



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 Wrist Elbow Flexion Shoulder Foot 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: _____