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 #:
IW 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 Physical Strength Rating.**

   - **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 Physical Strength Rating form.**
   - **If applicable, provide any further work place limitations additional to the established Department of Labor categories.**
   - **Complete Physical Strength Rating form.**

_____ _____

(Signature) (Date)

PHYSICAL STRENGTH RATING

INJURED WORKER: **CLAIM NUMBER(S):**

Based solely on impairment due to the allowed conditions in the claim within my specialty and with no consideration of the injured worker's age, education, or work training:

( ) This injured worker has no work limitations.

( ) This injured worker is incapable of work.

( ) This injured worker is capable of work as indicated below.

This box must be checked if indicating a work level listed below.

( ) "SEDENTARY WORK"
Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated:
_____
_____

The work place limitations on this form must match what was stated in your report. If further limitations are indicated, you may write "see report" to ensure they are identical.

( ) "LIGHT WORK"
Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling, or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated:
_____
_____

( ) "MEDIUM WORK"
Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

( ) "HEAVY WORK"
Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

( ) "VERY HEAVY WORK"
Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

PHYSICIAN'S SIGNATURE _____

PHYSICIAN'S NAME (PRINT)_____

DATE_____