OHIO INDUSTRIAL COMMISSION
SPECIALIST REPORT

INJURED WORKER NAME:
DATE OF BIRTH:
CLAIM NUMBER(S):
DATE(S) OF INJURY:
CLAIM ALLOWANCE(S):
DISALLOWED CONDITION(S):

This information can be found on the Medical Scheduling Worksheet and/or the Statement of Facts and must be listed exactly as provided.
Do NOT include Social Security number.

PLACE OF EXAMINATION:
DATE OF EXAMINATION:
DATE OF REPORT:
EXAMINER NAME:

Your examiner information.

PURPOSE OF EXAMINATION: The purpose of the examination was discussed at the request of the Ohio Industrial Commission in response to the Injured Worker's application for permanent total disability, that I would be providing a written report to the Ohio Industrial Commission and that the results of this examination are not confidential. I explained that I would not be providing the Injured Worker with any type treatment or advice.

OCCUPATIONAL HISTORY:

HISTORY OF THE PRESENT CONDITION:
(*In this area include: description of injury, job duties at the time, treatment, response to treatment, current treatment, treatment plan)*

CURRENT SYMPTOMS: *(In this area include: pain location, character, intensity, aggravating and alleviating factors. Review systems pertinent to each allowed condition.)*

IMPACT ON ACTIVITIES: *(In this area include: walking, sitting, standing tolerance, housework, yard work, basic self-care [dressing, bathing, toileting], hobbies, sleep, driving; describe daily activities).*

PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY:

CURRENT MEDICATIONS:

ALLERGIES:

SOCIAL HISTORY:

HEALTH HABITS: *(Tobacco, alcohol, drugs, exercise)*

In each section, provide a summary with information from your exam and your review of the medical records provided.

When describing the Impact on Activities, it is important to compare/contrast the pre-injury and the post-injury activities.

Claim #:
Injured Worker Name:

Provide a claim identifier (claim #, Injured Worker's name) and page number on every page to ensure we have received your complete report.

REVIEW OF MEDICAL RECORDS: I reviewed all of the medical records provided to me by the Industrial Commission.

This statement encompasses the Medical Scheduling Worksheet, Statement of Facts, Referral letter, and the Specialist Packet.

PHYSICAL EXAMINATION: Height: Weight:
(Examine each body part and/or system for which there is a claim allowance, in the manner required by the AMA Guides, 5th Edition.)

This is your examination. Report all pertinent positive and negative findings. ROM should be well documented with the use of goniometers and inclinometers.

OPINION:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**

   - **Provide an answer regarding MMI status with supporting rationale.**
   - **Note: If NOT at MMI, please provide proper rationale according to State of Ohio definitions.**

2. **Based on the AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Allowed condition	Table/figure/page number	Comments	Whole Person Impairment %
Group your specialty assigned allowances by body part, and/or system being evaluated. List them exactly as on pg. 1.	**Include the page number and the table or figure number for each table/figure used.**	**Provide comments that explain your table/percentage choice, such as: - DRE vs ROM rationale - Class ranking/ rationale for multi-class table/figure.**	**If there is no impairment for an allowance, indicate zero percent. WPI should always be expressed in a whole number percentage.**
	Combined Values Chart, pgs. 604 - 606	**Combined whole person impairment:**	

3. **Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Residual Function Assessement.**

   - **Summarize <u>objective</u> findings from examination and record review that relate to the allowed condition(s) in the claim. Compare/contrast to Impact of Activities section.**
   - **Relate these findings to functional deficits or capabilities.**
   - **Cite the corresponding work capacity level as listed on the Residual Function Assessment form.**
   - **If applicable, provide any further work place limitations additional to the established Department of Labor categories.**
   - **Complete Residual Function Assessment form.**

_____ _____

(Signature) (Date)