Associates In Neurosurgery

Workers' Comp Patient Information

Name: *Last* ______ *First* ______ *MI* ______

Address: ______ City: ______ ST: ____ Zip: ______

Home Phone: ______ Work Phone: ______ Fax Number: ______

Cell Phone: ______ E-mail Address: ______

SS#: ____ - ____ - ____ Date of Birth ______ Age ______ ☐ Male ☐ Female

Employer: ______ Occupation: ______

Address: ______

Employee Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired *or* Student Status: ☐ Full-time ☐ Part-Time

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse Name: ______

Do you have a Living Will? ______

Do you have a Power Of Attorney? ____ If yes, list their name and Number: ______

Workers Comp Case Manager

Name: ______

City: ______ State: ____ Zip Code: ______

Telephone Number: ( ) ______

Fax Number: ( ) ______

Emergency Contact:

Name: ______

Address: ______ City: ______ ST: ____ Zip: ______

Phone #: ______ Cell Phone: ______ Relationship to Patient ______

Workers' Comp Insurance: ______

Address: ______

Phone Number: ______ Fax Number: ______

Claim #: ______ Date of accident: ______

Adjuster Name: ______ Phone: ______ Fax: ______

I authorize the release of any medical information necessary to process an insurance claim for services rendered to me. I also authorize payment of medical benefits directly to Associates in Neurosurgery for services rendered to me. I accept full responsibility for my bill if my insurance carrier does not pay.

Date: ______ **Patient Signature:** ______

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/Review Date:	FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth:	5. Social Security #:
6. Date of Accident:	7. Employer Name	8. Initial visit with this physician? ☐ a) NO ☐ b) YES

SECTION I — CLINICAL ASSESSMENT / DETERMINATIONS

9. ☐ No change in items 9 - 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ Illness for which treatment is sought is:
☐ a) NOT WORK RELATED ☐ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ☐ b) YES ☐ c) UNDETERMINED as of this date
If YES or UNDETERMINED, explain: __________

12. Diagnosis(es): __________

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.

a) Is there a pre-existing condition contributing to the current medical disorder?
☐ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date

b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date

c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES

d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES the reported medical condition?
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) YES the functional limitations and restrictions determined?

SECTION II — PATIENT CLASSIFICATION LEVEL

☐ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III -Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III — MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in items 20a - 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.

[illegible]

☐ a) Consultation with or referral to a specialist. Identify principal physician: __________
Identify specialty & provide rationale: __________
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify) __________

☐ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): __________

☐ d) Pharmaceutical(s) (specify): __________

☐ e) DME or Medical Supplies: __________

☐ f) Surgical Intervention - specify procedure(s): __________
☐ f_1) In-Office: __________
☐ f_2) Surgical Facility: __________
☐ f_3) Injectable(s) (e.g. pain management): __________

☐ g) Attendant Care: __________

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: Soc.Sec.#: D/A: Visit/Review Date:

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☐ 21 No functional limitations identified or restrictions prescribed as of the following date: ________________.

☐ 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: ________________. *Use additional sheet if needed.*

☐ 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part ________________________. Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist>overhead			
☐ Pull			
☐ Push			
☐ Reach-overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐ _			
☐ Other			

COMMENTS:

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date. Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?
☐ a) YES, Date: ________________ ☐ b) NO ☐ c) Anticipated MMI date: ________________
☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: e) ☐ Yes f) ☐ No
Comments: ________________

25. _____% Permanent Impairment Rating (body as a whole) Body part/system: ________________

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):
☐ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify ________________

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?
☐ a) YES ☐ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: ________________

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient." *"I certify to any MMI / PIR information provided in this form."*

Physician Group: ________________ Date: ________________
Physician Signature: ________________ Physician DOH License #: ________________
Physician Name: ________________ (print name) Physician Specialty: ________________

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: ________________ Provider DOH License #: ________________
Provider Name: ________________ (print name) Date: ________________

Associates In Neurosurgery

532 Virginia Drive Orlando, Florida 32803· Phone: 407-898-8644· Fax: 407-898-8646 · Web: www.ain.md · E-mail: info@ai-neurosurgery.com

Phillip G. St. Louis, M.D.
Tara L. Batz, PA-C

Health History General/ Brain Packet

Date: ____________________

Name: *Last* ______________________ *First* ______________________ *MI* ______

SS#: ______ - ______ - ______ DOB: ______________ Age ________ Gender: Male ☐ Female ☐

Height: ____________ Weight: ____________ Left Handed ☐ Right Handed ☐

Occupation: ______________________________ Occupational Exposure? ______________

Employee Status: ☐ Full-Time ☐ Part-Time (☐ Light Duty or ☐ Full Duty) ☐ Not Employed ☐ Retired

Restrictions: ____

Case Manager

Name: ______________________________
Address: ______________________________
City: ______________ State: ________ Zip Code: ____________
Telephone Number: ( ) ______________________
Fax Number: ( ) ______________________

Chief Complaint - (The main reason for your visit)

Primary reason for your visit: ____

____

Symptoms: ____

____

____

What makes your problem worse? ____

____

What makes your problem feel better? ____

____

How long have you had this problem? ____

Your problem is the result of a: ☐ Work Accident ☐ Don't Know
☐ Other: ____

Since the start of your problem, has it gotten worse since it started: ______________ If yes, please explain:

____

____

What have you had done for your problem: ☐ MRI ☐ CT ☐ Myelogram ☐ EMG/NCT
☐ Nerve Blocks ☐ Angiogram ☐ Physical Therapy ☐ Other ______________

Have you had similar problems before: ______________ If yes, please explain: ______________

____

____

Patient Name: *Last* ______________ *First* ______________ *MI* ______ *DOB:* ______

Medical Problems: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Heart Attack

☐ Cancer ______________ ☐ Other ______________

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? ☐ Yes ☐ No

Current Medication(s)	Dose	Frequency

Do you take aspirin or any aspirin products? _______ If yes, How much and how often?______________

ALLERGIES TO MEDICATIONS AND THE REACTION:

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (Mom's)	A	D		
Grandfather (Mom's)	A	D		
Grandmother (Dad's)	A	D		
Grandfather (Dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Are you pregnant? _______ Breastfeeding ______ Do you have children? __________ How many? ________

Do you live alone?_____Who lives with you? _________

Do you travel? ______________________ How often in a year? ______________

Do you smoke? ☐ Yes, I've smoked ______ packs of cigarettes per day for _______ years.
☐ Yes, I've smoked cigars or a pipe for_______ years.
☐ No, I have never smoked
☐ No, I quit ___ years ago. At that time I was smoking _______packs per day for _____years.

Do you drink alcohol? ☐ No, never ☐ No, but I used to ☐ Rarely ☐ Daily
☐ 1 or more times a week ☐ 1 or more times a month

How often do you have caffeine? ______________ Exercise routine? ______________

Are you at risk for Immune Deficiency (e.g. HIV/AIDS sexual orientation/behavior, drug abuse, previous blood transfusion?) ☐ No ☐ Yes, Please Explain: ______________________

REVIEW OF SYSTEMS

Name: Last:____________________ First:____________________ DOB:_________

Are you currently, or have had problems with the following:

Constitutional		
Fever	Yes	No
Weight Loss	Yes	No
Excessive fatigue	Yes	No
Chills/Night Sweats	Yes	No
Eyes		
Wear Glasses	Yes	No
-Date of Last Exam_________		
Glaucoma/Partial Vision Loss	Yes	No
Cataracts	Yes	No
Painful Vision	Yes	No
Ear, Nose, Throat, and Mouth		
Hearing Loss	Yes	No
Ear Infections	Yes	No
Ringing in Ears	Yes	No
-Circle: Left Right Both	Yes	No
Balance Disturbance (e.g. Vertigo or Spinning)	Yes	No
Nosebleeds	Yes	No
Nasal Congestion	Yes	No
Nasal Drainage	Yes	No
-Amount_____ Color______		
Inability to Smell	Yes	No
Sinus Problems	Yes	No
Sinus headaches	Yes	No
Sore Throats	Yes	No
Mouth Sores	Yes	No
Cardiovascular		
Chest Pain or Angina	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
High Cholesterol	Yes	No
Swelling in Feet or Hands	Yes	No
Leg Pain While Walking	Yes	No
Respiratory		
Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung cancer	Yes	No
Bloody Sputum	Yes	No
Gastrointestinal		
Indigestion or Pain with Eating	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Blood in Your Vomit	Yes	No
Liver Disease	Yes	No
Jaundice	Yes	No
Abdominal Pain	Yes	No
Change in Your Bowel Habits	Yes	No
Ulcers or Gastritis	Yes	No
Colon Cancer	Yes	No

Genitourinary		
Urinary Tract Infections	Yes	No
Painful Urination	Yes	No
Blood in Your Urine	Yes	No
Difficulty Starting and Stopping	Yes	No
Stream	Yes	No
Incontinence	Yes	No
Kidney Stones	Yes	No
Prostate Cancer (males)	Yes	No
Endometriosis (females)	Yes	No
Uterine or Cervical Cancer (females)	Yes	No
Musculoskeletal		
Neck Pain	Yes	No
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling	Yes	No
Arthritis	Yes	No
Muscle/Pain or Tenderness in Joints	Yes	No
Integumentary		
Skin Disease	Yes	No
Skin Cancer	Yes	No
Breast Pain, Tenderness, or Swelling	Yes	No
Nipple Discharge (females)	Yes	No
Neurological		
Fainting Spells or Blacking Out	Yes	No
Seizures---Last One________	Yes	No
Problems with Memory	Yes	No
Disorientation	Yes	No
Difficulty with Speech	Yes	No
Inability to Concentrate	Yes	No
Double or Blurred Vision	Yes	No
Face Weakness	Yes	No
Coordination in Arms/or Legs	Yes	No
Headaches	Yes	No
Stroke	Yes	No
Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder	Yes	No
Endocrine		
Diabetes	Yes	No
Thyroid Disease	Yes	No
Increase Appetite	Yes	No
Excessive Thirst or Urination	Yes	No
Hormone Problems	Yes	No
Hematology/Lymphatic		
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands or Lymph	Yes	No
Nodes	Yes	No
Blood Transfusion	Yes	No
Allergic/Immunologic		
Food Allergies	Yes	No
Inhalant (nasal) Allergies	Yes	No
Immunology Disorders	Yes	No

I have reviewed this information with the patient. ____________________________________

Physician Signature *Date*

Associates In Neurosurgery

Phillip G. St. Louis, M.D., FACS

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: ______________________________

Social Security Number: ________________ Date of birth: ________________

Name of legal guardian or parent of minor: ______________________________

I do hereby request that my medical records to be released to:

Associates in Neurosurgery
532 Virginia Drive
Orlando, FL 32803
Phone: (407) 898-8644
Fax: (407) 898-8646

I hereby request that the following records be sent:

☐ Operative Reports	☐ Consultation Records	☐ Lab/Pathology Reports
☐ EMG/NCT Reports	☐ Work Release Forms	☐ Office Notes
☐ X-Ray/Test Results	☐ All medical records	☐ Other ____________

______________________________ ________________

Patient or Legal Guardian/Parent Signature Date

CONFIDENTIALITY NOTE

The information contained in this transmission is absolutely confidential and intended for the use of the addressee listed above and no one else. If you are not the intended recipient, or the employee or agent responsible to deliver this document to the intended recipient, you are hereby notified that any dissemination or copying of this facsimile is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone.

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ______________________________, hereby authorize Associates in Neurosurgery to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify to carry out my treatment, payment and health care operations I understand that while this consent is voluntary, if I refuse to sign this consent, Associates in Neurosurgery can refuse to treat me.

I have been informed that Associates in Neurosurgery has prepared a notice ("Notice"), which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Associates in Neurosurgery in writing, but if I revoke my consent; such revocation will not affect any actions that Associates in Neurosurgery took before receiving my revocation.

I understand that Associates in Neurosurgery reserves the right to change its privacy practices and that I can obtain such notice changes upon request.

I understand that I have the right to request that Associates in Neurosurgery restrict how my individual identifiable health information is used and/or disclosed to carry out treatment, payment or health operations I understand that Associates in Neurosurgery does not have to agree to such restrictions, but that once such restrictions are agreed to, Associates in Neurosurgery must adhere to such restrictions.

I authorize the names listed below to receive my medical information (e.g. Family, friends, fax, e-mail, phone number, etc...)

1.______________________________ Phone Number: ____________________

2.______________________________ Phone Number: ____________________

3.______________________________ Phone Number: ____________________

We will contact you by e-mail, fax, mail, or phone unless you otherwise notify our office in writing below.

____

____

____

____

____ ____________________

Signature of Patient or Patient's Representative **Date**

____

Print Name

____

Relationship to the patient

Associates in Neurosurgery

Acknowledgement Form

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name

Print Name:____

Signature: ____

Witness: ____

Date: __________________________