

**Fill in this information to identify the case:**

Debtor 1 Belvidere Associates LLC

Debtor 2  
(Spouse, if filing) \_\_\_\_\_

United States Bankruptcy Court for the: Northern District of Illinois

Case number 18-30043

**Official Form 410****Proof of Claim** AMENDED

04/16

**Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.**

**Filers must leave out or redact** information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

**Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.**

**Part 1: Identify the Claim**

1. <b>Who is the current creditor?</b>	<u>Cynthia Levandoski</u> Name of the current creditor (the person or entity to be paid for this claim)	
	Other names the creditor used with the debtor _____	
2. <b>Has this claim been acquired from someone else?</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. <b>Where should notices and payments to the creditor be sent?</b>  Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	<b>Where should notices to the creditor be sent?</b>  <u>Cynthia Levandoski c/o Fonfrias Law</u> Name <u>125 S Wacker Dr. #300</u> Number Street <u>Chicago</u> <u>IL</u> <u>60606</u> City State ZIP Code Contact phone <u>312-969-0730</u> Contact email <u>rfonfrias2025@gmail.com</u>  Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____	<b>Where should payments to the creditor be sent? (if different)</b>  Name _____ Number Street _____ City State ZIP Code Contact phone _____ Contact email _____
4. <b>Does this claim amend one already filed?</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY	
5. <b>Do you know if anyone else has filed a proof of claim for this claim?</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

**Part 2: Give Information About the Claim as of the Date the Case Was Filed**

6. Do you have any number you use to identify the debtor?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ____ ____ ____ ____
7. How much is the claim?	\$ <u>75,000.00</u> . Does this amount include interest or other charges? <input type="checkbox"/> No <input type="checkbox"/> Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).
8. What is the basis of the claim?	Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card. Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as health care information.  <u>Work Injury as employee of Debtor</u>
9. Is all or part of the claim secured?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property.  <b>Nature of property:</b> <input type="checkbox"/> Real estate. If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i> . <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Other. Describe: _____  <b>Basis for perfection:</b> _____ Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)  <b>Value of property:</b> \$ _____ <b>Amount of the claim that is secured:</b> \$ _____ <b>Amount of the claim that is unsecured:</b> \$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)  <b>Amount necessary to cure any default as of the date of the petition:</b> \$ _____  <b>Annual Interest Rate</b> (when case was filed) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable
10. Is this claim based on a lease?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition. \$ _____
11. Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check one:

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).

Amount entitled to priority

\$ \_\_\_\_\_

☐ Up to \$2,850\* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).

\$ \_\_\_\_\_

☐ Wages, salaries, or commissions (up to \$12,850\*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).

\$ \_\_\_\_\_

☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).

\$ \_\_\_\_\_

☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).

\$ \_\_\_\_\_

☐ Other. Specify subsection of 11 U.S.C. § 507(a)( ) that applies.

\$ \_\_\_\_\_

\* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.

**Part 3: Sign Below**

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☐ I am the creditor.

☒ I am the creditor's attorney or authorized agent.

☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 01/24/2019  
MM / DD / YYYY

  
Signature

Print the name of the person who is completing and signing this claim:

Name	Heath S. Isaacs		
	First name	Middle name	Last name
Title	Paralegal		
Company	Fonfrias Law Group		
	Identify the corporate servicer as the company if the authorized agent is a servicer.		
Address	125 S Wacker Dr., #300		
	Number	Street	
	Chicago	IL	60606
	City	State	ZIP Code
Contact phone	801-726-7704		Email heath@casedriver.com

# ILLINOIS WORKERS' COMPENSATION COMMISSION

## APPLICATION FOR ADJUSTMENT OF CLAIM (APPLICATION FOR BENEFITS)

ATTENTION. Please type or print. Answer all questions. File three copies of this form.

Workers' Compensation Act ☒ Occupational Diseases Act ☐ Fatal case? No ☒ Yes ☐ Date of death \_\_\_\_\_

OCT 19 2017

Cynthia Levandoski  
Employee/Petitioner

Case #  
(Office use only)

17WC030779

Home Owners Bargain Outlet  
Belvidere Associates, LLC  
Employer/Respondent

Location of accident Waukegan IL  
or last exposure City, State

Cynthia Levandoski	2206 Waverly Place	Waukegan	IL	60084
Injured employee's name <sup>1</sup>	Street address	City, State, Zip code		
Home Owners Bargain Outlet	2650 Belvidere Road	Waukegan	IL	60085
Belvidere Associates, LLC	2650 Belvidere Road	Waukegan	IL	60085
Employer's name	Street address	City, State, Zip code		

Employee information: State Employee? Yes ☐ No ☒ Male ☐ Female ☒ Married ☐ Single ☒

# Dependents under age 18 0 Birthdate 05/03/1963 Average weekly wage \$ 630.00

Date of accident <sup>2</sup> 05/22/2017 The employer was notified of the accident orally ☒ in writing ☐  
How did the accident occur? Pulling out a bedding set.

What part of the body was affected? Left hand/wrist.

What is the nature of the injury? To be determined. Return-to-work date <sup>3</sup> \_\_\_\_\_

Is a *Petition for an Immediate Hearing* attached? Yes ☐ No ☒

Is the injured employee currently receiving temporary total disability benefits? Yes ☐ No ☒

If a prior application was ever filed for this employee, list the case number and its status \_\_\_\_\_

ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before you sign this. Refer to the Commission's *Handbook on Workers' Compensation and Occupational Diseases* <sup>4</sup> for more information.

Cynthia Levandoski  
Signature of petitioner

8/28/17  
Date

### APPEARANCE OF PETITIONER'S ATTORNEY

Please attach a copy of the *Attorney Representation Agreement*.

[Signature]  
Signature of attorney

Mark J. Vogt 1919  
Attorney's name and IC code #<sup>5</sup> (please print)

3416 W. Elm Street  
Street address

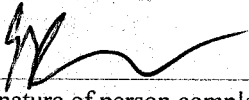
McHenry IL 60050  
City, State, Zip code

Law Offices of Thomas J. Popovich  
Firm name

815-344-3797  
Telephone number E-mail address

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.  
If you prefer, you may submit the front of this application form with the *Proof of Service* on a separate page.

I, Mark J. Vogg, affirm that I delivered \_\_\_\_\_ mailed with proper postage X  
in the city of McHenry, IL a copy of this form  
at 5:00 AM/PM on 10-10-17 to the respondent listed on this application and to each  
additional party, if any, at the address listed below.

  
\_\_\_\_\_  
Signature of person completing *Proof of Service*

Signed and sworn to before me on \_\_\_\_\_

\_\_\_\_\_  
Notary Public

<sup>1</sup> In most cases, the injured employee files this application and is referred to as the petitioner. If the injury was fatal, or if the worker is a minor or incapacitated, another person (as allowed by law) may file. In those cases, the person filing the application is the petitioner, and the worker is referred to as the injured employee. Please complete information related to age, etc., for the injured employee.

<sup>2</sup> This may be the date of the accident, last exposure, disability, or death.

<sup>3</sup> If the employee has not returned to work, leave this space blank.

<sup>4</sup> The Commission publishes a handbook that explains the workers' compensation system. If you would like a copy, please call any of the Commission offices listed on the other side of this form.

<sup>5</sup> The Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

IC1 page 2



Corporate Health Services  
**WORK STATUS REPORT**

EMPLOYEE NAME: Cynthia Levanowski

EMPLOYER: Waukegan

Date: 5/17/19

Admit Time: 11:30

**WORK STATUS**

- ☐ Regular Work as of: \_\_\_\_\_  
☐ Off Work Rest of Today Only  
☐ Off Work Until: \_\_\_\_\_  
☒ Work Status to be determined by Specialist  
☒ Can Work with the Restrictions Specified Below:

LIFTING/BENDING	ARMS/SHOULDERS	WALK/SIT/STAND
<input type="checkbox"/> No lifting, pushing or pulling over _____ lbs <input type="checkbox"/> No repetitive lifting <input type="checkbox"/> No lifting above the shoulder level <input type="checkbox"/> Gradually increase lifting to _____ lbs over the next _____ days <input type="checkbox"/> Limit bending, stooping and twisting	<input type="checkbox"/> No work using RIGHT/LEFT arm <input type="checkbox"/> Limited use of RIGHT/LEFT arm <input type="checkbox"/> No reaching while lifting <input type="checkbox"/> No working with RIGHT/LEFT arm above chest level <input type="checkbox"/> Wear sling for _____ days	<input type="checkbox"/> Sitting job, minimum of walking <input type="checkbox"/> Uses crutches <input type="checkbox"/> Get up from sitting position every half hour <input type="checkbox"/> Alternate standing/sitting positions every _____ <input type="checkbox"/> half hour <input type="checkbox"/> as needed
HANDS/WRISTS	SQUAT/CLIMB	SKIN
<input checked="" type="checkbox"/> No use of RIGHT/LEFT hand <input type="checkbox"/> Limit use of RIGHT/LEFT hand <input type="checkbox"/> No tight gripping with RIGHT/LEFT hand <input type="checkbox"/> No repeat twisting/bending of RIGHT/LEFT wrist <input checked="" type="checkbox"/> Wear splint on RIGHT/LEFT WRIST/FINGER	<input type="checkbox"/> No squatting or kneeling <input type="checkbox"/> No climbing <input type="checkbox"/> Ground level work only	<input type="checkbox"/> Keep wound clean and dry <input type="checkbox"/> Keep covered at work <input type="checkbox"/> Avoid exposure to:
	NECK	MACHINE/VEHICLE
	<input type="checkbox"/> Avoid repeated neck motions	<input type="checkbox"/> No hazardous or fast moving machinery <input type="checkbox"/> No driving

**PATIENT INSTRUCTIONS**

- ☐ Start PT/OT ☐ Exercises/stretching as instructed  
☒ Ibuprofen: 600 mg; every 6 hrs; take with food ☐ Bacitracin to wound twice daily  
☐ Cyclobenzaprine: \_\_\_\_\_ mg; every \_\_\_\_\_ hrs; take at bedtime ONLY; DO NOT drive within 8 hrs of each dose - may make drowsy

**ADDITIONAL INSTRUCTIONS**

**DIAGNOSIS:**

Acute low back pain

MD/PA Signature: [Signature]

Next Appointment:	Date: _____ Time: _____	<input type="checkbox"/> DISCHARGED
Physical/Occupational Therapy	Date: _____ Time: _____	
Referral to Specialist	Doctor: <u>[Signature]</u> Date: _____ Time: _____ Location: <u>Neurology</u> Phone: <u>[Number]</u>	
Drug Screen	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/> After care instructions given and discussed	Discharge Time: _____

Call Corporate Health at 847.360.2860 or 847.356.4746

Vista West 2615 Washington St., Waukegan

Vista Lindenhurst 1050 Red Oak Lane, Lindenhurst

SIGNATURES - PATIENT [Signature]

RN/TECH [Signature]

WHITE - CHS

YELLOW - COMPANY

PINK - PATIENT





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## Workers' Compensation Work Status Report

Date: 5/24/2017

Physician: S. DeLeon

Serafin DeLeon, MD

Name: Levandowski, Cynthia

Diagnosis: Left distal radius fracture

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17

- ☐ Employee can return to work as of \_\_\_\_\_ without restrictions.
- ☒ Employee can return to work as of 5-29-17 with the restrictions identified below which are expected to last through 5-30-17. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.
- ☒ Employee is unable to return to work as of 5-24-17 and is expected to be off of work through:
- ☒ 5-28-17 (date) ☐ until next appointment (listed below) and will be assessed then.
- ☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

### Posture/Motion Restrictions (if any):

- |   |                             |                                      |                             |
|---|-----------------------------|--------------------------------------|-----------------------------|
| <input type="checkbox"/> Standing           | Not to exceed _____ hrs/day | <input type="checkbox"/> Walking     | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Sitting            | Not to exceed _____ hrs/day | <input type="checkbox"/> Climbing    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Kneeling/Squatting | Not to exceed _____ hrs/day | <input type="checkbox"/> Grasping    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Bending/Stooping   | Not to exceed _____ hrs/day | <input type="checkbox"/> Squeezing   | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Twisting           | Not to exceed _____ hrs/day | <input type="checkbox"/> Reaching    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Pushing/Pulling    | Not to exceed _____ hrs/day | <input type="checkbox"/> Overhead    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Lifting/Carrying   | Not to exceed _____ hrs/day | <input type="checkbox"/> Keyboarding | Not to exceed _____ hrs/day |

### No Work Involving:

- Hand/Wrist/Arm ☐ R ☐ L
- Leg ☐ R ☐ L
- Foot/Ankle ☐ R ☐ L
- Neck ☐
- Back ☐

### Lift/Carry/Push/Pull Restrictions

- ☐ Not to exceed \_\_\_\_\_ lbs ☐ R ☐ L
- ☒ No lifting/carrying ☐ R ☒ L
- ☐ No pushing/pulling ☐ R ☐ L
- ☐ No pinching ☐ R ☐ L
- ☐ No grasping/squeezing ☐ R ☐ L
- ### Climbing Restrictions
- ☐ No ladder ☐ R ☐ L
- ☐ No stairs ☐ R ☐ L
- ☐ No ramp ☐ R ☐ L

### Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): \_\_\_\_\_

### Expected Follow-up Services Include:

- ☒ Next Appointment Date: 5-30-17 Time: 7:40am at Gurnee Office
- ☐ Diagnostic Studies Requested: \_\_\_\_\_
- ☐ Surgery Recommended: \_\_\_\_\_
- ☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_
- ☐ Referral to: \_\_\_\_\_
- ☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Krystal Perez



P 847.336.3335

F 847.336.3249

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### Workers' Compensation Work Status Report

Date: 5/30/2017

Physician: S. DeLeon

Name: Levandoski, Cynthia

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17

Serafin DeLeon, MD

Diagnosis: left distal radius fracture

- ☐ Employee can return to work as of \_\_\_\_\_ without restrictions.
- ☒ Employee can return to work as of 5-30-17 with the restrictions identified below which are expected to last through pending surgery. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.
- ☐ Employee is unable to return to work as of \_\_\_\_\_ and is expected to be off of work through:
- ☐ \_\_\_\_\_ (date) ☐ until next appointment (listed below) and will be assessed then.
- ☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

#### Posture/Motion Restrictions (if any):

- |   |                             |                                      |                             |
|---|-----------------------------|--------------------------------------|-----------------------------|
| <input type="checkbox"/> Standing           | Not to exceed _____ hrs/day | <input type="checkbox"/> Walking     | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Sitting            | Not to exceed _____ hrs/day | <input type="checkbox"/> Climbing    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Kneeling/Squatting | Not to exceed _____ hrs/day | <input type="checkbox"/> Grasping    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Bending/Stooping   | Not to exceed _____ hrs/day | <input type="checkbox"/> Squeezing   | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Twisting           | Not to exceed _____ hrs/day | <input type="checkbox"/> Reaching    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Pushing/Pulling    | Not to exceed _____ hrs/day | <input type="checkbox"/> Overhead    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Lifting/Carrying   | Not to exceed _____ hrs/day | <input type="checkbox"/> Keyboarding | Not to exceed _____ hrs/day |

#### No Work Involving:

- Hand/Wrist/Arm ☐ R ☐ L
- Leg ☐ R ☐ L
- Foot/Ankle ☐ R ☐ L
- Neck ☐
- Back ☐

#### Lift/Carry/Push/Pull Restrictions

- ☐ Not to exceed \_\_\_\_\_ lbs ☐ R ☐ L
- ☒ No lifting/carrying ☐ R ☒ L
- ☐ No pushing/pulling ☐ R ☐ L
- ☐ No pinching ☐ R ☐ L
- ☐ No grasping/squeezing ☐ R ☐ L
- Climbing Restrictions**
- ☐ No ladder ☐ R ☐ L
- ☐ No stairs ☐ R ☐ L
- ☐ No ramp ☐ R ☐ L

#### Misc. Restrictions

- ☒ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated.
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): Patient may not work at the register.

#### Expected Follow-up Services Include:

- ☒ Next Appointment Date: pending surgery Time: \_\_\_\_\_ at Select Office
- ☐ Diagnostic Studies Requested: \_\_\_\_\_
- ☒ Surgery Recommended: left distal radius open reduction and internal fixation; PENDING APPROVAL
- ☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_
- ☐ Referral to: \_\_\_\_\_
- ☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Krystal Perez



**Hawthorn Surgery Center**  
Patient Centéred. Extraordinary Care.

To the Patient or Guardian:

Your physician may dispense an orthopedic soft good or bracing device as part of your treatment at Hawthorn Surgical Center. These products include but are not limited to:

<input checked="" type="checkbox"/> Arm Sling	_____ Shoulder Abduction Sling
_____ CAM Walker/ Boot	_____ Crutches
_____ Knee Immobilizer	_____ Post-Op Shoe/APB
_____ TED Compression Hose	_____ 4-Prong Walker

These products are very common conservative orthopedic devices covered by most insurance companies and Medicare. The charges for a soft good or bracing device will be billed directly to your insurance company by Specialty Medical Services, INC. not Hawthorn Surgical Center. Payment for the soft good or bracing device will be made according to your members plan benefits. For example, you may be charged a deductible for the soft good or bracing device from Specialty Medical Services, INC.

If you have any questions regarding you bill or insurance claim, please contact you insurance carrier directly or Specialty Medical Services, Inc., at the number below. There is no financial interest or other business association between Specialty Medical Services, Inc. and Hawthorn Surgery Center.

Please read the assignment of insurance benefits for the soft good or bracing device that you may receive from you physician, then sign below.

**Specialty Medical Services, Inc. has instituted privacy practice that are in compliance with the Health Insurance Portability and Accountability Act.**

The rules in our office are intended to safeguard you private health information. We disclose only that information necessary to process your claim for benefits and payment. This include: demographic information, the nature of treatment requiring our product and pertinent information necessary to process your claim with your insurance carrier/responsible party for payment. As it is a business associate, Specialty Medical Services, Inc. complies with the HIPAA guidelines presented to you at the facility prescribing your orthotic, soft good or durable medical equipment.

**PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION, RELEASE OF MEDICAL INFORMATION, AND BENEFIT ASSIGNMENT DISCLOSURE FORM**

**SPECIALTY MEDICAL SERVICES, INC.** is the supplier of the soft good, orthotic or bracing device prescribed by my physician at this facility. I authorize the release of my medical information necessary to process the resulting claim for the product(s) provided to me. Additionally, I authorize assignment of my insurance benefit to Specialty Medical Service, Inc. **I understand that I will be responsible for any co-payment, deductible or non-covered expenses that may result from this billing.**

Patient/ Guardian Signature: *[Signature]* Date: 6-8-17

Physician Signature: V.O. per Dr. DeLeon Date: 6-8-17

**SPECIALTY MEDICAL SERVICES, INC**

479 Business Center Dr.

Mount Prospect, IL 60056

(847) 720-4310 – Billing Department

**Specialty Medical keep the original- one copy to patient, one copy remains in patient's chart**



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Workers' Compensation Work Status Report

Date: 6/19/2017

Physician:

S. DeLeon, MD

Name: Levandowski, Cynthia

Diagnosis: Status Post Left ORIF of 3-Part Intra-Articular

Employer: Home Owner's Bargain Outlet

Distal Radius Fracture

Date of Injury: 5/22/17 DOS: 6/8/17

- ☐ Employee can return to work as of \_\_\_\_\_ without restrictions.
- ☒ Employee can return to work as of 6/26/17 with the restrictions identified below which are expected to last through NEXT APPT. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.
- ☒ Employee is unable to return to work as of 6/19/17 and is expected to be off of work through:
- ☒ 6/25/17 (date) ☐ until next appointment (listed below) and will be assessed then.
- ☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

- |   |                             |                                      |                             |
|---|-----------------------------|--------------------------------------|-----------------------------|
| <input type="checkbox"/> Standing           | Not to exceed _____ hrs/day | <input type="checkbox"/> Walking     | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Sitting            | Not to exceed _____ hrs/day | <input type="checkbox"/> Climbing    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Kneeling/Squatting | Not to exceed _____ hrs/day | <input type="checkbox"/> Grasping    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Bending/Stooping   | Not to exceed _____ hrs/day | <input type="checkbox"/> Squeezing   | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Twisting           | Not to exceed _____ hrs/day | <input type="checkbox"/> Reaching    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Pushing/Pulling    | Not to exceed _____ hrs/day | <input type="checkbox"/> Overhead    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Lifting/Carrying   | Not to exceed _____ hrs/day | <input type="checkbox"/> Keyboarding | Not to exceed _____ hrs/day |

No Work Involving:

- |                |                            |                            |
|----------------|----------------------------|----------------------------|
| Hand/Wrist/Arm | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Leg            | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Foot/Ankle     | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Neck           | <input type="checkbox"/>   |                            |
| Back           | <input type="checkbox"/>   |                            |

Lift/Carry/Push/Pull Restrictions

- |   |                            |                                       |
|---|----------------------------|---------------------------------------|
| <input type="checkbox"/> Not to exceed _____ lbs        | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <input checked="" type="checkbox"/> No lifting/carrying | <input type="checkbox"/> R | <input checked="" type="checkbox"/> L |
| <input checked="" type="checkbox"/> No pushing/pulling  | <input type="checkbox"/> R | <input checked="" type="checkbox"/> L |
| <input type="checkbox"/> No pinching                    | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <input type="checkbox"/> No grasping/squeezing          | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <b>Climbing Restrictions</b>                            |                            |                                       |
| <input type="checkbox"/> No ladder                      | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <input type="checkbox"/> No stairs                      | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <input type="checkbox"/> No ramp                        | <input type="checkbox"/> R | <input type="checkbox"/> L            |

Misc. Restrictions

- |  |
|--|
| <input type="checkbox"/> Wear splint/brace/sling/cast at work        |
| <input type="checkbox"/> Sitting only                                |
| <input type="checkbox"/> Must use crutches                           |
| <input type="checkbox"/> Walking/Standing as tolerated               |
| <input type="checkbox"/> No driving                                  |
| <input type="checkbox"/> No operating heavy equipment/moving machine |
| <input type="checkbox"/> No overhead work                            |

Other Restrictions (if any): No use of arm sling

Expected Follow-up Services Include:

- ☒ Next Appointment Date: 7/17/17 Time: 12:15PM at Gurnee Office
- ☐ Diagnostic Studies Requested: \_\_\_\_\_
- ☐ Surgery Recommended: \_\_\_\_\_
- ☒ Rehab (PT/OT) Recommended: 2 x per week for 4 weeks starting pending WC approval
- ☐ Referral to: \_\_\_\_\_
- ☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Ofelia Diaz, CCMA



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Workers' Compensation Work Status Report

Date: 7/17/2017

Physician:

S. DeLeon, MD

Name: Levandoski, Cynthia

Diagnosis: Left three-part intraarticular distal radius

Employer: Home Owner's Bargain Outlet

Fracture S/P Open Reduction Internal Fixation

Date of injury: 5/22/17 DOS: 6/8/17

- ☐ Employee can return to work as of \_\_\_\_\_ without restrictions.
- ☒ Employee can return to work as of 7/17/17 with the restrictions identified below which are expected to last through 8/15/17. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.
- ☐ Employee is unable to return to work as of \_\_\_\_\_ and is expected to be off of work through: \_\_\_\_\_ (date) ☐ until next appointment (listed below) and will be assessed then.
- ☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

- |   |                             |                                      |                             |
|---|-----------------------------|--------------------------------------|-----------------------------|
| <input type="checkbox"/> Standing           | Not to exceed _____ hrs/day | <input type="checkbox"/> Walking     | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Sitting            | Not to exceed _____ hrs/day | <input type="checkbox"/> Climbing    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Kneeling/Squatting | Not to exceed _____ hrs/day | <input type="checkbox"/> Grasping    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Bending/Stooping   | Not to exceed _____ hrs/day | <input type="checkbox"/> Squeezing   | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Twisting           | Not to exceed _____ hrs/day | <input type="checkbox"/> Reaching    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Pushing/Pulling    | Not to exceed _____ hrs/day | <input type="checkbox"/> Overhead    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Lifting/Carrying   | Not to exceed _____ hrs/day | <input type="checkbox"/> Keyboarding | Not to exceed _____ hrs/day |

No Work Involving:

- |                |                            |                            |
|----------------|----------------------------|----------------------------|
| Hand/Wrist/Arm | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Leg            | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Foot/Ankle     | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Neck           | <input type="checkbox"/>   |                            |
| Back           | <input type="checkbox"/>   |                            |

Lift/Carry/Push/Pull Restrictions

- |   |                            |                                       |
|---|----------------------------|---------------------------------------|
| <input checked="" type="checkbox"/> Not to exceed 5 lbs | <input type="checkbox"/> R | <input checked="" type="checkbox"/> L |
| <input type="checkbox"/> No lifting/carrying            | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <input type="checkbox"/> No pushing/pulling             | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <input type="checkbox"/> No pinching                    | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <input type="checkbox"/> No grasping/squeezing          | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <b>Climbing Restrictions</b>                            |                            |                                       |
| <input type="checkbox"/> No ladder                      | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <input type="checkbox"/> No stairs                      | <input type="checkbox"/> R | <input type="checkbox"/> L            |
| <input type="checkbox"/> No ramp                        | <input type="checkbox"/> R | <input type="checkbox"/> L            |

Misc. Restrictions

- |  |
|--|
| <input type="checkbox"/> Wear splint/brace/sling/cast at work        |
| <input type="checkbox"/> Sitting only                                |
| <input type="checkbox"/> Must use crutches                           |
| <input type="checkbox"/> Walking/Standing as tolerated               |
| <input type="checkbox"/> No driving                                  |
| <input type="checkbox"/> No operating heavy equipment/moving machine |
| <input type="checkbox"/> No overhead work                            |

Other Restrictions (If any): \_\_\_\_\_

Expected Follow-up Services Include:

- ☒ Next Appointment Date: 8/15/17 Time: 8:15AM at Gurnee Office
- ☐ Diagnostic Studies Requested: \_\_\_\_\_
- ☐ Surgery Recommended: \_\_\_\_\_
- ☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_
- ☐ Referral to: \_\_\_\_\_
- ☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Claire Chicas, CCMA



Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
07/17/2017	12:15 pm	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

Create Date: 6/19/2017 Due Date: 7/19/2017  
 Procedure: OT Facility: IBI Rehab Gurnee  
 Ordering Provider: Serafin DeLeon - NPI # 1326091414



# ILLINOIS BONE AND JOINT INSTITUTE, LLC OCCUPATIONAL THERAPY ORDER

Patient Name: Levandoski, Cynthia Patient ID: 1520501  
 Treatment Frequency: ☐ x1 ☒ x2 ☐ x3 per week Treatment Duration: ☐ 1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☒ weeks ☐ months  
☐ Right ☒ Left Diagnosis:

☐ Right ☒ Left **SPLINT FABRICATION** Notes:

<input type="checkbox"/> Hand based	<input type="checkbox"/> Fingertip Protector	<input type="checkbox"/> T <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> S	<input type="checkbox"/> DIPs <input type="checkbox"/> flex <input type="checkbox"/> ext
<input type="checkbox"/> Forearm based	<input type="checkbox"/> Mallet Finger Splint	<input type="checkbox"/> T <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> S	<input type="checkbox"/> PIPs <input type="checkbox"/> flex <input type="checkbox"/> ext
<input type="checkbox"/> Dorsal	<input type="checkbox"/> Ulnar Gutter Splint	<input type="checkbox"/> T <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> S	<input type="checkbox"/> MCPs <input type="checkbox"/> flex <input type="checkbox"/> ext
<input type="checkbox"/> Volar	<input type="checkbox"/> Radial Gutter: include	<input type="checkbox"/> T <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> S	<input type="checkbox"/> Wrist <input type="checkbox"/> flex <input type="checkbox"/> ext
<input type="checkbox"/> Static	<input type="checkbox"/> Dorsal Blocking: include	<input type="checkbox"/> T <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> S	<input type="checkbox"/> Forearm <input type="checkbox"/> pro <input type="checkbox"/> sup
<input type="checkbox"/> Dynamic	<input type="checkbox"/> Short Opponens Splint	<input type="checkbox"/> Include IP joint	<input type="checkbox"/> Elbow <input type="checkbox"/> flex <input type="checkbox"/> sup
<input type="checkbox"/> Ext/Flex	<input type="checkbox"/> Long Opponens Splint	<input type="checkbox"/> Exclude IP joint	
<input type="checkbox"/> Pro/Sup	<input type="checkbox"/> Wrist Splint	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Elbow (arm to wrist)		

☐ Right ☒ Left **THERAPY**

☐ Elbow ☒ Wrist ☐ MCPs ☐ PIPs ☐ DIPs ☐ Thumb ☐ Index ☐ Long ☐ Ring ☐ Small

<input type="checkbox"/> <b>Range of Motion</b> <input type="checkbox"/> Unlimited Mobilization <input type="checkbox"/> Specific Goals <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Flexion <input type="checkbox"/> Extension <input type="checkbox"/> Pronation <input type="checkbox"/> Supination <input type="checkbox"/> Internal / External Rotation <input type="checkbox"/> Abduction / Forward Flexion <input checked="" type="checkbox"/> Evaluate and Treat	<input type="checkbox"/> <b>Soft Tissue Care</b> <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Desensitization <input type="checkbox"/> Edema Control <input type="checkbox"/> Electrical Stim <input type="checkbox"/> Fluidotherapy <input type="checkbox"/> Friction Massage <input type="checkbox"/> Iontophoresis <input type="checkbox"/> Scar Massage <input type="checkbox"/> TENS <input type="checkbox"/> Ultrasound <input type="checkbox"/> Wound Care	<input type="checkbox"/> <b>Strengthening</b> <input type="checkbox"/> Digital Flexion/Extension <input type="checkbox"/> T <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> S <input type="checkbox"/> Wrist <input type="checkbox"/> Forearm Rotation <input type="checkbox"/> Elbow Flexion / Extension <input type="checkbox"/> Shoulder Abduction / Flexion <input type="checkbox"/> Physical Measurements <input type="checkbox"/> Edema Measurement <input type="checkbox"/> Detailed ROM <input type="checkbox"/> Return to Work Evaluation <input type="checkbox"/> Limited <input type="checkbox"/> Complete <input type="checkbox"/> Full Computerized Hand Exam <input type="checkbox"/> Grip and Pinch Strengths <input type="checkbox"/> Semmes-Weinstein Monofilament Exam
--	---	--

☐ **Protocols**

<input type="checkbox"/> CMC Resection Arthroplasty	<input type="checkbox"/> Extensor Tenolysis	Zone _____	<input type="checkbox"/> Rheumatoid Arthritis Education
<input type="checkbox"/> Dupuytren's Fasciectomy	<input type="checkbox"/> Flexor Tendon Repair	Zone _____	<input type="checkbox"/> Rotator Cuff Repair
<input type="checkbox"/> Distal Radius Fracture	<input type="checkbox"/> Flexor Tenolysis	Zone _____	<input type="checkbox"/> Rotator Cuff Tendinitis
<input type="checkbox"/> Distal Radius External Fixator	<input type="checkbox"/> Job Site Analysis		<input type="checkbox"/> Shoulder Arthroplasty
<input type="checkbox"/> Ergonomic Instruction	<input type="checkbox"/> PIP Contracture / Sprain		<input type="checkbox"/> Sympathetically Mediated Pain
<input type="checkbox"/> Extensor Tendon Repair Zone _____	<input type="checkbox"/> Proximal Humerous Fracture		<input type="checkbox"/> Work Hardening

## NOTES

### Letter of Medical Necessity:

I certify that the above prescribed equipment, its setup and related patient education are medically indicated and necessary to the accepted standards of medicine of this patient's condition.

Signed

Signed

Date 6/19/2017

Serafin DeLeon, MD

For your information, the Physical Therapists, Occupational Therapists and Athletic Trainers at IBI are financially integrated. If you are referred to a clinician in IBI for any related services, you may request and receive a referral for these services outside or independent of IBI.

40720-NVC Gurnee IL  
15 Tower Court, Suite 235  
Gurnee, IL 60031  
Phone: (847) 336-7468  
Fax: (847) 336-3923

Patient Appointment list for Levandoski, Cindy Account#: 040R840251462.

Report includes appointments with statuses of Void, Scheduled, Arrived, Rescheduled, Cancelled, No Show.

Date	Time	Appt. Status	Clinician	Location	Copay Collected	Date Created	Last Changed Date	Last Changed UserID
Jul 06, 2017	08:30 AM	Rescheduled	Almanza, PT, Stacy	40720-NVC Gurnee IL	\$ .00	Jun 27, 2017	Jul 06, 2017	SELECT\escobedc
Jul 10, 2017	12:30 PM	Arrived	Leipold, PT, Tracy	40720-NVC Gurnee IL	\$ .00	Jul 06, 2017	Jul 11, 2017	SELECT\leipoldt
Jul 12, 2017	09:30 AM	Void	Bastable, PTA, Todd	40720-NVC Gurnee IL	\$ .00	Jul 10, 2017	Jul 11, 2017	SELECT\leipoldt
Jul 14, 2017	11:30 AM	Arrived	Bastable, PTA, Todd	40720-NVC Gurnee IL	\$ .00	Jul 10, 2017	Jul 14, 2017	SELECT\lorRivera
Jul 18, 2017	03:00 PM	Arrived	Leipold, PT, Tracy	40720-NVC Gurnee IL	\$ .00	Jul 17, 2017	Jul 18, 2017	SELECT\leipoldt
Jul 20, 2017	04:30 PM	Void	Leipold, PT, Tracy	40720-NVC Gurnee IL	\$ .00	Jul 17, 2017	Jul 19, 2017	SELECT\escobedc
Jul 21, 2017	02:00 PM	Arrived	Bastable, PTA, Todd	40720-NVC Gurnee IL	\$ .00	Jul 19, 2017	Jul 21, 2017	SELECT\lorRivera
Jul 25, 2017	03:30 PM	Scheduled	Leipold, PT, Tracy	40720-NVC Gurnee IL	\$ .00	Jul 21, 2017	Jul 21, 2017	SELECT\lorRivera
Jul 27, 2017	04:30 PM	Scheduled	Leipold, PT, Tracy	40720-NVC Gurnee IL	\$ .00	Jul 21, 2017	Jul 21, 2017	SELECT\lorRivera

TUES - 3 HES LATE ST PER MATHS  
JULY 18th 2 HR  
JULY 25th 1 HR



**NovaCare Rehabilitation**

15 Tower Court, Suite 235

Gurnee, IL 60031

Phone: (847) 336-7468

Fax: (847) 336-3923

**Appointment list for Levandoski, Cindy**

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Jul 12, 2017	09:30 AM	Workers Comp	Bastable, PTA, Todd	0.00
Fri, Jul 14, 2017	11:30 AM	Workers Comp	Bastable, PTA, Todd	0.00

**Additional Instructions:**

TUESDAY July 18th - 300pm

THURSDAY July 20th - 430pm

Thank you,  
NovaCare Rehabilitation

**NovaCare Rehabilitation**

15 Tower Court, Suite 235

Gurnee, IL 60031

Phone: (847) 336-7468

Fax: (847) 336-3923

**Appointment list for Levandoski, Cindy**

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Jul 12, 2017	09:00 AM	Workers Comp	Bastable, PTA, Todd	0.00
Fri, Jul 14, 2017	11:30 AM	Workers Comp	Bastable, PTA, Todd	0.00

**Additional Instructions:**

TUESDAY July 18th - 300pm

THURSDAY July 20th - 430pm

Thank you,  
NovaCare Rehabilitation

**NovaCare Rehabilitation**

15 Tower Court, Suite 235  
Gurnee, IL 60031  
Phone: (847) 336-7468  
Fax: (847) 336-3923

**Appointment list for Levandoski, Cindy**

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Aug 23, 2017	12:00 PM	Workers Comp	Bastable, PTA, Todd	0.00
Tue, Aug 29, 2017	04:00 PM	Workers Comp	Leipold, PT, Tracy	0.00
Wed, Aug 30, 2017	04:00 PM	Workers Comp	Bastable, PTA, Todd	0.00
Thu, Aug 31, 2017	12:00 PM	Workers Comp	Leipold, PT, Tracy	0.00

**Additional Instructions:**

Thank you,  
NovaCare Rehabilitation

### **NovaCare Rehabilitation**

15 Tower Court, Suite 235

Gurnee, IL 60031

Phone: (847) 336-7468

Fax: (847) 336-3923

#### **Appointment list for Levandoski, Cindy**

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

<b>Date</b>	<b>Time</b>	<b>Appointment Type</b>	<b>Clinician</b>	<b>Copay</b>
Tue, Aug 01, 2017	12:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 02, 2017	04:30 PM	Workers Comp	Bastable, PTA , Todd	0.00
Mon, Aug 07, 2017	09:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Wed, Aug 09, 2017	11:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 15, 2017	12:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 16, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Tue, Aug 22, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 23, 2017	12:00 PM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 29, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 30, 2017	12:00 PM	Workers Comp	Bastable, PTA , Todd	0.00

#### **Additional Instructions:**

Thank you,  
NovaCare Rehabilitation

LEVANDOSKI^CYNTHIA  
51732  
2017-06-08 11:04:14



LEVANDOSKI^CYNTHIA  
51732  
2017-06-08 11:04:40



LEVANDOSKI^CYNTHIA  
51732  
2017-06-08 11:04:14





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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
08/15/2017	08:15 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.





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## Workers' Compensation Work Status Report

Date: 9/21/2017

Physician:

S. DeLeon  
Serafin DeLeon, MD

Name: Levandoski, Cynthia

Diagnosis: Left distal radius retained hardware as well as possible triangular fibrocartilage complex tear.

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17

- ☐ Employee can return to work as of \_\_\_\_\_ without restrictions.
- ☐ Employee can return to work as of \_\_\_\_\_ with the restrictions identified below which are expected to last through \_\_\_\_\_. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.
- ☒ Employee is unable to return to work as of 09/28/17 and is expected to be off of work through: \_\_\_\_\_ (date) ☒ until next appointment (listed below) and will be assessed then.
- ☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

### Posture/Motion Restrictions (if any):

- |   |                             |                                      |                             |
|---|-----------------------------|--------------------------------------|-----------------------------|
| <input type="checkbox"/> Standing           | Not to exceed _____ hrs/day | <input type="checkbox"/> Walking     | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Sitting            | Not to exceed _____ hrs/day | <input type="checkbox"/> Climbing    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Kneeling/Squatting | Not to exceed _____ hrs/day | <input type="checkbox"/> Grasping    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Bending/Stooping   | Not to exceed _____ hrs/day | <input type="checkbox"/> Squeezing   | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Twisting           | Not to exceed _____ hrs/day | <input type="checkbox"/> Reaching    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Pushing/Pulling    | Not to exceed _____ hrs/day | <input type="checkbox"/> Overhead    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Lifting/Carrying   | Not to exceed _____ hrs/day | <input type="checkbox"/> Keyboarding | Not to exceed _____ hrs/day |

### No Work Involving:

- Hand/Wrist/Arm ☐ R ☐ L
- Leg ☐ R ☐ L
- Foot/Ankle ☐ R ☐ L
- Neck ☐
- Back ☐

### Lift/Carry/Push/Pull Restrictions

- ☐ Not to exceed \_\_\_\_\_ lbs ☐ R ☐ L
- ☐ No lifting/carrying ☐ R ☐ L
- ☐ No pushing/pulling ☐ R ☐ L
- ☐ No pinching ☐ R ☐ L
- ☐ No grasping/squeezing ☐ R ☐ L
- Climbing Restrictions**
- ☐ No ladder ☐ R ☐ L
- ☐ No stairs ☐ R ☐ L
- ☐ No ramp ☐ R ☐ L

### Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): \_\_\_\_\_

### Expected Follow-up Services Include:

- ☒ Next Appointment Date: 10/06/17 Time: 8:45 AM at Gurnee Office
- ☐ Diagnostic Studies Requested: \_\_\_\_\_
- ☒ Surgery Recommended: left distal radius removal of hardware as well as an arthroscopy with possible triangular fibrocartilage complex debridement versus repair
- ☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_
- ☐ Referral to: \_\_\_\_\_
- ☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.



Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
10/06/2017	08:45 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Delcon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.



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### Workers' Compensation Work Status Report

Date: 11/3/2017

Physician: S. DeLeon

Serafin DeLeon, MD

Name: Levandowski, Cynthia

Diagnosis: Left distal radius retained hardware as well as possible triangular fibrocartilage complex tear.

Employer: Home Owner's Bargain Outlet

s/p removal of hardware, arthroscopy & synovectomy

Date of Injury: 05/22/17 DOS 9/28/17

☐ Employee can return to work as of \_\_\_\_\_ without restrictions.

☒ Employee can return to work as of 11/3/17 with the restrictions identified below which are expected to last through next appt. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is unable to return to work as of \_\_\_\_\_ and is expected to be off of work through:

☐ \_\_\_\_\_ (date) ☐ until next appointment (listed below) and will be assessed then.

☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

#### Posture/Motion Restrictions (if any):

☐ Standing Not to exceed \_\_\_\_\_ hrs/day  
☐ Sitting Not to exceed \_\_\_\_\_ hrs/day  
☐ Kneeling/Squatting Not to exceed \_\_\_\_\_ hrs/day  
☐ Bending/Stooping Not to exceed \_\_\_\_\_ hrs/day  
☐ Twisting Not to exceed \_\_\_\_\_ hrs/day  
☐ Pushing/Pulling Not to exceed \_\_\_\_\_ hrs/day  
☐ Lifting/Carrying Not to exceed \_\_\_\_\_ hrs/day

☐ Walking Not to exceed \_\_\_\_\_ hrs/day  
☐ Climbing Not to exceed \_\_\_\_\_ hrs/day  
☐ Grasping Not to exceed \_\_\_\_\_ hrs/day  
☐ Squeezing Not to exceed \_\_\_\_\_ hrs/day  
☐ Reaching Not to exceed \_\_\_\_\_ hrs/day  
☐ Overhead Not to exceed \_\_\_\_\_ hrs/day  
☐ Keyboarding Not to exceed \_\_\_\_\_ hrs/day

#### No Work Involving:

Hand/Wrist/Arm ☐ R ☐ L  
Leg ☐ R ☐ L  
Foot/Ankle ☐ R ☐ L  
Neck ☐  
Back ☐

#### Lift/Carry/Push/Pull Restrictions

☒ Not to exceed 5 lbs ☐ R ☒ L  
☐ No lifting/carrying ☐ R ☐ L  
☐ No pushing/pulling ☐ R ☐ L  
☐ No pinching ☐ R ☐ L  
☐ No grasping/squeezing ☐ R ☐ L  
**Climbing Restrictions**  
☐ No ladder ☐ R ☐ L  
☐ No stairs ☐ R ☐ L  
☐ No ramp ☐ R ☐ L

#### Misc. Restrictions

☒ Wear splint/brace/sling/cast at work  
☐ Sitting only  
☐ Must use crutches  
☐ Walking/Standing as tolerated  
☐ No driving  
☐ No operating heavy equipment/moving machine  
☐ No overhead work

Other Restrictions (if any): \*\*\*NO REGISTER\*\*\*

#### Expected Follow-up Services Include:

☒ Next Appointment Date: 11/3/17 Time: 8:15 AM at Gurnee Office

☐ Diagnostic Studies Requested: \_\_\_\_\_

☐ Surgery Recommended: \_\_\_\_\_

☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_

☐ Referral to: \_\_\_\_\_

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Adriana Cortez, CCMA



P 847.336.3335  
 F 847.336.3249

Gurnee | Lake Bluff | Lindenhurst  
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# Workers' Compensation Work Status Report

Date: 11/7/2017 \*Updated\*

Physician: S. DeLeon

Name: Levandoski, Cynthia

Serafin DeLeon, MD

Employer: Home Owner's Bargain Outlet

Diagnosis: Left distal radius retained hardware and possible triangular fibrocartilage complex tear.

Date of Injury: 05/22/17 DOS 9/28/17

s/p removal of hardware, arthroscopy & synovectomy

- ☐ Employee can return to work as of \_\_\_\_\_ without restrictions.
- ☒ Employee can return to work as of 11/3/17 with the restrictions identified below which are expected to last through next appt. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.
- ☐ Employee is unable to return to work as of \_\_\_\_\_ and is expected to be off of work through: \_\_\_\_\_
- ☐ \_\_\_\_\_ (date) ☐ until next appointment (listed below) and will be assessed then.
- ☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

## Posture/Motion Restrictions (if any):

- |   |                             |                                      |                             |
|---|-----------------------------|--------------------------------------|-----------------------------|
| <input type="checkbox"/> Standing           | Not to exceed _____ hrs/day | <input type="checkbox"/> Walking     | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Sitting            | Not to exceed _____ hrs/day | <input type="checkbox"/> Climbing    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Kneeling/Squatting | Not to exceed _____ hrs/day | <input type="checkbox"/> Grasping    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Bending/Stooping   | Not to exceed _____ hrs/day | <input type="checkbox"/> Squeezing   | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Twisting           | Not to exceed _____ hrs/day | <input type="checkbox"/> Reaching    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Pushing/Pulling    | Not to exceed _____ hrs/day | <input type="checkbox"/> Overhead    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Lifting/Carrying   | Not to exceed _____ hrs/day | <input type="checkbox"/> Keyboarding | Not to exceed _____ hrs/day |

## No Work Involving:

- Hand/Wrist/Arm ☐ R ☐ L
- Leg ☐ R ☐ L
- Foot/Ankle ☐ R ☐ L
- Neck ☐
- Back ☐

## Lift/Carry/Push/Pull Restrictions

- ☒ Not to exceed 5 lbs ☐ R ☒ L
- ☐ No lifting/carrying ☐ R ☐ L
- ☐ No pushing/pulling ☐ R ☐ L
- ☐ No pinching ☐ R ☐ L
- ☐ No grasping/squeezing ☐ R ☐ L
- Climbing Restrictions**
- ☐ No ladder ☐ R ☐ L
- ☐ No stairs ☐ R ☐ L
- ☐ No ramp ☐ R ☐ L

## Misc. Restrictions

- ☒ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): \*\*\*NO REGISTER\*\*\*

## Expected Follow-up Services Include:

- ☒ Next Appointment Date: 12/01/17 Time: 8:15 AM at Gurnee Office
- ☐ Diagnostic Studies Requested: \_\_\_\_\_
- ☐ Surgery Recommended: \_\_\_\_\_
- ☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_
- ☐ Referral to: \_\_\_\_\_
- ☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Isabel Villarreal, CCMA



P 847.336.3335

F 847.336.3249

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## Workers' Compensation Work Status Report

Date: 12/1/2017

Physician:

S. DeLeon  
Serafin DeLeon, MD

Name: Levandoski, Cynthia

Diagnosis: Left distal radius retained hardware and

Employer: Home Owner's Bargain Outlet

possible triangular fibrocartilage complex tear.

Date of Injury: 05/22/17 DOS 9/28/17

s/p removal of hardware, arthroscopy & synovectomy

☒ Employee can return to work as of 12/1/17

without restrictions.

☐ Employee can return to work as of \_\_\_\_\_ with the restrictions identified below which are expected to last through \_\_\_\_\_. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of \_\_\_\_\_ and is expected to be off of work through:

☐ \_\_\_\_\_ (date) ☐ until next appointment (listed below) and will be assessed then.

☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

### Posture/Motion Restrictions (if any):

<input type="checkbox"/> Standing	Not to exceed _____ hrs/day
<input type="checkbox"/> Sitting	Not to exceed _____ hrs/day
<input type="checkbox"/> Kneeling/Squatting	Not to exceed _____ hrs/day
<input type="checkbox"/> Bending/Stooping	Not to exceed _____ hrs/day
<input type="checkbox"/> Twisting	Not to exceed _____ hrs/day
<input type="checkbox"/> Pushing/Pulling	Not to exceed _____ hrs/day
<input type="checkbox"/> Lifting/Carrying	Not to exceed _____ hrs/day

<input type="checkbox"/> Walking	Not to exceed _____ hrs/day
<input type="checkbox"/> Climbing	Not to exceed _____ hrs/day
<input type="checkbox"/> Grasping	Not to exceed _____ hrs/day
<input type="checkbox"/> Squeezing	Not to exceed _____ hrs/day
<input type="checkbox"/> Reaching	Not to exceed _____ hrs/day
<input type="checkbox"/> Overhead	Not to exceed _____ hrs/day
<input type="checkbox"/> Keyboarding	Not to exceed _____ hrs/day

### No Work Involving:

Hand/Wrist/Arm	<input type="checkbox"/> R <input type="checkbox"/> L
Leg	<input type="checkbox"/> R <input type="checkbox"/> L
Foot/Ankle	<input type="checkbox"/> R <input type="checkbox"/> L
Neck	<input type="checkbox"/>
Back	<input type="checkbox"/>

### Lift/Carry/Push/Pull Restrictions

<input type="checkbox"/> Not to exceed _____ lbs	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> No lifting/carrying	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> No pushing/pulling	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> No pinching	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> No grasping/squeezing	<input type="checkbox"/> R <input type="checkbox"/> L
<b>Climbing Restrictions</b>	
<input type="checkbox"/> No ladder	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> No stairs	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> No ramp	<input type="checkbox"/> R <input type="checkbox"/> L

### Misc. Restrictions

<input type="checkbox"/> Wear splint/brace/sling/cast at work
<input type="checkbox"/> Sitting only
<input type="checkbox"/> Must use crutches
<input type="checkbox"/> Walking/Standing as tolerated
<input type="checkbox"/> No driving
<input type="checkbox"/> No operating heavy equipment/moving machine
<input type="checkbox"/> No overhead work

Other Restrictions (if any): \_\_\_\_\_

### Expected Follow-up Services Include:

☒ Next Appointment Date: 1/8/18 Time: 12:45PM at Gurnee Office

☐ Diagnostic Studies Requested: \_\_\_\_\_

☐ Surgery Recommended: \_\_\_\_\_

☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_

☐ Referral to: \_\_\_\_\_

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Adriana Cortez, CCMA



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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
12/01/2017	08:15 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.





P 847.336.3335

F 847.336.3249

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### Workers' Compensation Work Status Report

Date: 1/8/2018

Physician: S. DeLeon

Serafin DeLeon, MD

Name: Levandowski, Cynthia

Diagnosis: Left wrist retained hardware and TFCC tear

Employer: Hobo

S/P removal of hardware as well as scar excision and left

Date of Injury: 5/22/17 Surgery: 9/20/17

wrist arthroscopy and synovectomy

☒ Employee can return to work as of 1/8/18 without restrictions.

☐ Employee can return to work as of \_\_\_\_\_ with the restrictions identified below which are expected to last through \_\_\_\_\_. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is unable to return to work as of \_\_\_\_\_ and is expected to be off of work through:

☐ \_\_\_\_\_ (date) ☐ until next appointment (listed below) and will be assessed then.

☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

#### Posture/Motion Restrictions (if any):

☐ Standing Not to exceed \_\_\_\_\_ hrs/day  
☐ Sitting Not to exceed \_\_\_\_\_ hrs/day  
☐ Kneeling/Squatting Not to exceed \_\_\_\_\_ hrs/day  
☐ Bending/Stooping Not to exceed \_\_\_\_\_ hrs/day  
☐ Twisting Not to exceed \_\_\_\_\_ hrs/day  
☐ Pushing/Pulling Not to exceed \_\_\_\_\_ hrs/day  
☐ Lifting/Carrying Not to exceed \_\_\_\_\_ hrs/day

☐ Walking Not to exceed \_\_\_\_\_ hrs/day  
☐ Climbing Not to exceed \_\_\_\_\_ hrs/day  
☐ Grasping Not to exceed \_\_\_\_\_ hrs/day  
☐ Squeezing Not to exceed \_\_\_\_\_ hrs/day  
☐ Reaching Not to exceed \_\_\_\_\_ hrs/day  
☐ Overhead Not to exceed \_\_\_\_\_ hrs/day  
☐ Keyboarding Not to exceed \_\_\_\_\_ hrs/day

#### No Work Involving:

Hand/Wrist/Arm ☐ R ☐ L  
Leg ☐ R ☐ L  
Foot/Ankle ☐ R ☐ L  
Neck ☐  
Back ☐

#### Lift/Carry/Push/Pull Restrictions

☐ Not to exceed \_\_\_\_\_ lbs ☐ R ☐ L  
☐ No lifting/carrying ☐ R ☐ L  
☐ No pushing/pulling ☐ R ☐ L  
☐ No pinching ☐ R ☐ L  
☐ No grasping/squeezing ☐ R ☐ L  
**Climbing Restrictions**  
☐ No ladder ☐ R ☐ L  
☐ No stairs ☐ R ☐ L  
☐ No ramp ☐ R ☐ L

#### Misc. Restrictions

☐ Wear splint/brace/sling/cast at work  
☐ Sitting only  
☐ Must use crutches  
☐ Walking/Standing as tolerated  
☐ No driving  
☐ No operating heavy equipment/moving machine  
☐ No overhead work

Other Restrictions (if any): \_\_\_\_\_

#### Expected Follow-up Services Include:

☒ Next Appointment Date: 2/2/18 Time: 7:45am at Gurnee Office

☐ Diagnostic Studies Requested: \_\_\_\_\_

☐ Surgery Recommended: \_\_\_\_\_

☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_

☐ Referral to: \_\_\_\_\_

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Claire Chicas, CCMA



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### Workers' Compensation Work Status Report

Date: 2/16/2018

Physician: S. DeLeon

Serafin DeLeon, MD

Name: Levandowski, Cynthia

Diagnosis: Left wrist retained hardware and TFCC tear

Employer: Hobo

s/p removal of hardware, scar excision, arthroscopy and

Date of Injury: 5/22/17 DOS 9/20/17 & 6/8/17

ECU tendonitis

- ☒ Employee can return to work as of 2/16/18 without restrictions.
- ☐ Employee can return to work as of \_\_\_\_\_ with the restrictions identified below which are expected to last through \_\_\_\_\_. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.
- ☐ Employee is unable to return to work as of \_\_\_\_\_ and is expected to be off of work through: \_\_\_\_\_ (date) ☐ until next appointment (listed below) and will be assessed then.
- ☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

#### Posture/Motion Restrictions (if any):

- |   |                             |                                      |                             |
|---|-----------------------------|--------------------------------------|-----------------------------|
| <input type="checkbox"/> Standing           | Not to exceed _____ hrs/day | <input type="checkbox"/> Walking     | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Sitting            | Not to exceed _____ hrs/day | <input type="checkbox"/> Climbing    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Kneeling/Squatting | Not to exceed _____ hrs/day | <input type="checkbox"/> Grasping    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Bending/Stooping   | Not to exceed _____ hrs/day | <input type="checkbox"/> Squeezing   | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Twisting           | Not to exceed _____ hrs/day | <input type="checkbox"/> Reaching    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Pushing/Pulling    | Not to exceed _____ hrs/day | <input type="checkbox"/> Overhead    | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Lifting/Carrying   | Not to exceed _____ hrs/day | <input type="checkbox"/> Keyboarding | Not to exceed _____ hrs/day |

#### No Work Involving:

- |                |                            |                            |
|----------------|----------------------------|----------------------------|
| Hand/Wrist/Arm | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Leg            | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Foot/Ankle     | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Neck           | <input type="checkbox"/>   |                            |
| Back           | <input type="checkbox"/>   |                            |

#### Lift/Carry/Push/Pull Restrictions

- |  |                            |                            |
|--|----------------------------|----------------------------|
| <input type="checkbox"/> Not to exceed _____ lbs | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> No lifting/carrying     | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> No pushing/pulling      | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> No pinching             | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> No grasping/squeezing   | <input type="checkbox"/> R | <input type="checkbox"/> L |

#### Climbing Restrictions

- |                                    |                            |                            |
|------------------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> No ladder | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> No stairs | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> No ramp   | <input type="checkbox"/> R | <input type="checkbox"/> L |

#### Misc. Restrictions

- |  |
|--|
| <input type="checkbox"/> Wear splint/brace/sling/cast at work        |
| <input type="checkbox"/> Sitting only                                |
| <input type="checkbox"/> Must use crutches                           |
| <input type="checkbox"/> Walking/Standing as tolerated               |
| <input type="checkbox"/> No driving                                  |
| <input type="checkbox"/> No operating heavy equipment/moving machine |
| <input type="checkbox"/> No overhead work                            |

Other Restrictions (if any): \_\_\_\_\_

#### Expected Follow-up Services Include:

- ☒ Next Appointment Date: 3/16/18 Time: 8:15AM at Gurnee Office
- ☐ Diagnostic Studies Requested: \_\_\_\_\_
- ☐ Surgery Recommended: \_\_\_\_\_
- ☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_
- ☐ Referral to: \_\_\_\_\_
- ☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Adriana Cortez, CCMA



**Serafin DeLeon, MD**  
 350 S. Greenleaf, Ste 405~ Gurnee, IL 60031  
 Phone (847) 336-3335~ Fax (847) 336-3249

## WORKERS' COMP WORK STATUS REPORT

**Patient Name:** Cynthia L Levandoski  
**Employer:** Home Owner's Bargain Outlet  
**Occupation:**  
**Diagnosis:** Left wrist extensor carpi ulnaris tendinitis

**DOV:** 1/8/2019  
**MR#:** 1520501  
**Date of Injury:** 5/22/2017

- ☐ Employee can return to work as of \_\_\_\_\_ without restrictions.  
☐ Employee can return to work as of \_\_\_\_\_ with restrictions as identified below, which are expected to last through \_\_\_\_\_. If modified duty meeting these restrictions is not available, the patient should be considered off work.  
☒ Employee is unable to return to work as of 1/14/2019 and is expected to be off of work through \_\_\_\_\_.

☒ until next appointment (listed below) and will be assessed then.

OR: ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)  
☐ until surgery. (awaiting W/C approval)

### Posture/Motion Restrictions (if any):

- |   |                             |   |                             |
|---|-----------------------------|---|-----------------------------|
| <input type="checkbox"/> Bending/Stooping           | Not to exceed _____ hrs/day | <input type="checkbox"/> Overhead                       | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Climbing                   | Not to exceed _____ hrs/day | <input type="checkbox"/> Power Tools or Vibratory Tools | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Crawling                   | Not to exceed _____ hrs/day | <input type="checkbox"/> Pushing/Pulling                | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Exposure to Water/Oil/Dust | Not to exceed _____ hrs/day | <input type="checkbox"/> Reaching                       | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Extreme Hot/Cold           | Not to exceed _____ hrs/day | <input type="checkbox"/> Sitting                        | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Grasping                   | Not to exceed _____ hrs/day | <input type="checkbox"/> Squeezing                      | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Keyboarding                | Not to exceed _____ hrs/day | <input type="checkbox"/> Standing                       | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Kneeling/Squatting         | Not to exceed _____ hrs/day | <input type="checkbox"/> Twisting                       | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Lifting/Carrying           | Not to exceed _____ hrs/day | <input type="checkbox"/> Walking                        | Not to exceed _____ hrs/day |

<b>No Work Involving</b> Hand/Wrist/Arm <input type="checkbox"/> R <input type="checkbox"/> L Leg <input type="checkbox"/> R <input type="checkbox"/> L Foot/Ankle <input type="checkbox"/> R <input type="checkbox"/> L Neck <input type="checkbox"/> Back <input type="checkbox"/> <b>Climbing Restrictions</b>	<b>Lift/Carry/Push/Pull Restrictions</b> Not to exceed _____ lbs <input type="checkbox"/> R <input type="checkbox"/> L No lifting/carrying <input type="checkbox"/> R <input type="checkbox"/> L No pushing/pulling <input type="checkbox"/> R <input type="checkbox"/> L No Pinching <input type="checkbox"/> R <input type="checkbox"/> L No Grasping/squeezing <input type="checkbox"/> R <input type="checkbox"/> L <b>Weight Restrictions:</b>	<b>Misc. Restrictions</b> <input type="checkbox"/> Wear splint/brace/sling/cast at work <input type="checkbox"/> Sitting only <input type="checkbox"/> Must use <input type="checkbox"/> Walking/standing as tolerated <input type="checkbox"/> No driving <input type="checkbox"/> No operating heavy equip/machines <input type="checkbox"/> No overhead work
---	---	--

**Other Restrictions (if any):** \_\_\_\_\_

### Expected Follow-up Services Include:

- ☒ Next appointment date: 1/21/2019 Time: 12:15 pm Location: Gurnee-350 S. Greenleaf, Ste 405B  
☐ Diagnostic Studies Requested: \_\_\_\_\_  
☒ Surgery Recommended: left extensor carpi ulnaris release SURGERY DATE: 1/14/19  
☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_.  
☐ Referral to: \_\_\_\_\_  
☐ NONE: This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

*S. DeLeon*

Physician/Provider Digital Signature

Note prepared by: Melissa Villalobos

Date: 1/8/2019



left extensor  
carpi ulnaris  
release.



HAWTHORN SURGERY CENTER  
**Dr. DeLeon Hand, Wrist and Elbow**  
**POST-OPERATIVE HOME CARE INSTRUCTIONS**  
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**1. DIET:**

- ☒ Begin with liquids and light foods – Ginger Ale, soup, jello, etc. Progress to a normal diet, if there is no nausea. If nausea and vomiting continue, stay on liquids and call your physician.  
☐ No restrictions on diet.

**2. MEDICATIONS:**

☒ Resume all home medication(s), if applicable.

- ☐ Other instructions, if applicable: \_\_\_\_\_  
☒ Use prescription as directed. If you have any problems taking the prescription medication, notify your physician.  
☒ When taking pain medications be careful walking and climbing stairs. Dizziness is not unusual.  
 \*Pain medications may cause constipation. You may need a stool softener such as Senokot or Colace.  
☒ Side effects information for new medications given.  
☐ You have been prescribed OxyContin. It is a very powerful pain medication. Take it for severe pain not relieved by the Norco alone. **You must wait 4 hours between taking doses of Norco and OxyContin.**

Due to the side effects of most pain medications, if you have been diagnosed with sleep apnea and are prescribed a CPAP/BiPAP, it is **STRONGLY** advised to be compliant with use post operatively to avoid complications.

**3. ACTIVITIES:**

- ☒ Because of anesthesia, limit activities for 24 hours. Do not drive a motor vehicle, operate machinery, power tools or appliances. Do not make critical decisions. Do not sign any legal documents. Do not drink any alcoholic beverages.  
☐ Resume normal activities as tolerated  
☐ No activity restrictions  
☐ See additional instructions below/attached

**4. HAND THERAPY:**

- ☐ None until instructed further.  
☒ Several times a day, try to bend and straighten your fingers and move your wrist and elbow to prevent stiffness.

**5. DRESSING CARE:**

- ☒ You may remove your bandage in 5 days and get incision wet.  
☐ Do not remove your bandages. Wounds heal with the fewest problems if they are kept clean and dry. When bathing protect your bandage in a plastic bag.

**6. DANGER SIGNALS:**

Excessive pain, bleeding, swelling, temperature over 101 degrees, if extremity becomes cold to touch/tingly/numb, or there are ANY OTHER PROBLEMS IN REGARD TO YOUR SURGERY, please call your physician immediately.

**7. FOLLOW-UP APPOINTMENTS:**

- ☐ Post-operative appointment: 1 week Dr. DeLeon Location: \_\_\_\_\_

**ADDITIONAL INSTRUCTIONS:** \_\_\_\_\_

**WE STRIVE FOR EXCELLENCE! IF YOU HAD A POSITIVE EXPERIENCE WHILE AT HAWTHORN SURGERY CENTER, PLEASE GIVE US RATINGS OF "STRONGLY AGREE" OR 9s AND 10s ON YOUR PATIENT SATISFACTION SURVEY!**

A recovery room nurse will call you in a day or two. This is a routine call to find out how you are progressing after surgery. We wish you a pleasant and uneventful recovery.

Discharge instructions reviewed by

Date

Instructions understood by patient/authorized authority

Date

FM-06355 (07/17)



**Serafin DeLeon, MD**350 S. Greenleaf, Ste 405~ Gurnee, IL 60031  
Phone (847) 336-3335~ Fax (847) 336-3249**WORKERS' COMP WORK STATUS REPORT****Patient Name:** Cynthia L Levandoski**DOV:** 1/21/2019**Employer:** Home Owner's Bargain Outlet**MR#:** 1520501**Occupation:****Date of Injury:** 05/22/2017**Diagnosis:**

Left wrist extensor carpi ulnaris tendinitis status post left wrist extensor carpi ulnaris release

- ☐ Employee can return to work as of \_\_\_\_\_ without restrictions.
- ☐ Employee can return to work as of \_\_\_\_\_ with restrictions as identified below, which are expected to last through \_\_\_\_\_. If modified duty meeting these restrictions is not available, the patient should be considered off work.
- ☒ Employee is unable to return to work as of 1/21/2019 and is expected to be off of work through \_\_\_\_\_.  
     ☒ until next appointment (listed below) and will be assessed then.
- OR: ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)
- ☐ until surgery. (awaiting W/C approval)

**Posture/Motion Restrictions (if any):**

- |   |                             |   |                             |
|---|-----------------------------|---|-----------------------------|
| <input type="checkbox"/> Bending/Stooping           | Not to exceed _____ hrs/day | <input type="checkbox"/> Overhead                       | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Climbing                   | Not to exceed _____ hrs/day | <input type="checkbox"/> Power Tools or Vibratory Tools | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Crawling                   | Not to exceed _____ hrs/day | <input type="checkbox"/> Pushing/Pulling                | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Exposure to Water/Oil/Dust | Not to exceed _____ hrs/day | <input type="checkbox"/> Reaching                       | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Extreme Hot/Cold           | Not to exceed _____ hrs/day | <input type="checkbox"/> Sitting                        | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Grasping                   | Not to exceed _____ hrs/day | <input type="checkbox"/> Squeezing                      | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Keyboarding                | Not to exceed _____ hrs/day | <input type="checkbox"/> Standing                       | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Kneeling/Squatting         | Not to exceed _____ hrs/day | <input type="checkbox"/> Twisting                       | Not to exceed _____ hrs/day |
| <input type="checkbox"/> Lifting/Carrying           | Not to exceed _____ hrs/day | <input type="checkbox"/> Walking                        | Not to exceed _____ hrs/day |

<b>No Work Involving</b> Hand/Wrist/Arm <input type="checkbox"/> R <input type="checkbox"/> L Leg <input type="checkbox"/> R <input type="checkbox"/> L Foot/Ankle <input type="checkbox"/> R <input type="checkbox"/> L Neck <input type="checkbox"/> Back <input type="checkbox"/>	<b>Lift/Carry/Push/Pull Restrictions</b> Not to exceed _____ lbs <input type="checkbox"/> R <input type="checkbox"/> L No lifting/carrying <input type="checkbox"/> R <input type="checkbox"/> L No pushing/pulling <input type="checkbox"/> R <input type="checkbox"/> L No Pinching <input type="checkbox"/> R <input type="checkbox"/> L No Grasping/squeezing <input type="checkbox"/> R <input type="checkbox"/> L	<b>Misc. Restrictions</b> <input type="checkbox"/> Wear splint/brace/sling/cast at work <input type="checkbox"/> Sitting only <input type="checkbox"/> Must use <input type="checkbox"/> Walking/standing as tolerated <input type="checkbox"/> No driving <input type="checkbox"/> No operating heavy equip/machines <input type="checkbox"/> No overhead work
<b>Climbing Restrictions</b>	<b>Weight Restrictions:</b>	

**Other Restrictions (if any):** \_\_\_\_\_**Expected Follow-up Services Include:**

- ☒ Next appointment date: 2/20/2019 Time: 7:45 am Location: Gurnee-350 S. Greenleaf, Ste 405
- ☐ Diagnostic Studies Requested: \_\_\_\_\_
- ☐ Surgery Recommended: \_\_\_\_\_
- ☐ Rehab (PT/OT) Recommended: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks starting \_\_\_\_\_.
- ☐ Referral to: \_\_\_\_\_
- ☐ NONE: This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

**Physician/Provider Digital Signature**Date: 1/21/2019  
Note prepared by: Isabel Villarreal CCMA

# Northern District of Illinois Claims Register

## [18-30043 Belvidere Associates LLC](#)

**Honorable Judge:** Jacqueline P. Cox

**Chapter:** 11

**Office:** Eastern Division

**Last Date to file claims:**

**Trustee:**

**Last Date to file (Govt):**

*Creditor:* (27477857)

**Claim No:** 65

*Status:*

Cynthia Levandoski

*Original Filed*

*Filed by:* CR

c/o Fonfrias Law Group

*Date:* 01/24/2019

*Entered by:* Richard G. Fonfrias

125 S Wacker Dr. #300

*Original Entered*

*Modified:*

Chicago, IL 60606

*Date:* 01/24/2019

*Last Amendment*

*Filed:* 01/28/2019

*Last Amendment*

*Entered:* 01/28/2019

Amount claimed: \$75000.00

### *History:*

[Details](#) [65-1](#) 01/24/2019 Claim #65 filed by Cynthia Levandoski, Amount claimed: \$75000.00 (Fonfrias, Richard)

[Details](#) [65-2](#) 01/28/2019 Amended Claim #65 filed by Cynthia Levandoski, Amount claimed: \$75000.00 (Fonfrias, Richard)

### *Description:*

### *Remarks:*

## Claims Register Summary

**Case Name:** Belvidere Associates LLC

**Case Number:** 18-30043

**Chapter:** 11

**Date Filed:** 10/25/2018

**Total Number Of Claims:** 1

<b>Total Amount Claimed*</b>	\$75000.00
<b>Total Amount Allowed*</b>	

\*Includes general unsecured claims

**The values are reflective of the data entered. Always refer to claim documents for actual amounts.**



	<b>Claimed</b>	<b>Allowed</b>
<b>Secured</b>		
<b>Priority</b>		
<b>Administrative</b>		