

# Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Physicians shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/Review Date:	FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth:	5. Social Security #:
6. <input type="checkbox"/> a) NO <input type="checkbox"/> b) YES This report is for the initial visit with this physician.		7. Date of Accident:

## SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

8.  No change in Items 9 - 12d since last reported visit. GO TO SECTION II.

9. Injury/ Illness for which treatment is sought is:

a) NOT WORK RELATED  b) WORK RELATED  c) UNDETERMINED as of this date

10. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.

a) NO  b) YES  c) UNDETERMINED as of this date

If YES or UNDETERMINED, explain: \_\_\_\_\_

11. Diagnosis(es): \_\_\_\_\_

12. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 10.

a) Is there a pre-existing condition contributing to the current medical disorder?

a<sub>1</sub>) NO  a<sub>2</sub>) YES  a<sub>3</sub>) UNDETERMINED as of this date

b) Do the objective relevant medical findings identified in Item 10 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?

b<sub>1</sub>) NO  b<sub>2</sub>) YES  b<sub>3</sub>) UNDETERMINED as of this date

c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?

c<sub>1</sub>) NO  c<sub>2</sub>) YES

d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:

d<sub>1</sub>) NO  d<sub>2</sub>) YES the reported medical condition?  
 d<sub>3</sub>) NO  d<sub>4</sub>) YES the treatment recommended (management/treatment plan)?  
 d<sub>5</sub>) NO  d<sub>6</sub>) YES the functional limitations and restrictions determined?

## SECTION II MANAGEMENT / TREATMENT PLAN

13. No change in Items 15a - 15g since last report submitted. GO TO SECTION III

14. No clinical services indicated at this time.

15. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.

\*\*\* THIS IS A WRITTEN REQUEST FOR AUTHORIZATION BY THE INSURER. \*\*\*

a) Consultation with or referral to a specialist. Identify principal physician: \_\_\_\_\_

Identify specialty & provide rationale: \_\_\_\_\_

a<sub>1</sub>) CONSULT ONLY  a<sub>2</sub>) REFERRAL & CO-MANAGE  a<sub>3</sub>) TRANSFER CARE

b) Diagnostic Testing: (Specify) \_\_\_\_\_

c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:

c<sub>1</sub>) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.

c<sub>2</sub>) Physical Reconditioning (Level II Patient Classification)

c<sub>3</sub>) Interdisciplinary Rehabilitation Program (Level III Patient Classification)

Specific instruction(s): \_\_\_\_\_

d) Pharmaceutical(s) (specify): \_\_\_\_\_

e) DME or Medical Supplies: \_\_\_\_\_

f) Surgical Intervention - specify procedure(s): \_\_\_\_\_

f<sub>1</sub>) In-Office: \_\_\_\_\_

f<sub>2</sub>) Surgical Facility: \_\_\_\_\_

f<sub>3</sub>) Injectable(s) (e.g. pain management): \_\_\_\_\_

g) Attendant Care: \_\_\_\_\_

## SECTION III PATIENT CLASSIFICATION LEVEL

16. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment - correlates to the specific findings.

17. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment -physical reconditioning and functional restoration.

18. LEVEL III - Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment - interdisciplinary rehabilitation and management.

19. LEVEL UNDETERMINED AS OF THIS DATE.

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Patient Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Visit/Review Date: \_\_\_\_\_

**SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS**

*Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.*

- 20. No functional limitations identified or restrictions prescribed as of this date or future date: \_\_\_\_\_.
- 21. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of this date or future date: \_\_\_\_\_.
- 22. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part \_\_\_\_\_ Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
<input type="checkbox"/> Stand			
<input type="checkbox"/> Walk			
<input type="checkbox"/> Climb			
<input type="checkbox"/> Sit			
<input type="checkbox"/> Push			
<input type="checkbox"/> Kneel			
<input type="checkbox"/> Lift-floor > waist			
<input type="checkbox"/> Reach-overhead			
<input type="checkbox"/> Carry			
<input type="checkbox"/> Pull			
<input type="checkbox"/> Lift-waist>overhead			
<input type="checkbox"/> Grasp			
<input type="checkbox"/> Twist			
<input type="checkbox"/> Bend			
<input type="checkbox"/> Squat			
<input type="checkbox"/> Other			
<input type="checkbox"/> Other			

**COMMENTS:**

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

*NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date. Specify those functional limitations and restrictions which are permanent if MMI / PIR have been assigned in Item 23.*

**SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING**

23. Patient has achieved maximum medical improvement?  
 a) YES, Date: \_\_\_\_\_  b) NO  c) Anticipated MMI date: \_\_\_\_\_  
 d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: e)  Yes f)  No  
 Comments: \_\_\_\_\_

24. \_\_\_\_\_ % Permanent Impairment Rating (body as a whole) Body part/system: \_\_\_\_\_

25. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):  
 a) 1996 FL Uniform PIR Schedule  b) Other, specify \_\_\_\_\_

26. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?  
 a) YES  b) NO

**SECTION VI FOLLOW-UP**

27. Next Scheduled Appointment Date & Time: \_\_\_\_\_

**SECTION VI ATTESTATION STATEMENT**

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient. I certify to any MMI / PIR information provided in this form."

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_ (print name) Physician DOH License #: \_\_\_\_\_  
 Physician Specialty: \_\_\_\_\_

**If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:**

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: \_\_\_\_\_ Provider DOH License #: \_\_\_\_\_  
 Provider Name: \_\_\_\_\_ (print name) Date: \_\_\_\_\_