

Division of Workers' Compensation

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

Check the box(es) 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 Form PR-3 or IMC Form 81556.

Form with checkboxes for: Periodic Report, Change in treatment plan, Discharged, Change in work status, Need for referral or consultation, Info. requested by, Change in patient's condition, Need for surgery or hospitalization, Other.

Patient:

Form for patient information: Last, First, M.I., Sex, Address, City, State, Zip, Date of Injury, Date of Birth, Occupation, SS #, Phone.

Claims Administrator:

Form for claims administrator information: Name, Claim Number, Address, City, State, Zip, Phone, FAX.

Employer name:

Employer Phone ()

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

Subjective complaints:

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Diagnoses:

Form for diagnoses: 1. ICD-9, 2. ICD-9, 3. ICD-9

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?

Work Status: This patient has been instructed to:

Form with checkboxes for work status: Remain off-work until, Return to modified work on, Return to full duty on.

Primary Treating Physician: (original signature, do not stamp)

Date of exam:

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.

Form for signature and contact information: Signature, Executed at, Name, Address, Next report due no later than, Cal. Lic. #, Date, Specialty, Phone.