

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.

<input checked="" type="checkbox"/> Periodic Report (required 45 days after last report)	<input type="checkbox"/> Change in treatment plan	<input type="checkbox"/> Released from care
<input type="checkbox"/> Change in work status	<input checked="" type="checkbox"/> Need for referral or consultation	<input type="checkbox"/> Response to request for information
<input type="checkbox"/> Change in patient's condition	<input type="checkbox"/> Need for surgery or hospitalization	<input checked="" type="checkbox"/> Request for authorization <input type="checkbox"/> 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 07/29/2008 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: 7/29/2008

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: 7/29/2008
Specialty: Occupational Medicine
Phone: (209) 461-3196
Fax: (209) 461-7529

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AUG 28 2008
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