



Health Care Provider Report

Patient Information

Employee Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Employer at time of injury: _____

Patient's subjective complaint regarding this injury: _____

Medical Information – Attach Additional Sheets if Necessary

Date of Injury: _____

Body Part and Nature of Injury: _____

Date of Examination: _____ Initial Visit Follow-up Visit

Diagnosis/Medical Condition: _____

This diagnosis/condition: is work related is not work related cause not yet determined

Provider's objective opinion regarding causal relationship: _____

Have diagnostic tests been performed: Yes No

Identify tests performed and results: _____

Treatment Plan: _____

Medications prescribed at this visit: _____

Other medications patient is taking as a result of this injury: _____

Work Capacity

May return to work with NO RESTRICTIONS May not return to work

May return to work with modified duty restrictions (see below)

Restrictions: _____

Health Care Provider Information

Name: _____

Address: _____

Phone Number: _____

Treatment Facility: _____

Health Care Provider's Signature

Date

Narratives/Test Results Attached: Yes No