

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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

<input type="checkbox"/> Lifting (maximum weight in pounds) _____ lbs.	<input type="checkbox"/> Walking _____ hours per day
<input type="checkbox"/> Repetitive lifting _____ lbs.	<input type="checkbox"/> Standing _____ hours per day
<input type="checkbox"/> Carrying _____ lbs.	<input type="checkbox"/> Sitting _____ hours per day
<input type="checkbox"/> Pushing / Pulling _____ lbs.	<input type="checkbox"/> Crawling _____ hours per day
<input type="checkbox"/> Pinching / Gripping _____	<input type="checkbox"/> Kneeling _____ hours per day
<input type="checkbox"/> Reaching over head _____	<input type="checkbox"/> Squatting _____ hours per day
<input type="checkbox"/> Reaching away from body _____	<input type="checkbox"/> Climbing _____ hours per day
<input type="checkbox"/> 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 Permanent Impairment (attach required worksheets and narrative)
 Anticipate permanent impairment 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 _____

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.**