RiversEdge Orthopedics
3318 N. Grand Mill Lane
Coeur d'Alene, ID 83814
208-277-1060/ 277-1065 (fax)

INDEPENDENT MEDICAL EVALUATION
DEMOGRAPHICS and CONSENT

PATIENT INFORMATION:

Full Name: _____ DOB:_____ Sex: _____

Address_____ City_____ State_____ Zip:_____

Phone#: _____ Alt. Phone#: _____ SS#: _____

Race:_____ Ethnicity:_____ Email: _____

Name and address of Employer_____
(AT TIME OF INJURY)

_____Emergency Contact_____

Occupation: _____ Employment Status: FT PT Not Emp Retired

Workman's Comp Carrier: _____ Claim #_____

Name of Adjuster:_____ Date of Injury: _____

SIGNED:_____**DATE:**_____

IME Informed Consent

Please read and **initial** each yellow box. Thank you!

OFFICE POLICY FOR THIS OFFICE IS AS FOLLOWS: CLAIMANT WILL BE THE ONLY PERSON ALLOWED IN EXAM ROOM DURING EXAMINATION WITH THE DOCTOR & HIS MEDICAL ASSISTANT. SPOUSES, FRIENDS, RELATIVES, THERAPISTS, OR ANY OTHER PERSONNEL WILL NOT BE PERMITTED. AUDIO/VIDEO RECORDING IS NOT ALLOWED. THIS EXAMINATION DOES NOT CONSIST OF PATIENT TREATMENT OR MEDICAL ADVICE RENDERED. THE IME REPORT WILL BE SENT TO THE ORDERING PARTY ONLY.

I understand that I am being seen for an Independent Medical Examination for an impartial assessment of my orthopedic condition.

I understand that during the course of this exam, I will not do anything that I feel will cause me any injury or discomfort, and I will advise the physician immediately if I experience any difficulties.

I understand no Physician – Patient relationship is established. Nor will I be able to call Dr. Greendyke to discuss his findings after this examination.

This Examination has been requested by _____, and a report will be sent to this client. I will not contact RiversEdge for a copy of the report, but will contact who requested this exam to discuss any finding or to get a copy of the report.

I consent to this report being sent to this client, and to those participating in the assessment.

_____ Date:_____
Signature of Examinee

_____

IME Intake Form

Date:_____

Name: _____ DOB: _____ Age:_____

REVIEW OF SYSTEMS

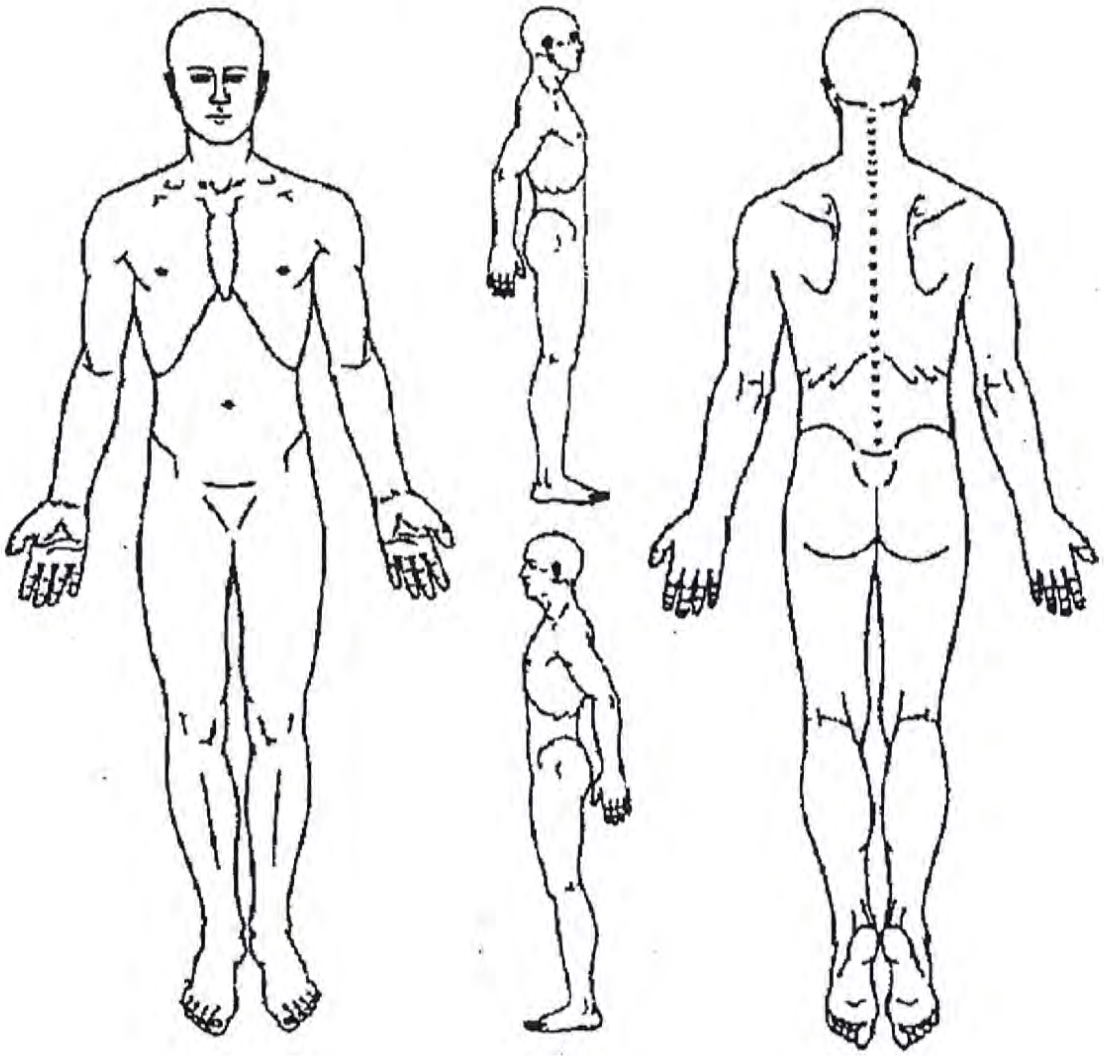
• Please place a check mark next to any of the problems you have experienced in the past 6 months.

- ☐ Fevers
- ☐ Weight gain
- ☐ Weight loss (unexplained)
- ☐ Weight loss (planned)
- ☐ Vision changes
- ☐ Trouble swallowing
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Other joint pain
- ☐ Other muscle pain
- ☐ Rashes
- ☐ Loss of coordination
- ☐ Fainting
- ☐ Headaches/Migraines
- ☐ Anxiety
- ☐ Incontinence
- ☐ Burning urination
- ☐ Difficulty urinating
- ☐ Sweats
- ☐ Fatigue
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Wheezing
- ☐ Leg cramps
- ☐ Palpitations
- ☐ Chest pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Fracture
- ☐ Bone pain
- ☐ Muscle spasm
- ☐ Skin ulcers
- ☐ Hives
- ☐ Weakness
- ☐ Numbness
- ☐ Depression
- ☐ Disoriented
- ☐ Discharge
- ☐ Frequent urination
- ☐ Bleeding

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



NAME _____ DATE _____

No Pain |—————————————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature

Name:_____ Date:_____

QuickDASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

QuickDASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A QuickDASH score may <u>not</u> be calculated if there is greater than 1 missing item.