



### 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