Patient's Name: _____ Date of injury/onset of illness: _____
Last First MI

E. History

1. Based on the patient's history, where and how did the injury/illness happen: _____

2. How did you learn about the injury/illness (*check one*): ☐ Patient ☐ Medical Records ☐ Other(*specify*): _____

3. Did another health provider treat this injury/illness including hospitalizaton and/or surgery? ☐ Yes ☐ No If yes, give details:

4. Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☐ No If yes, when: _____

F. Exam Information

1. Date(s) of Examination: _____

2. Patient's subjective complaints: *Check all that apply and identify specific affected body part(s)*.

☐ Numbness/Tingling _____ ☐ Swelling _____
☐ Pain _____ ☐ Weakness _____
☐ Stiffness _____ ☐ Other (*specify*) _____

3. 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 _____
☐ Other (*specify*) _____

Patient's Name: _____ Date of injury/onset of illness: _____
Last First MI

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- ☐ None at present
- ☐ Bruising _____
- ☐ Burns _____
- ☐ Crepitation _____
- ☐ Deformity _____
- ☐ Edema _____
- ☐ Hematoma/Lump/Swelling _____
- ☐ Joint Effusion _____
- ☐ Laceration/Sutures _____
- ☐ Pain/Tenderness _____
- ☐ Scar _____
- ☐ Other findings: _____

- ☐ Neuromuscular Findings:
  - ☐ Abnormal/Restricted ROM
    - ☐ Active ROM _____
    - ☐ Passive ROM _____
  - ☐ Gait _____
  - ☐ Palpable Muscle Spasm _____
  - ☐ Reflexes _____
  - ☐ Sensation _____
  - ☐ Strength (Weakness) _____
  - ☐ Wasting/Muscle Atrophy _____

5. Describe any diagnostic test(s) rendered at this visit: _____

6. Describe any treatment(s) rendered at this visit: _____

7. Describe prognosis for recovery: _____

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No
If yes, list and describe: _____

G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☐ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? _____%
5. Describe findings and relevant diagnostic test results: _____

H. Plan of Care

1. What is your proposed treatment? _____

2. Medication(s):(a) list medications prescribed: _____
(b) list over-the-counter medications advised: _____

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:

Patient's Name: _____ Date of injury/onset of illness: _____
Last First MI

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:

- ☐ CT Scan
- ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals:

- ☐ Chiropractor
- ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in _____
- ☐ Other (*specify*): _____

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair
☐ 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 ☐ 5-6 weeks ☐ 7-8 weeks ☐ _____ months ☐ Return as needed

6. Did you adhere to the New York Treatment Guidelines for 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: _____

Is the patient currently working? ☐ Yes ☐ No If yes, 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 (explain): _____

b. ☐ The patient can return to work without limitations on _____

c. ☐ The patient can return to work with the following limitations (check all that apply) on _____

- ☐ Bending/twisting
- ☐ Climbing stairs/ladders
- ☐ Environmental conditions
- ☐ Kneeling
- ☐ Lifting
- ☐ Operating heavy equipment
- ☐ Operation of motor vehicles
- ☐ Personal protective equipment
- ☐ Sitting
- ☐ Standing
- ☐ Use of public transportation
- ☐ Use of upper extremities
- ☐ Other (explain): _____

Describe/quantify the limitations: _____

_____

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's return to work and/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 who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

_____ _____ _____ _____
Name Signature Specialty Date