

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Additional pages attached

Patient Last Armed First Tilkney M.I. \_\_\_\_\_ Date of Exam: 7/6/2011 Case #: \_\_\_\_\_

Occupation: \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Injury \_\_\_\_\_ Claim # \_\_\_\_\_

Employer: ST County Contact: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Claims Administrator \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

**REASON FOR SUBMITTING REPORT** (Check all that apply. If any box aside from "Other" applies, this report qualifies as mandatory.)

- Significant change in patient's condition
- Significant change in work status
- Significant change in treatment plan
- Need for referral or consultation
- Need for surgery or hospitalization
- Periodic Report (45 days after last report)
- Info requested by: \_\_\_\_\_
- Released from care
- Request for authorization
- Other: WFR

**PATIENT STATUS** Since the last exam, this patient's condition has:

- improved as expected
- worsened
- improved, but slower than expected
- reached plateau and no further improvement is expected
- not improved significantly
- been determined to be non-work related

**SUBJECTIVE COMPLAINTS** (Document and describe significant complaints.)

**OBJECTIVE FINDINGS** (Document significant exam findings, lab, imaging, and other diagnostic testing.)

**DIAGNOSES** (Include ICD-9 code, if possible)

abrasion/contusion @ knee

**TREATMENT**

- Office Visit / Injury Treatment
- Start /  Continue  Therapy: \_\_\_\_\_ times / week for \_\_\_\_\_ weeks.
- Ergonomic Evaluation
- Medications / Supplies Dispensed Tylenol
- Consultation /  Referral  Requested /  Pending. Specialty \_\_\_\_\_
- Work status to be determined by specialist.
- Estimated length of treatment is now \_\_\_\_\_ weeks

**WORK STATUS**

- First Aid Case
- Return /  Continue... to work without restrictions
- Off work until (DATE) \_\_\_\_\_ Estimated period of total temporary disability \_\_\_\_\_ days,
- Off the balance of this shift only. Then RTW on (DATE) \_\_\_\_\_ to Full /  Modified duty.  Re-evaluate work status before next shift.
- Return to work as of \_\_\_\_\_ with the restrictions indicated below. Estimated duration of modified duty is \_\_\_\_\_ days.
  - ( ) No work near moving machinery
  - ( ) No / ( ) Limited use of R / L hand to \_\_\_\_\_ hrs/day
  - ( ) No / ( ) Limited standing or walking to \_\_\_\_\_ hrs/day
  - ( ) No / ( ) Limited overhead work to \_\_\_\_\_ hrs/day
  - ( ) No / ( ) Limited stooping and bending to \_\_\_\_\_ hrs/day
  - ( ) No / ( ) Limited kneeling or squatting to \_\_\_\_\_ hrs/day
  - ( ) No / ( ) Limited  Lift  Pull  Push  
Up to:  10 lbs  25 lbs  50 lbs  \_\_\_\_\_ lbs
  - ( ) No Climbing
  - ( ) Sit down job
  - ( ) Must wear  Splint  Immobilizer  Back support  Cage  Other \_\_\_\_\_
  - ( ) Must keep \_\_\_\_\_ elevated
  - ( ) Keep wound/bandage clean and dry
  - ( ) Must take a \_\_\_\_\_ minute stretch break every \_\_\_\_\_ minutes from  Keyboard /  Other: \_\_\_\_\_
  - ( ) Other \_\_\_\_\_

Medical status was discussed with employer representative John Strach

**DISCHARGE STATUS**

- Return to full duty on (DATE) \_\_\_\_\_ with no limitations or restrictions.
- Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.
- NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

**PRIMARY TREATING PHYSICIAN**

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.

Name \_\_\_\_\_ Cal. Lic # \_\_\_\_\_ Date of Exam \_\_\_\_\_

Specialty: \_\_\_\_\_ Signature (Original) \_\_\_\_\_

Executed at: U.S. HealthWorks / Stockton, 3663 E. Arch Road, Suite 400, Stockton, CA 95215 Tel: (209) 943-2202 • Fax: (209) 943-2209

<p><b>YOUR NEXT APPOINTMENT WITH THE DOCTOR IS:</b></p> <p><input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT</p> <p>DATE: <u>7/13</u> TIME: <u>9:30am</u> <input type="checkbox"/> Before / After Shift</p> <p>PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.</p>	<p><b>YOUR NEXT APPOINTMENT WITH THE DOCTOR IS:</b></p> <p><input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT</p> <p>DATE: _____ TIME: _____ <input type="checkbox"/> Before / After Shift</p> <p>PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.</p>
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