

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 **EXAM DATE** _____

2. CASE INFORMATION
Date of Injury _____ Insurer Claim # _____
Injured Worker _____ Insurer Name/TPA _____
Social Security # _____ Insurer Phone/Fax _____
Date of Birth _____ Employer Name _____

3. INITIAL VISIT (only)
a. Injured worker's description of accident/injury _____

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

4. CURRENT WORK STATUS 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 _____
 Able to return to modified duty from _____ to _____
 Unable to work from _____ to _____
 Able to return to part time work on _____ for _____ hours 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 - *7c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)
a. Return Appointment Date _____
b. Referral for Treatment (specify) _____ Evaluation (specify) _____
 Impairment Rating _____ Other (specify) _____
 Referred Provider's Name _____ Phone # _____
c. Discharged for Non-Compliance* Discharged from Care for Nonmedical Reasons*

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)
 Injured Worker has reached MMI Date of MMI _____
 Injured Worker is not at MMI, but is anticipated to be at MMI in/on _____
 MMI date unknown at this time because _____

9. MAINTENANCE CARE AFTER MMI Yes No
If yes, specify care: _____

10. PERMANENT MEDICAL IMPAIRMENT (REQUIRED)
 No permanent impairment Permanent Impairment (attached required worksheets and narrative)
 Anticipate permanent impairment Needs referral to Level II physician for impairment rating (see 7b above)

11. PHYSICIAN'S SIGNATURE _____ Date of Report _____
Print Name _____ License # _____ Phone # _____

**PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY
INSTRUCTIONS / DEFINITIONS**

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 and Exam Date:** 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 the injured worker is at MMI, requires an impairment rating, or is discharged from care. On "Exam Date," include the date of the office visit, if applicable.
2. **Case Information:**
 - ♦ **Date of Injury:** Date of this injury.
 - ♦ **Injured Worker:** Name of the injured worker.
 - ♦ **Social Security #:** The injured worker's social security number.
 - ♦ **Date of Birth:** The injured worker's date of birth.
 - ♦ **Insurer Claim #:** The name of the insurance carrier or self-insured employer associated with the claim.
 - ♦ **Employer Name:** The name of the employer associated with the claim.
3. **Initial Visit:**
 - a. Describe how the accident or injury occurred in the injured worker's words.
 - b. 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 equipment, 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 and phone number. Designate who is to make the referral appointment.
 - c. If the authorized physician refuses to provide medical treatment to an injured worker or discharges the injured worker from medical care for nonmedical reasons when the injured worker requires medical treatment to cure and relieve the effects of the work injury, then the physician must, within three (3) business days from the refusal or discharge, provide written notice of the refusal or discharge by certified mail, return receipt requested, to the injured worker and insurer. The notice must explain the reasons for the refusal or discharge and must offer to transfer the injured worker's medical records to any new authorized physician upon receipt of a signed authorization to do so from the injured worker. For a template letter, flowchart, and information on reimbursement, refer to Desk Aid #15 on the Division website.
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.
9. **Maintenance Care after MMI:** In some cases, MMI may be unknown because the injured worker has not returned for care.
10. **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.
11. **Physician Information:** List the name, license number, and telephone number of the physician responsible for the report.
The physician responsible for the report must sign and date the report.