab equipment and if for any reason, I do not return the unit directly to Care Rehab, Inc. I agree to pay the rental or purchase price. I authorize the release of any medical information necessary to process my claim and I agree to pay for all charges not covered by this authorization or not otherwise paid by my insurance company. I permit a copy of this authorization to be valid as the original. I, the undersigned, select Care Rehab, Inc. as my DME provider of choice and represent that I have insurance coverage and do hereby authorize my carrier to pay and assign directly to Care Rehab, Inc. surgical and medical benefits, if any, otherwise payable to me for the services described. I understand that I am financially responsible for all charges, whether or not paid for by said insurance. I hereby authorize said assignee to release and obtain all information necessary.

Patient's Signature: _____ Date: 7/8/08

Insured's Signature (if different from patient): _____ Date: _____ / _____ / _____

Please Enroll me

Please mail me fresh electrodes/batteries monthly if covered by my insurance.

Please initial below:

Initial: _____