# CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

**NAME:** Anderson, Tiffany K **DOS:** 06/09/2004
**DOB:** 8/22/1970

## CONSENT

I hereby authorize the Dameron Hospital occupational Health Department to:

- ☐ Obtain a complete medical history and physical examination including any required medical tests
- ☑ Provide medical treatment for a work-related injury
- ☐ Obtain a urine specimen and/or breath sample for drug and/or alcohol testing

## AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize the Dameron Hospital Occupational Health Department to furnish to an agent, designee or representative of ***SJ Mosquito and Vector Control*** the results of my medical evaluation and/or treatment including past or present records pertaining to employment history, medical history, test results, urine drug and/or breath alcohol test results, services rendered or treatment provided to me.

## USE

I understand that this medical information will be used for the purpose of determining my ability to perform the essential functions of my job with ***SJ Mosquito and Vector Control***.

## RESTRICTIONS

I understand that ***SJ Mosquito and Vector Control*** may use these medical records only for employment-related purposes and that they may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

## DURATION

This authorization is effective immediately and shall remain in effect for one year from **6/ 9/2004** .

## ADDITIONAL COPY

I understand that I have a right to receive a copy of this form and that a copy of this document is as valid as the original.

I would like a copy of this form ☐ Yes ☐ No Received: ☐ Yes ☐ No Initial _____

## SIGNATURE

*Employee signature*

*Witness Signature*

Date: 6/ 9/2004

***Non-DOT Drug Screens Only***

List current meds: ☐ None

Rx:_____

_____

OTC:_____

Occupational Injury Clinic

# Injury Worksheet

**Patient**

Anderson, Tiffany K
1830 S Hutchins Apt304
Lodi, CA 95240-

PHONE: (209) 333-9249

**Employer**

SJ Mosquito and Vector Control
7759 S Airport Way

Stockton, CA 95206-

CONTACT:
PHONE / FAX: (209) 982-4675x / (209) 982-0120

**Guarantor**

Gregory B Bragg and Associates-Roseville
PO Box 619058

Roseville, CA 95661-9058

PHONE / FAX: (800) 422-7244 / (916) 783-0335

**Sex:** F **DOB :** 08/22/1970 **Age :** 33 **SSN# :** 549-23-5133
**Occupation :** Tech
**Department :**
**Injury Location :**
**Patient History :**

**Date/Hour of Injury :** 06/07/2004 at 12:00 pm
**Case Number :** 56808
**Claim Number :** Pending

## Check In Instructions

**Date/Time of Visit :** 06/09/2004 at 07:55 am

*Chart Up* ____:____ am / pm
*Patient Back* ____:____ am / pm
*Discharged* ____:____ am / pm

**Drug/Alcohol Testing:**
--DOT BAT at company request
--DOT UDS at company request
----Quest, Test #35304N, Client #76337
--Page OHS @ 929-2541 before discharge!

***Results in Stolas:*** *Date* _____ *Initials* _____

**Work Status:**
--Modified duty available

--New injuries must have written or verbal auth
from one of the following contacts:
----1. John Stroh
----2. Carol Aksland
----3. Eddie Lucchesi

## Service Procedures

| Ord. | Compl. | | Service Procedures / Service Instructions | Charge |
|---|---|---|---|---|
| _____ | _____ | 84483 | DOT Panel (co req)<br>- At company request | 13.50 |
| _____ | _____ | 84460 | Urine Drug Screen Collection - OIC (co req)<br>- At company request | 20.00 |
| _____ | _____ | 84178 | MRO - DOT (co req)<br>- At company request | 10.00 |
| _____ | _____ | 84542 | Breath Alcohol Test - OIC (co req)<br>- At company request | 20.00 |
| _____ | _____ | 84461 | Urine Drug Screen Collection - ER | 20.00 |
| _____ | _____ | 84543 | Breath Alcohol Test - After Hours | 20.00 |

# Injury Worksheet

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Sex:** F | **DOB** : | 08/22/1970 | **Age** : 33 | **SSN#** : 549-23-5133 | **Date/Hour of Injury** : | 06/07/2004 at 12:00 pm |
| **Occupation** | : | Tech | | | **Case Number** : | 56808 |
| **Department** | : | | | | **Claim Number** : | Pending |
| **Injury Location** | : | | | | | |
| **Patient History** | : | | | | | |

## Check Out Instructions

**Reporting Instructions:**
--Autofax work status to employer

--Verbal results to:
----1. John Stroh
----2. Carol Aksland
----3. Eddie Lucchesi

**Special Instructions:**
--None

Occupational Injury Clinic
420 W. Acacia Street , STE # 2 Linacia 1st F
Stockton, CA 95204-

# DOCTOR' S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE OF CALIFORNIA

**Within 5 days of your initial examination**, for every occupational injury or illness, send two copies of this report to the **employer's worker's compensation insurance carrier** or the **self-insured employer.** Failure to file a timely doctor's report may result in assessment of a civil penalty. **In case of diagnosed or suspected pesticide poisoning** send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24-hours.

1. **INSURED NAME AND ADDRESS**
Gregory B Bragg and Associates-Roseville 8115 PO Box 619058, Roseville, CA 95661-9058

PLEASE DO NOT USE THIS COLUMN
Case no
Industry
County
Age
Hazard
Disease
Hospitalization
Occupation
Return Date/Code

2. **EMPLOYER NAME**
SJ Mosquito and Vector Control

3. Address — No. and Street: 7759 S Airport Way — City: Stockton — Zip: 95206

4. Nature of Business (e.g., food manufacturing, building construction, retailer of women's clothes)

5. **PATIENT NAME**
Anderson, Tiffany K

6. Sex [ ] Male [X] Female

7. Date of Birth: Mo. Day Year 08/22/1970

8. Address — No. and Street: 1830 S Hutchins Apt304 — City: Lodi — Zip: 95240

9. Telephone Number: ( 209) 333-9249

10. Occupation (Specific Job title)
Tech

11. Social Security Number
549-23-5133

12. Injured at: No. and Street: WORK PLACE — City: STOCKTON — County: SAN JOAQUIN

13. Date and hour of injury or onset of illness: Mo. Day Yr. 06/07/2004 — Hour 12:00 pm

14. Date Last Worked: Mo. Day Yr.

15. Date and hour of first examination or treatment: Mo. Day Yr. 06/09/2004 — Hour

16. Have you (or your office) previously treated patient? [ ] Yes [X] No

**Patient please complete this portion, if able to do so.** Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED** (Give specific object, machinery or chemical. Use reverse side if more space is required.)
SEE ATTACHED DICTATION

18. **SUBJECTIVE COMPLAINTS (Describe fully. Use the reverse side if more space is required.)**
SEE ATTACHED DICTATION

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination
SEE ATTACHED DICTATION

B. X-ray and laboratory results (State if none pending)

20. **DIAGNOSIS** (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? [ ] Yes [X] No ICD-9
692.0 Dermatitis, Contact Irritant

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? [X] Yes [ ] No
If "no" please explain.

22. Is there any other current condition that will impede or delay patient's recovery? [ ] Yes [X] No
If "yes" please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)
SEE ATTACHED DICTATION

If further treatment required, specify treatment. Estimated duration:

24. If Hospitalized as inpatient, give hospital name and location. Date admitted: Mo. Day Yr. Estimated stay

25. **WORK STATUS** Is patient able to perform usual work? [X] Yes [ ] No
If "no", patient can return to: Mo. Day Yr.
Regular work 06/09/2004
Modified work
Specify restrictions

**I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.**

Doctor's signature _____ Date: 06/09/2004 CA License Number C35074

Doctor name and degree (Please type) Donald Rossman, M.D. IRS Number _____

Case # 56808 Telephone Number _____

**ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY**

Received 10/3/14

8115

**DAMERON HOSPITAL ASSOCIATION**
**Occupational Injury Clinic** **Initial Visit** **6/ 9/2004 7:55 a.m.**

| | | |
|---|---|---|
| **Patient Name:** *Nombre de paciente* Tiffany Anderson | **Sex:** *Sexo* ☐ Male *Masculino* ☒ Female *Femenino* | **Birthdate:** *Fecha de nacimiento* 8-22-70 |
| **Street Address:** *Domicilio* 1830 S. Hutchins #304 | **Status:** ☐ Married *Casado* ☒ Single *Soltero* | **Home Telephone No.:** *Telefono de casa* 209-333-9249 |
| **City, State, Zip:** *Ciudad, Estado, Zip* Lodi CA 95240 | | **Social Security Number:** *Seguro Social* ~~[illegible]~~ 549-23-5133 |
| **Employer:** *Empleador* S.J County mosquito & vector control | | **Job Title:** *Ocupacion* Tech |
| **Date of Injury :** *Fecha de accidente* 6/7/04 Hour *Hora* ☐ A.M. ☒ P.M. | **Date last worked:** *Dia que trabajo ultimo* | **Have you been seen here before?** *Ha venido aqui antes?* ☐ YES/*Si* ☒ NO |
| **Have you received treatment for this injury elsewhere?** *A recibido tratamiento para este accidente en otro lugar?* ☐ YES/*Si* ☒ NO | If yes, where? *Si, Cuando?* | Date *Feche* |
| **Describe how the injury occurred:** *Como ocurrio el accidente* walking through brush poison oak | | |

## SUMMARY OF DIAGNOSIS AND CONDITIONS

| Significant Diagnosis | Major Surgery | Medications | Drug Allergies |
|---|---|---|---|
| 1. rash itching | 1. -0- | 1. -0- | 1. NKDA |
| 2. | 2. | 2. | 2. |
| 3. | 3. | 3. | 3. |
| 4. | 4. | 4. | 4. |

**Tetanus:** ?  **Vision:** Rt 20/ Lt 20/  **Dominant Hand:** (Rt) Lt

## PROVIDER NOTES

**Subjective:** ☐ *dictated*

LAST M.P. 6/2/04 due pr

**Objective:** ☐ *dictated* contact dermit

**Assesment:** ☐ *dictated*

**Orders:** X-Ray _____ **Lab** _____ **Injection** _____

**Results:** _____ _____

**Treatments:**
Medications T.A.C 0.1% cream Dose _____ Quantity _____
Medications Tradmycin 10% Dose thin Quantity _____
Medications _____ Dose _____ Quantity _____

Physician Signature: _____

# Occupational Injury Clinic

420 W. Acacia Street , STE # 2 Linacia 1st Floor
Stockton, CA 95204

| | | | |
|---|---|---|---|
| DATE | : 06/09/2004 | | |
| PATIENT | : Anderson, Tiffany K | DATE OF INJURY | : 06/07/2004 |
| EMPLOYER | : SJ Mosquito and Vector Control | SOC. SEC.# | : 549-23-5133 |
| CASE # | : 56808 | CLAIM # | : Pending |

SUBJECTIVE:

She works for SJ Mosquito and Vector Control. She was out in brush and developed a rash, possible contact dermatitis from the brush. She experienced a light itching in the last couple of days of her upper legs and buttocks and neck.

OBJECTIVE:

She is in no acute distress. Past medical history is unremarkable. Currently taking no medications. No drug allergies. Currently she is not pregnant. Last menstrual period was 6/4/04. Vital signs are within normal limits. There is a faint macular papular type rash, kind of pink. There is no streaking of the posterior aspect of the lower legs and there are some patches around her neck.

ASSESSMENT:

Contact dermatitis.

PLAN:

1. _____ cream 0.1%. apply b.i.d. 30 grams.
2. We will give her Prednisone dose pack she is to take for 6 days and taper the dose. Start with 60 mg and reduce the dose within 6 days to 10 mg and discontinue #21 10 mg Prednisone tablets dispensed.
3. Return to clinic prn.

DR/ds

D: 6/9/04
T: 6/10/04

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

# DAMERON HOSPITAL
# OCCUPATIONAL INURY CLINIC

## WORK STATUS REPORT - WORKSHEET

Employee Name: Anderson, Tiffany K  Date of this Examination: 06/09/2004

Employer: SJ Mosquito and Vector  Clinic Case Number: 56808

**DIAGNOSIS:** contact dermatitis

**CLINICAL STATUS:** __**Q1**: Improved, as expected __**Q2**: Improving slowly __**Q3**: No significant change __**Q4**: Worse

**PT/OT:** __**W1**: Continue as prescribed __**W2**: 3x/wk - 2 week__**W3**:3x/wk – 1 week __**W4**: One visit __**W5**: Non-DHA PT

**RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES:**

__**E1**: MRI __**E2**: CT Scan __**E3**: NCS __**E4**: Work Conditioning __**E5**: Epidurals __**E6**: Ergo Evaluation

**REFERRAL / CONSULT:**

__ **R10**: Orthopedist
__ **R11**: Ophthalmologist
__ **R12**: Neurosurgeon
__ **R13**: Hand Specialist
__ **R14**: General Surgeon
__ **R15**: Neurologist
__ **R16**: Psych
__ **R17**: Physiatrist
__ **R18**: ENT
__ **R19**: Dermatology
__ **R20**: Pain Mgmt
__ **R21**: Dentist
__ **R22**: Health Club
__ **R23**: Urology
__ **R24**: Acupuncture
__ **R25**: Podiatrist

**WORK STATUS:** X Full work duties __ Modified work duties __ Off balance of shift, modified work __ Off balance of shift, full work duties __ No work until next appt. __ Current WS until Specialist appt.

**WORK RESTRICTIONS:**

No lift / carry >:
__**A09**: 50#
__**A10**: 10-15#
__**A11**: 30#
__**A12**: 5#

No prolonged:
__**A15**:Stand/Walk
__**A16**:Sitting

Other Back/Neck
__**A13**: No frequent lift, bend, twist, stoop at waist
__**A14**: Limit twist / bend at neck
__**A17**: Desk / sedentary only

Lower Extremity
__**A18**: No crawl / kneel / squat
__**A19**: No climbing ladders
__**A20**: Use crutches as directed
__**A21**: Elevate as directed
__**A22**: Use cane as directed

Upper Extremity
__**S10**: Wear splint / sling as directed
__**S11**: No frequent / repetitive use of wrist / hand
__**S12**: No heavy pushing or pulling
__**S13**: No use of arm above shoulder
__**S14**: No forceful hand grasp
__**S15**: No use of injured body part

Miscellaneous
__**S16**: Limited use of injured body part
__**S17**: May advance work activities as tolerated
__**S18**: Keep dressing clean and dry
__**S19**: No operating company vehicles
__**S20**: No exposure to heat
__**S21**: No exposure to cold
__**S22**: No exposure to chemical, vapors, fumes
__**S23**: No welding
__**S24**: Avoid physical altercations
__**S25**: Avoid wearing latex gloves
__**S27**: Limit keyboarding: 45 min/hr
__**S28**: Limit keyboarding: 4 hr/day

**PR STATUS:**

__ **PR-1**: Periodic Report
__ **PR-2**: Change in Work Status
__ **PR-3**: Change in Pt. Condition
__ **PR-4**: Change in Tx Plan
__ **PR-5**: Referral/Consult
__ **PR-6**: Surgery/Hospitalization
__ **PR-7**: Discharge
__ **PR-8**: Request by Adjuster
__ **PR-9**: Other: _____

**DISPOSITION:**

__**D1**: Consult
__**D2**: Final Discharge without residuals, PR-2 to follow
__**D5**: Referral / Transfer of care
__**D4**: Final Discharge with residuals, PR-3 to follow
__**D6**: Non-occupational, refer to PMD
X **D3**: First Aid

Next scheduled appointment: 1 week

Provider Initial: _____

6-18-04

10/3/14

Dameron Hospital Occupational Health Services
525 W. Acacia St., Stockton, CA 95203

# WORK STATUS REPORT

| | | | |
|---|---|---|---|
| **Employee Name:** | Anderson, Tiffany K | **Date of Visit:** | 06/09/2004 |
| **Social Security No.:** | 549-23-5133 | **Time In:** 07:55 am | **Time Out:** 08:45 am |
| **Employer:** | SJ Mosquito and Vector Control | | |
| **Date of Injury:** | 06/07/2004 | **Guarantor:** | Gregory B Bragg and |
| **Clinic Case Number:** | 56808 | **Claim Number:** | Pending |

## CLINICAL STATUS

**Diagnosis:** Dermatitis, Contact Irritant

Since the last visit, this patient's condition has:

## EVALUATION AND TREATMENT PLAN

**Physical / Occupational Therapy:**

**Recommended Evaluation / Diagnostic Studies:**

## WORK STATUS

**Work Status:** Full work duties **From:** 06/09/2004 **To:** 06/18/2004

**Work Restrictions:**

**Estimated return to full duty:**

## DISPOSITION

**Disposition:**

**Next Scheduled Appointment:** 07:40 am 06/18/2004

*Note: Missed appointments without 24 hours advance notice will be charged a $25 fee.*

*"I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."*

*Signed,*

Corky Hull, MD (Original signature on file)

**Doctor's Phone:** (209) 461-3196 opt. 3
**Doctor's Fax:** (209) 461-7529
**Case Coordinator Phone:** (209) 461-3196 opt.1

DH-WSR 8/14/02