

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.**