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

Michael R. Dixon

Next Scheduled Appointment:

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

Printed: 7/8/2008

Employer Copy

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Michael R. Dixon

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

— intermittent (R) knee effusion

— may need MRI later

— Darvocet

— brace for

— TBL wrist

Printed: 7/8/2008

Employer Copy

Script for Tens unit

[redacted]
7/8/08

CARE 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

Name: Tiffany Anderson

SS #: _____

DOB: 6 / 19 / 08

Phone: (_____) _____ - _____

Referring Clinic

Clinic: _____

Phone: (_____) _____ - _____

Physical Therapist: _____

Physician

Prescribing Physician: _____

NPI #: _____

Phone: (_____) _____ - _____ Ext: _____

Modality

- [x] Care TENS®
- [ ] Care Stim®
- [ ] Care Select Stim®
- [ ] Care Select Stim Plus®
- [ ] Care IFC Sport®
- [ ] Care IFC Plus®
- [ ] Care EMG®
- [ ] Care ETS®
- [ ] Care High Volt®
- [ ] Starr Cervical Traction®
- [ ] Care Lumbar Traction®
- [ ] Acustim Adapter®
- [ ] Hand Switch
- [x] Electrodes & Supplies
- [ ] Other: _____

CTNS
Serial #: 148214

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

Diagnosis and Device Duration

	Diagnosis	ICD-9-CM
Primary:	_____	_____
Secondary:	_____	_____

Recommended Device Duration: [ ] 6-9 Months [ ] Long Term [ ] Purchase [ ] 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? [x] Yes [ ] No

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

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

Is there a reasonable expectation that the prescribed device will result in significant improvement for the patient? (Please explain). [x] 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. Rivera MD Date: 7 / 8 / 08

Rev. 6/2007

718108

CARE REHAB® and Orthopedic Products Inc.

Patient Information Form

07

Please Fax to:
Tracy Cook
800-611-5733

Patient Information

Name: Tiffany Andersun

Address: _____

City: _____ State: ____ Zip: _____

Patient Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Other

SS #: _____

Birth Date: ____/____/____

Home Phone: (____) ____ - ____

Work Phone: (____) ____ - ____ Ext: ____

Health Insurance

Policy Effective Date: /

Insured Name: _____

Insurer: _____

Policy #: _____

Group #: _____

Phone: (____) ____ - ____

Billing Address: _____

City: _____ State: ____ Zip: _____

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 this 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.

Attorney

Attorney Name: _____

Law Firm: _____

Address: _____

City: _____

State: ____ Zip: _____

Phone: (____) ____ - ____ Ext: ____

Self-Pay Patients

Amount: $ ___,___.__

☐ Visa ☐ MasterCard ☐ Amex ☐ Diner's Club

Card #: _____

Expiration Date: ____/____

☐ Payment by Check Check #: _____ ☐ Payment by Cash

Modality

☒ Care TENS®
☐ Care Stim®
☐ Care Select Stim®
☐ Care Select Stim Plus®
☐ Care IFC Sport®
☐ Care IFC Plus®
☐ Care EMG®
☐ Care ETS®
☐ Care High Volt®

☐ Stan Cervical Traction®
☐ Care Lumbar Traction®
☐ Acustim Adapter®
☐ Hand Switch
☒ Electrodes & Supplies
☐ Other: _____

CTNS
Serial #: 148214

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

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.

X 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 : _____

Rev. 6/2007