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)*

IMPACT ON ACTIVITIES: *In this area include: visual impact on mobility, reading ability, driving ability, hobbies, 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, compare/contrast the pre-injury and the post-injury activities and abilities to fully convey the injury's effect on the functional capabilities.

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 Ohio Industrial Commission.

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

PHYSICAL EXAMINATION:

This is <u>your</u> examination, report all pertinent positive and negative findings

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 your answer regarding MMI status with supporting rationale.**
   - **Note: If you opine <u>NOT</u> at MMI, please provide proper rationale according to State of Ohio definitions.**

2. **Based on the AMA Guides, Fourth 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 conditions	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: 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 322-324	Combined whole person impairment:	

Claim #:
IW Name:

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 Assessment.**

   - **Summarize <u>objective</u> findings from your examination and record review that are related to the allowed conditions in the claim.**
   - **Relate these findings to functional deficits or capabilities.**
   - **Cite the corresponding work capacity level.**
   - **If applicable, provide any further work place limitations.**
   - **Complete Residual Function Assessment form.**

_____ _____

(Signature) (Date)