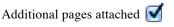
# State of California Division of Workers' Compensation



# PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

Periodic Report (required 45 days after last report)		nge in treatment plan	Released from	care
Change in work status	Need for referral or consultation	Response to request for information		
Change in patient's condition	Need for surgery or hospitalization	Request for authorization		
Other:				
Patient:				•
Last: Doe	First: John	M.I.: M		Sex: Male
Address: Employee Address	City: Employee City	State: CA	Zip: 96570	
Date of Injury: 11/11/2015	Date of Birth: 11/01/1985			
Occupation: Computer/Tech	SS#: 123-45-6789	Phone: Home: (123) 456-7890 Cell: (123) 777-6666 Work: (123) 456-8900		
Claims Administrator:				
Name: Jen Williams, Joe Denham		Claim Number: 2346789XY		
Address: 567 Insurance Blvd.	City: Santa Rosa	State: CA	Zip: 91840	
Phone: (567) 890-3133 ext. 2	·	Fax: (324) 567-8905		
Email: jen@fourfivesix.com				
Employer name: Ace Computers		Employer phone: (123) 456-3235		

The information below must be provided. You may use this form or you may substitute or append a narrative report.

## **History of Injury/Illness:**

Mr. John Doe is a right-handed 30 year-old male who worked at Ace Computers at the time of his injury. His industrial injury occurred on 11/11/2015. At the time of his injury, patient had worked 3 years at his job. The location of the injury/condition was the office. His right shoulder was injured due to lifting. The injury/condition was reported to: supervisor. After the injury occurred, he continued working.

## **Subjective Complaints:**

Mr. Doe and I discuss his current complaints.

## Shoulder - Right

He reports that he has no symptoms associated with this injury and is not experiencing any pain.

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture)). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

## Shoulder - Right

Treatment is indicated for the right shoulder. Ibuprofen (Motrin, Advil) (600 mg) is prescribed.

Work Status: Return to clinic: Yes. 1 month.	
Ability to Resume Usual and Customary Occupation The employee can return to his occupation.	

#### **Documentation:**

I declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report.

I verify under penalty of perjury that the total time I spend on the following activities is true and correct:

## **Primary Treating Physician:**

Date of Exam: 11/15/2015

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor

Code 139.3.

Signature:

Executed at: Contra Costa

Name: Claire Williams

Address: 653 Alhambra St., Crockett, 94525, CA, US

e-signed by Claire Williams, MD

Cal. Lic. # D12456

Date: 12/05/15, 3:22 p.m.

Specialty: Family Medicine

Phone: (707) 799-6326