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"NORWOOD"

BRAND

TO DUPLICATE THIS FOLDER ORDER

Globe-Wernicke

NO. 91-1/3

MADE IN U. S. A.

KE 0016537

DR. SIDNEY McCURDY,
SUPERVISOR OF
MEDICAL SECTION

WORKMEN'S COMPENSATION
THE INDUSTRIAL COMMISSION OF OHIO
MEDICAL SECTION
COLUMBUS

Dr. R. A. Kehoe
University of Cincinnati
College of Medicine
Cincinnati, Ohio

3-15-40

Claim No. OD 12362

NAME [redacted]

ADDRESS 411 Laurel St.

Transient Bureau

Cincinnati, Ohio

Dear Doctor:-

We are referring the above claimant to you for examination & diagnosis to determine the degree of disability now present, if any, due to occupational disease and advise as to treatment.

You may notify the claimant at the address given above when to appear at your office for this purpose.

We are enclosing, herewith entire file for review

which will give you a history of the case, as shown by our files. Kindly send your report in TRIPLICATE, together with your fee bill, direct to the Medical Section, as soon as possible. The extra form enclosed is for your files.
In preparing your report, please use the following subheadings in the order given:-

(1.) HISTORY—of injury and treatment, past medical history, previous injuries, family history (if applicable).

(2.) PATIENTS COMPLAINTS—describe in detail even if they have no apparent connection with the injury.

(3.) EXAMINATION—include all objective findings, clinical, laboratory and X-ray.

(4.) DISCUSSION—summary and treatment indicated.

(5.) OPINION—extent of disability (total or partial). If total how soon will he be able to work. If partial, estimate degree on percentage basis if possible.

Use the Form (C-111)enclosed and continue your report on the reverse if necessary.

Very truly yours,
DR. SIDNEY McCURDY,
Supervisor of Medical Section.

SMH:mpr

IN REPLYING, ALWAYS GIVE CLAIM NUMBER.
NOTIFY THE CHIEF IF YOUR INQUIRIES ARE NOT ANSWERED WITHIN TEN DAYS.

MED. 11—5M—5-39.