

Doctor's Initial Report

C-4

State of New York - Workers' Compensation Board

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board and to the insurance carrier. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.state.ny.us.

A. Patient's information				
1. Name:		2. Social Security	/ #:	
Last	First MI			
3. Home pnone #:	4. WCB Case # (if known)	5. Carrier Case	4 (II KIIOWII)	
6. Mailing address:	Number and Street	Citv	State	Zip Code
7. Date of injury/onset of illness:			der: Male	Female
0. On the date of injury/illness what w	vas the patient's job title or description:			
1. On the date of injury/illness what w	vere the patient's usual work activities:			
B. Employer Information				
Employer when injury occured		2. Ph	one #:	
	Company/Agency Name			
2. Employer Address.				
3. Employer Address:	Number and Street	City	State	Zip Code
	Number and Street	City	State	Zip Code
. Doctor's Information	Number and Street	2. WCB Autho		·
Doctor's Information 1. Your name: Last	Number and Street First MI	2. WCB Autho	orization #:	
. Doctor's Information 1. Your name: 3. You are a (check one): Physic	Number and Street First MI cian Podiatrist Chiropractor 4. V	2. WCB Autho	orization #:	
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Doctor's Information 1. Your name: 3. You are a (check one): Physic 5. Office address: 6. Billing address:	Number and Street First MI cian Podiatrist Chiropractor 4. V Number and Street Number and Street	2. WCB Author/CB Rating Code: City City	orization #:State	Zip Code Zip Code
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Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

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□ Pain □ Weakness □ Stiffness □ Other (specify) Type/nature of injury: Check all that apply and identify specific affected body part(s). □ Abrasion □ Infectious Disease □ Amputation □ Inhalation Exposure □ Avulsion □ Laceration □ Bite □ Needle Stick □ Burn □ Poisoning/Toxic Effects □ Contusion/Hematoma □ Psychological □ Crush Injury □ Puncture Wound □ Dermatitis □ Repetitive Strain Injury □ Dislocation □ Spinal Cord Injury □ Fracture □ Sprain/Strain □ Hearing Loss □ Torn Ligament, Tendon or Muscle □ Hernia □ Vision Loss	Pain	Pat	ient's	subje	ective	comp	laints	Chec	k all th	nat apply and id	dentify specific a	ffected body pa	rt(s).			
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Amputation	Amputation	\Box	Abras	sion								Infectious Dise	ase			
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Hearing Loss Torn Ligament, Tendon or Muscle Vision Loss	Hearing Loss Torn Ligament, Tendon or Muscle Hernia Vision Loss Other (specify)		Fractu	ure								Sprain/Strain				
Hernia Vision Loss	Hernia Vision Loss Other (specify)		Heari	ng Lo								Torn Ligament,	Tendon or Musc	cle		
	Other (specify)	_										Vision Loss				
			Other	(spe	cifv)											
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	.0 (9-08) Page 2 of 4			` '	-											

atient's Name:	Date of injury/onset of illness:
4. Physical examination: Check all relevant objective file	
	Navasanias Findiasa
Bruising	Neuromuscular Findings: Abnormal/Restricted ROM
Burns	
Crepitation	
Deformity	Tassive NOW
Edema	Gail
Hematoma/Lump/Swelling	Paipable Muscle Spasm
Joint Effusion	Retiexes
Laceration/Sutures	
Pain/Tenderness_	Strength (Weakness)
Other findings:	
b. Describe any diagnostic test(s) rendered at this visit: _	
6. Describe any treatment(s) rendered at this visit:	
o. Describe any treatment(s) rendered at this visit.	
7. Describe prognosis for recovery:	
	ting condition(s) that may affect the treatment and/or prognosis? Yes No
If yes, list and describe:	
Destade Oninies	
6. Doctor's Opinion	aniha al tha a commetent mandical acuse of this injury/illegac?
	cribed the competent medical cause of this injury/illness? Yes No
2. Are the patient's complaints consistent with his/her h3. Is the patient's history of the injury/illness consistent	
, , , , , , , , , , , , , , , , , , , ,	
4. What is the percentage (0-100%) of temporary impai	
5. Describe findings and relevant diagnostic test results	S:
. Plan of Care	
1. What is your proposed treatment:	
2. Medication(s):(a) list medications prescribed:	
(b) list over-the-counter medications ad	lvised:
Medication restrictions: None May affect p	patient's ability to return to work, make patient drowsy, or other issue. Explain below:
	•
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Patient's Name: Last First	Date of injury/onset of illness:
3. Does the patient need diagnostic tests or referrals?	
Tests:	Referrals:
CT Scan	Chiropractor
EMG/NCS	Internist/Family Physician
MRI (specify):	Occupational Therapist
Labs (specify):	Physical Therapist
X-rays(specify):	
Other (specify):	Other (specify):
Assistive devices prescribed for this patient: Other (specify):	
Important: You must fill out form C-4 AUTH to request any	special medical service over \$1000 that is not on the pre-authorized procedures list
5. When is the patient's next follow-up appointment? Within a week 1-2 weeks 3-4 weeks 5	
·	your evaluation and treatment of this injury/illness? Yes No
If yes, identify applicable sections of Treatment Guidelines	:
If no, explain why not, including the basis for any variance	from the Guidelines:
I. Work Status	
1 Has the patient missed work because of the injury/illness?	Yes No If yes, date patient first missed work:
	_ ·
	, did the patient return to: usual work activities limited work activities
2. Can the patient return to work? (check only one):	
a. The patient cannot return to work because (exp	lain):
b. The patient can return to work without limitations	s on
c. The patient can return to work with the following	limitations (check all that apply) on
	Lifting Sitting
	Operating heavy equipment Standing
	Operation of motor vehicles Use of public transportation
	Personal protective equipment Use of upper extremities
Describe/quantify the limitations:	
How long will these limitations apply?	3-7 days 8-14 days 15+ days Unknown at this time N/A
•	d/or limitations? with patient with patient's employer N/A
This form is signed under penalty of perjury.	
Board Authorized Health Care Provider - Check one:	
☐ I provided the services listed above. ☐ I actively supervised the health-care provider named below	ow who provided these services.
Provider's name	
Board Authorized Health Care Provider signature:	оренацу
Name Signature	Specialty Date
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