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Instructions for Completing the

Physician's Report

Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the appropriate check box (field) and use the tab key to navigate to the next field. To fill in a check box, click inside the box with your mouse. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers *only* to fill in the fields for Social Security # and phone and fax numbers . Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.

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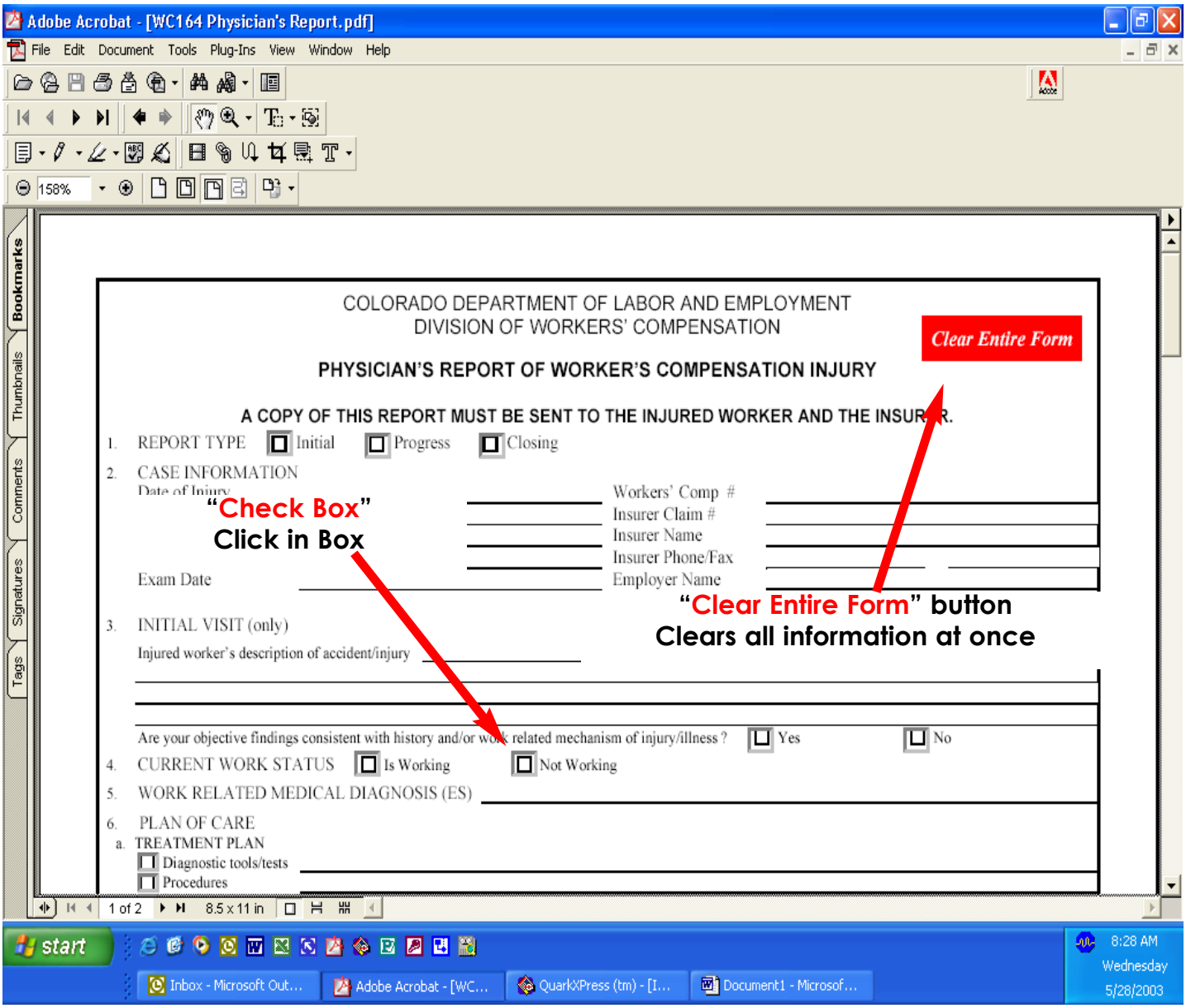

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Clear Entire Form

PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY

A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER AND THE INSURER.

1. REPORT TYPE ☐ Initial ☐ Progress ☐ Closing

2. CASE INFORMATION

Date of Injury _____ Workers' Comp # _____
Injured Worker's Name _____ Insurer Claim # _____
Social Security # _____ Insurer Name _____
Date of Birth _____ Insurer Phone/Fax _____ _____
Exam Date _____ Employer Name _____
Employer Phone/Fax _____ _____

3. INITIAL VISIT (only)

Injured worker's description of accident/injury _____

_____

_____

_____

Are your objective findings consistent with history and/or work related mechanism of injury/illness ? ☐ Yes ☐ No

4. CURRENT WORK STATUS ☐ Is Working ☐ Not Working

5. WORK RELATED MEDICAL DIAGNOSIS (ES) _____

6. PLAN OF CARE

a. TREATMENT PLAN

☐ Diagnostic tools/tests _____
☐ Procedures _____
☐ Therapy _____
☐ Medications _____
☐ Supplies _____
☐ Other _____

b. WORK STATUS

☐ Able to return to full duty on _____ ☐ Unable to work from _____ to _____
☐ Able to return to modified duty from _____ to _____ ☐ Able to return to part time work on _____ for _____ hrs per day

c. LIMITATIONS/RESTRICTIONS ☐ No Restrictions ☐ Temporary Restrictions ☐ Permanent Restrictions

☐ Lifting (maximum weight in pounds) _____ lbs.		☐ Walking _____	hours per day
☐ Repetitive lifting _____ lbs.		☐ Standing _____	hours per day
☐ Carrying _____ lbs.		☐ Sitting _____	hours per day
☐ Pushing / Pulling _____ lbs.		☐ Crawling _____	hours per day
☐ Pinching / Gripping _____		☐ Kneeling _____	hours per day
☐ Reaching over head		☐ Squatting _____	hours per day
☐ Reaching away from body		☐ Climbing _____	hours per day

☐ Repetitive Motion Restrictions _____

☐ Other _____

_____

_____

7. FOLLOW UP CARE AND REFERRALS

a. ☐ Return Appointment Date _____

b. ☐ Referral for ☐ Treatment (specify) _____ ☐ Evaluation (specify) _____
☐ Impairment Rating _____ ☐ Other (specify) _____

Referral Appointment to be made by ☐ Injured Worker ☐ Referring physician's office
Referred Provider's Name and Address _____ Phone Number _____

c. ☐ Discharged for non-compliance ☐ Discharged from care (explain) _____

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)

☐ Injured Worker has reached MMI Date _____
Maintenance care after MMI required? ☐ No ☐ Yes If yes, specify care _____

_____

☐ Injured Worker is not at MMI, but is anticipated to be at MMI in/on _____

☐ MMI date unknown at this time because _____

9. PERMANENT MEDICAL IMPAIRMENT

☐ No permanent impairment
☐ Anticipate permanent impairment
☐ Permanent Impairment (attach required worksheets and narrative)
☐ Needs referral to Level II physician for impairment rating (see 7 b above)

10. PHYSICIAN'S SIGNATURE _____ Date of Report _____

Print Name _____ License number _____

Address _____ Telephone Number _____

WC164 05/06

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INSTRUCTIONS / DEFINITIONS

The use of this form is required by the Workers' Compensation Rules Of Procedure Rule *16-7(E)(1), 7 CCR 1101-3* to report all information specific to this workers' compensation injury.

Complete all applicable fields and attach your narrative report that further describes and supports your findings. Your narrative report does not replace this form.

1. **Report Type:** Check "Initial" if this is the first visit related to this described injury. Check "Progress" when a change in condition, diagnosis, or treatment occurs. Check "Closing" if: injured worker is at MMI, requires an impairment rating, or is discharged from care.
2. **Case Information:**
   - **Date of Injury:** Date of this injury.
   - **Injured Worker's Name:** Name of the injured worker.
   - **Social Security #:** The injured worker's social security number.
   - **Date of Birth:** The injured worker's date of birth.
   - **Exam Date:** Date of office visit if applicable.
   - **Workers' Comp #:** The Workers' Compensation number assigned by the Division to the claim, if known.
   - **Insurer Claim #:** The claim number assigned by the insurance carrier or self-insured employer, if known.
   - **Insurer Name:** The name of the insurance carrier or self-insured employer associated with the claim.
   - **Insurer Phone/Fax:** The phone and fax numbers of the insurance carrier or self-insured employer associated with the claim.
   - **Employer Name:** The name of the employer associated with the claim.
   - **Employer Phone/Fax:** The phone and fax numbers of the employer.
3. **Initial Visit:**
   - Relate in injured worker's words description of accident/injury.
   - Check the applicable box regarding physician's objective findings.
4. **Current Work Status:** Current work status as related by injured worker.
5. **Work Related Medical Diagnosis(es):** State the injured worker's work related medical diagnosis(es).
6. **Plan of Care:**
   a. **Treatment Plan:** Complete all applicable portions regarding treatment. Indicate frequency and duration.
      - **Diagnostic tools/tests:** EMG, MRI, CT-scan, etc.
      - **Procedures:** Any medical procedure including surgical procedures, castings, etc.
      - **Therapy:** Physical therapy, occupational therapy, home exercise, etc., include plan specifications.
      - **Medications:** Antibiotics, analgesics, anti-inflammatory drugs, etc.
      - **Supplies:** Durable medical equipments, splints, braces, etc.
      - **Other:** Any treatment not covered above.

   b. **Work Status:** Check the applicable work status box(es). List date(s) and hours as appropriate.
   c. **Limitations/Restrictions:** Check the applicable box(es) regarding any medical or physical limitations or restrictions including temporary or permanent restrictions.
7. **Follow Up Care And Referrals:**
   a. Provide the date of the next scheduled appointment.
   b. If a referral was made to another provider, supply that provider's name, address, and phone number. Designate who is to make the referral appointment.
   c. Complete and explain applicable discharge information.
8. **Maximum Medical Improvement (MMI):** Check the applicable box(es). List additional information as appropriate. MMI means a point in time when any impairment resulting from the injury has become stable and when no further treatment is reasonably expected to improve the condition. Maintenance care is medical care subsequent to a finding of MMI which is designed to prevent further deterioration from the injury. In some cases MMI may be unknown because the injured worker has not returned for care.
9. **Permanent Medical Impairment:** Check the applicable box(es). If the injury will cause a permanent impairment, an impairment rating performed by a Level II accredited physician is required. If an impairment rating is given, attach the worksheets required by the Division and a report describing the extent of the injured worker's impairment rating.
10. **Physician Information:** List the name, license number, address, and telephone number of the physician responsible for the report. **The physician responsible for the report must sign and date the report.**

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