CompCHOICE

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Medical Treatment Report

To Be Completed And Sent Within 48 Hours After Each Patient Visit

Employee's Name: _____ Appt. Date: _____

SSN: _____-_____-_____ Date of Injury: _____ Employer: _____
Diagnosis: _____ ICD9: _____ Surgery Date: _____

Patient response to prescribed care: (Circle appropriate response)
"Since the last treatment, the patient is feeling…" #1 Better # 2 Worse #3 Same

RETURN-TO-WORK STATUS

1. RELEASE (check only one)

A. ☐ Patient is unable to return to work.
B. ☐ Full Duty Release: Employee has reached maximum medical improvement and is released from active medical care.
C. ☐ Full Duty Release Without Temporary Restrictions: Employee is able to work full duty without restrictions, but is not released from active medical care.
D. ☐ Light Duty Release With Temporary Restrictions: Employee has NOT reached maximum medical improvement (MMI) and can return to Light Duty Work with the following temporary restrictions: (COMPLETE SECTION II)
E. ☐ Will medication use prohibit driving or operation of heavy equipment? ☐ Yes ☐ No

RESTRICTIONS (check all that apply and describe fully under number 9 below)

2. ☐ No Restrictions ☐ Temporary Restrictions ☐ Permanent Restrictions

1.____Restricted lifting/carrying (maximum weight in pounds) 10____ 25____ 50____ Other____ Frequency _____
2.____Restricted pushing/pulling of _____ lbs.
3.____Restricted reaching: above chest _____ overhead ____ away from body ____
4.____Restricted to one-handed duty. No use of: right hand ____ left hand ____
5.____Restricted: walking ____ standing ____ sitting (describe fully) ____ partial weight bearing (describe fully) ____
6.____Wear splint at: all times ____ Work ____ Night (describe fully) ____
7.____No more than _____ repetitive movements per _____ day or _____ hour of:
Hand Grasp ☐L ☐R Wrist ☐L ☐R Elbow Flexion ☐L ☐R Shoulder ☐L ☐R Foot ☐L ☐R Torso Flexion ☐
8.____DO NOT: ☐ Operate Machinery ☐ Crawl ☐ Kneel ☐ Squat ☐ Drive any Vehicle ☐ Climb ☐ Bend ☐ Stoop
9.____FULLY DESCRIBE RESTRICTIONS (i.e. duration, nature of limitation, etc.) Supplement with extra pages if needed:

_____

Patient requires follow-up treatment with me on: _____

Patient referred to: _____ Appointment Date: _____ Time: _____

Physical Therapy: _____ times/per week for _____weeks.

Description of Treatment provided today: _____

Diagnostic Studies: (MRI, CT & EMG require pre-authorization from CompCHOICE) _____

_____

Medications: _____

PHYSICIAN NOTES: _____

_____

MMI is expected by: _____

Physician's Signature: _____ Date: _____