



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? <input type="checkbox"/> a) NO <input type="checkbox"/> 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?

- a₁) NO a₂) YES a₃) 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?

- b₁) NO b₂) exacerbation b₃) aggravation b₄) UNDETERMINED as of this date

c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?

- c₁) NO c₂) YES

d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:

- d₁) NO d₂) YES the reported medical condition?
 d₃) NO d₄) YES the treatment recommended (management/treatment plan)?
 d₅) NO d₆) 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.

[REDACTED]

a) Consultation with or referral to a specialist. Identify principal physician: _____

Identify specialty & provide rationale:

- a₁) CONSULT ONLY a₂) REFERRAL & CO-MANAGE a₃) TRANSFER CARE

b) Diagnostic Testing: (Specify) _____

c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:

- c₁) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
 c₂) Physical Reconditioning (Level II Patient Classification)
 c₃) 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): _____

f₁) In-Office: _____

f₂) Surgical Facility: _____

f₃) 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 |
|--|------|----------------------|----------------------------------|
| <input type="checkbox"/> Bend | | | |
| <input type="checkbox"/> Carry | | | |
| <input type="checkbox"/> Climb | | | |
| <input type="checkbox"/> Grasp | | | |
| <input type="checkbox"/> Kneel | | | |
| <input type="checkbox"/> Lift-floor > waist | | | |
| <input type="checkbox"/> Lift-waist > overhead | | | |
| <input type="checkbox"/> Pull | | | |
| <input type="checkbox"/> Push | | | |
| <input type="checkbox"/> Reach-overhead | | | |
| <input type="checkbox"/> Sit | | | |
| <input type="checkbox"/> Squat | | | |
| <input type="checkbox"/> Stand | | | |
| <input type="checkbox"/> Twist | | | |
| <input type="checkbox"/> Walk | | | |
| <input type="checkbox"/> _____ | | | |
| <input type="checkbox"/> 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: _____ Physician Specialty: _____

(print name)

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: _____ Date: _____

(print name)



Associates In
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Phillip G. St. Louis, M.D.

Tara L. Batz, PA-C

Health History Spinal Packet

Account # _____

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)

Pain--Side: _____ Location: _____

Numbness --Side: _____ Location: _____

Weakness --Side: _____ Location: _____

Other: _____

Describe the quality of the symptom: Sharp Dull Burning Aching

Other: _____

Describe the intensity of the symptom: Mild Moderate Severe

Other: _____

Describe the frequency of your symptom: Constant Intermittent Daily

Other: _____

What makes it better? _____

What makes it worse? _____

How long have you had this problem? _____

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

Since the start of your problem, it has gotten: Worse Better Stayed the Same

Have you ever had similar symptoms prior to above: No Yes

If yes, explain: _____

Have you had prior spine surgery: No Yes If yes, explain: _____

Were you able to work since the symptoms started: No Yes Some On and Off

Have you tried physical therapy: No Yes If yes, did it work: No Yes Temporarily

Have you had epidural blocks: No Yes If yes, did it work: No Yes Temporarily

Have you had any other methods of treatment: _____

Have you had other tests: MRI CT Myelogram EMG/NCT

Nerve Blocks Angiogram Physical Therapy Other _____

Litigation pending (optional): Yes No

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:

| | | | | | | | |
|--|-----|----|--|--|-----|----|--|
| <u>Constitutional</u> | | | | <u>Genitourinary</u> | | | |
| Fever | Yes | No | | Urinary Tract Infections | Yes | No | |
| Weight Loss | Yes | No | | Painful Urination | Yes | No | |
| Excessive fatigue | Yes | No | | Blood in Your Urine | Yes | No | |
| Chills/Night Sweats | Yes | No | | Difficulty Starting and Stopping Stream | Yes | No | |
| <u>Eyes</u> | | | | Incontinence | Yes | No | |
| Wear Glasses | Yes | No | | Kidney Stones | Yes | No | |
| -Date of Last Exam | | | | Prostate Cancer (males) | Yes | No | |
| Glaucoma/Partial Vision Loss | Yes | No | | Endometriosis (females) | Yes | No | |
| Cataracts | Yes | No | | Uterine or Cervical Cancer (females) | Yes | No | |
| Painful Vision | Yes | No | | <u>Musculoskeletal</u> | | | |
| <u>Ear, Nose, Throat, and Mouth</u> | | | | Neck Pain | Yes | No | |
| Hearing Loss | Yes | No | | Arm or Leg Weakness | Yes | No | |
| Ear Infections | Yes | No | | Back Pain | Yes | No | |
| Ringing in Ears | Yes | No | | Arm or Leg Pain | Yes | No | |
| -Circle: Left Right Both | Yes | No | | Joint Pain or Swelling | Yes | No | |
| Balance Disturbance (e.g. Vertigo or Spinning) | Yes | No | | Arthritis | Yes | No | |
| Nosebleeds | Yes | No | | Muscle/Pain or Tenderness in Joints | Yes | No | |
| Nasal Congestion | Yes | No | | <u>Integumentary</u> | | | |
| Nasal Drainage | Yes | No | | Skin Disease | Yes | No | |
| -Amount _____ Color _____ | | | | Skin Cancer | Yes | No | |
| Inability to Smell | Yes | No | | Breast Pain, Tenderness, or Swelling | Yes | No | |
| Sinus Problems | Yes | No | | Nipple Discharge (females) | Yes | No | |
| Sinus headaches | Yes | No | | <u>Neurological</u> | | | |
| Sore Throats | Yes | No | | Fainting Spells or Blacking Out | Yes | No | |
| Mouth Sores | Yes | No | | Seizures---Last One _____ | Yes | No | |
| <u>Cardiovascular</u> | | | | Problems with Memory | Yes | No | |
| Chest Pain or Angina | Yes | No | | Disorientation | Yes | No | |
| High Blood Pressure | Yes | No | | Difficulty with Speech | Yes | No | |
| Irregular Pulse | Yes | No | | Inability to Concentrate | Yes | No | |
| Heart Murmur | Yes | No | | Double or Blurred Vision | Yes | No | |
| High Cholesterol | Yes | No | | Face Weakness | Yes | No | |
| Swelling in Feet or Hands | Yes | No | | Coordination in Arms/or Legs | Yes | No | |
| Leg Pain While Walking | Yes | No | | Headaches | Yes | No | |
| <u>Respiratory</u> | | | | Stroke | Yes | No | |
| Asthma | Yes | No | | <u>Psychiatric</u> | | | |
| Chronic Cough | Yes | No | | Anxiety | Yes | No | |
| Emphysema | Yes | No | | Depression | Yes | No | |
| Shortness of Breath | Yes | No | | Other Psychiatric Disorder | Yes | No | |
| Bronchitis | Yes | No | | <u>Endocrine</u> | | | |
| Pneumonia | Yes | No | | Diabetes | Yes | No | |
| Lung cancer | Yes | No | | Thyroid Disease | Yes | No | |
| Bloody Sputum | Yes | No | | Increase Appetite | Yes | No | |
| <u>Gastrointestinal</u> | | | | Excessive Thirst or Urination | Yes | No | |
| Indigestion or Pain with Eating | Yes | No | | Hormone Problems | Yes | No | |
| Nausea | Yes | No | | <u>Hematology/Lymphatic</u> | | | |
| Vomiting | Yes | No | | Anemia | Yes | No | |
| Blood in Your Vomit | Yes | No | | Hemophilia | Yes | No | |
| Liver Disease | Yes | No | | Bleeding Tendencies | Yes | No | |
| Jaundice | Yes | No | | Persistent Swollen Glands or Lymph Nodes | Yes | No | |
| Abdominal Pain | Yes | No | | Blood Transfusion | Yes | No | |
| Change in Your Bowel Habits | Yes | No | | <u>Allergic/Immunologic</u> | | | |
| Ulcers or Gastritis | Yes | No | | Food Allergies | Yes | No | |
| Colon Cancer | 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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Consultation Records | <input type="checkbox"/> Lab/Pathology Reports |
| <input type="checkbox"/> EMG/NCT Reports | <input type="checkbox"/> Work Release Forms | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> X-Ray/Test Results | <input type="checkbox"/> All medical records | <input type="checkbox"/> 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.



**Associates In
Neurosurgery**

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: _____