8-12-08

State of California
Division of Workers' Compensation

Additional pages attached ☑

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

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 DWC Form PR-3 or PR-4.

☑ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☑ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☑ Request for authorization ☐ Other:

Patient:
Last Anderson First Tiffany M.I. Sex Female
Address 1416 Iris Dr #7 City Lodi State CA Zip 95242
Date of Injury 06/19/2008 Date of Birth 08/22/1970
Occupation Pesticide Applicator SS # 549-23-5133 Phone (209) 333-1037

Claims Administrator:
Name AIMS-SACTO 8049 Claim Number VE0700184
Address PO BOX 269120 City Sacramento State CA Zip 95826
Phone (916) 563-1900 FAX (916) 563-1919

Employer name: SJ Mosquito & Vector Control Employer Phone (209) 982-4675

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints: **See Attached**

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

Diagnoses:
1. Effusion, lower leg, knee ICD-9 719.06
2. Sprain/strain knee, cruciate ligament ICD-9 844.2
3. ICD-9

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, acupuncture). Use of CPT codes is encouraged. Have there been any **changes** in treatment plan? If so, why?
See Attached

Work Status: This patient has been instructed to:

☐ Remain off-work until

☑ Return to *modified* work on 08/12/2008 with the following limitations or restrictions
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.): **See Attached**

☐ Return to full duty on with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp) Date of exam: 8/12/2008

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.

Signature:
Executed at: Dameron Hospital Occupational Health Services
Name: Donald Rossman, M.D.
Address: 420 W. Acacia Street, Ste#2 Stockton, CA 95203

Cal. Lic. # C35074
Date: 8/12/2008
Specialty: Occupational Medicine
Phone: (209) 461-3196
Fax: (209) 461-7529

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DWC Form PR-2 (Rev. 06/05)