**OHIO INDUSTRIAL COMMISSION**

**SPECIALIST REPORT**

**INJURED WORKER NAME:**

**DATE OF BIRTH:**

**CLAIM NUMBER(S):**

**DATE(S) OF INJURY:**

**CLAIM ALLOWANCE(S):**

**DISALLOWED CONDITION(S):**

**PLACE OF EXAMINATION:**

**DATE OF EXAMINATION:**

**DATE OF REPORT:**

**EXAMINER NAME:**

Prior to the examination, the following was discussed with the injured worker, to explain the purpose and nature of the examination:

* This examination is at the request of the Ohio Industrial Commission, in response the Injured Worker’s application for permanent total disability.
* The specialist examiner will be submitting a report to the Ohio Industrial Commission.
* This is not a comprehensive examination. It is focused toward the questions asked by the Ohio Industrial Commission.
* The results of this examination are not confidential. It will be sent to the Ohio Industrial Commission, where the parties to the claim(s) will receive a copy.
* The examining specialist will not be providing the injured worker with any type of treatment or medical advice. There will be no established doctor-patient relationship as a result of this examination.

The injured worker verbalized understanding and agreed to proceed.

**HISTORIAN:**

**ALSO PRESENT DURING EXAMINATION:**

**RECORD REVIEW:** I have reviewed all of the medical records provided to me by the Ohio Industrial Commission, including but not limited to those referenced in this report. I accept the findings of the examining physicians represented in the medical records provided, however do not necessarily agree with their opinions. I accept all of the allowed conditions in the claim(s).

**HISTORY OF THE PRESENT CONDITION:**

* **JOB DUTIES AT THE TIME OF THE INJURY OR INJURIES:**
* **DESCRIPTION OF INJURY OR INJURIES:**
* **TREATMENT(S) OF INJURY OR INJURIES AND REPORTED RESPONSE TO TREATMENT:**
* **CURRENT TREATMENT FOR ALLOWED CONDITION(S):**
* **TREATMENT PLAN FOR EACH ALLOWED CONDITION:**

**CURRENT REPORTED SYMPTOMS ARISING FROM ALLOWED CONDITION(S):**

* **LOCATION:**
* **CHARACTER:**
* **INTENSITY:**
* **AGGRAVATING FACTORS:**
* **ALLEVIATING FACTORS:**
* **ASSOCIATED SYMPTOMS:**

**INJURED WORKER’S SUBJECTIVE REPORT OF THE IMPACT OF THE ALLOWED CONDITION(S) ON ACTIVITIES:**

* **LEVEL OF ASSISTANCE NEEDED AND TEMPO FOR BASIC ACTIVITIES OF DAILY LIVING:**
* **MEAL PREPARATION:**
* **BATHING:**
* **GROOMING:**
* **DRESSING:**
* **TOILETING:**
* **TRANSFERING FROM SITTING TO STANDING:**
* **EATING:**
* **MOBILITY:**
* **SITTING TOLERANCE:**
* **STANDING TOLERANCE:**
* **WALKING** **TOLERANCE:**
* **BENDING TOLERANCE:**
* **TWISTING TOLERANCE:**
* **CLIMBING STAIRS TOLERANCE:**
* **CRAWLING TOLERANCE:**
* **REACHING TOLERANCE:**
* **EXERTION OF FORCE:**
* **LIFTING:**
* **CARRYING:**
* **PUSHING**
* **PULLING**
* **COMMUNICATION:**
* **WRITING:**
* **TYPING:**
* **SEEING:**
* **HEARING:**
* **SPEAKING:**

* **HOBBIES:**
* **HOUSEWORK:**
* **VACUUM:**
* **DUST:**
* **TAKE OUT TRASH:**
* **YARDWORK:**
* **RAKE LEAVES:**
* **MOW GRASS:**
* **USE HOSE OR LEAF BLOWER:**

* **DRIVING:**
* **SLEEPING:**
* **DESCRIPTION OF A TYPICAL DAY:**

**HISTORY OF NON-ALLOWED MEDICAL CONDITIONS:**

**HISTORY OF SURGERIES UNRELATED TO ALLOWED CONDITIONS:**

**MEDICATIONS:**

**HEALTH HABITS:**

* **EXERCISE:**
* **DIET:**
* **SUBSTANCE USE:**

**HOME LIFE, SOCIAL AND RELATIONAL SUPPORT:**

**PHYSICAL EXAMINATION:**

**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.**

*Maximum medical improvement, according to Ohio Administrative Code 3121-3-32, is a treatment plateau (static or well stabilized) where no fundamental functional or physiologic change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. An injured worker may require supportive treatment to maintain this level of function.*

**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 %** |
| --- | --- | --- | --- |
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|  |  |  |  |
|  | **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.**