



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
DIVISION OF WORKERS' COMPENSATION

**MEDICAL TREATMENT FORM**

P.O. BOX 58  
JEFFERSON CITY,  
MO 65102-0058

**INJURY NUMBER**

NOTE: THIS FORM MUST BE TYPED OR HAND PRINTED IN BLACK INK.

**INJURED WORKER INFORMATION**

1. NAME OF INJURED PERSON Last First		2. SOCIAL SECURITY NUMBER	3. DATE OF INJURY
4. NAME OF EMPLOYER			
5. NAME OF INSURANCE CARRIER			
6. DESCRIPTION OF HOW INJURY OCCURRED AS RELATED BY INJURED PERSON _____			
7. DATE OF FIRST TREATMENT		8. BODY PART	

**TREATMENT INFORMATION**

9. DESCRIBE TREATMENT GIVEN BY YOU		10. DID EMPLOYEE HAVE SURGERY? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. HOSPITALIZATION? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES," PROVIDE NAME AND ADDRESS OF HOSPITAL _____ Admission Date _____ Discharge Date _____		
12. PHYSICAL REHABILITATION PRESCRIBED? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. REFERRAL TO ANOTHER DOCTOR? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES," NAME AND ADDRESS	

**RETURN TO WORK INFORMATION**

14. DATE LOST TIME BEGAN FROM WORK _____ <input type="checkbox"/> RELEASED TO RTW WITHOUT PHYSICAL RESTRICTIONS <input type="checkbox"/> RELEASED TO RTW WITH PHYSICAL RESTRICTIONS <input type="checkbox"/> PERMANENT RESTRICTIONS <input type="checkbox"/> TEMPORARY RESTRICTIONS – DURATION		15. DATE RELEASED TO RETURN TO WORK _____ DESCRIBE THE RESTRICTIONS	
16. IS ADDITIONAL MEDICAL TREATMENT NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES," PROGNOSIS			17. NEXT APPOINTMENT DATE
18. DOCTOR'S RATING IF ANY: _____ % (percentage) OF THE _____ (body part) AT THE _____ (week level).			
19. TOTAL COST OF MEDICAL \$ _____ IS THE FINAL COST. <input type="checkbox"/> Yes <input type="checkbox"/> No			

**PHYSICIAN INFORMATION**

20. PHYSICIAN NAME (Type or Print) Last First		21. LICENSE NUMBER	
22. PHYSICIAN ADDRESS	CITY	STATE	ZIP CODE
23. PHYSICIAN SIGNATURE	24. TELEPHONE NUMBER ( )		25. DATE

*ATTACH A BRIEF NARRATIVE WITH THE FINAL REPORT, IF APPROPRIATE.*

The Division defines a "brief narrative" as the following "not to exceed a maximum of five (5) pages describing the course of treatment, the diagnosis, the evaluation for permanent injury and the need for future medical treatment, if any".