State of California
Division of Workers' Compensation

Additional pages attached ☒

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC 81556.

☒ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Other:

Patient:

Last EGER First ALAN M.I. Sex Male
Address 1423 W. Holgate Dr. City Anaheim State CA Zip 92802
Date of Injury 03/25/2015 Date of Birth 01/27/1956
Occupation Research/development director SS # 463-53-3987 Phone (714) 343-0003

Claims Administrator:

Name The Hartford Claim Number YMQ43423C
Address P.O. Box 14475 City Lexington State KY Zip 40512
Phone (866) 401-9222 Ext. 2305384 FAX (877) 536-1529
Employer name: Triace Bicycle/Bridgeway International Employer Phone:

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective Complaints:

Patient's treatment has finished. He continues with low back pain along with bilateral knee pain.

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Unchanged.

Diagnosis:

1. Strain, lumbar spine — ICD-9 S39.012A
2. Sprain, bilateral knees — ICD-9 S83.90
3. Lumbar spine spondylolisthesis L5-S1 — ICD-9 M43.16
4. — ICD-9

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture. Use CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Patient was scheduled today under his future medical. He was given a prescription for Tramadol 50mg #60 and Motrin 800mg #60. He will need pain management for continued medication.

Work Status: This patient has been instructed to:

☒ Remain off-work until _____. (TTD from __/__/__ thru __/__/__)
☐ Return to *modified* work on _____ with following limitations or restrictions
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

☐ Return to full duty on _____ with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp) Date exam: 01/17/2017

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature: [signature] Cal. Lic. # C30241

Executed at: First Hope Medical Clinic Inc. Date: 01/17/2017

Name: Brent Pratley, M.D. Specialty: Orthopedic

Address: 999 N. Tustin Ave. Suite 101, Santa Ana, CA 92705 Phone: (714) 543-5005

Next report due no later than _____

DWC Form PR-2 (Rev. 5/03) **(Use additional pages, if necessary)**