



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT



Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

FORM 3S - PHYSICIAN'S SUPPLEMENTAL REPORT

For Help and Information, call (202) 442-HELP (4357)

Completion and submission of this form is necessary to maintain continued entitlement to benefits.

PATIENT INFORMATION

Name: _____

Telephone: _____

Address (with unit number, zip code):

E-mail : _____

Employing Agency: _____

Claim Number: _____

SSN: _____ DOB: _____

Occupation: _____

Date of Injury/Illness: _____

Injured at: _____

Time of Injury/Illness: _____

Date of First Exam/Treatment: _____

Date Last Worked: _____

Time of First Exam/Treatment: _____

PHYSICIAN INFORMATION

Name: _____

Office Contact: _____

Office Address (with unit number, zip code):

Federal Tax ID No.: _____

Telephone: _____

E-mail: _____

Practice Name: _____

Fax: _____

Date of Examination: _____

Date Evaluation Completed: _____

1. **SUBJECTIVE COMPLAINTS.** *Describe fully. Use additional paper, if necessary.*

2. **OBJECTIVE FINDINGS.** *Use additional paper, if necessary.*

2a. Physical Examination Summary:

FORM 3S – PHYSICIAN'S SUPPLEMENTAL REPORT

Claimant Name:

Claim No.:

Blood Pressure	☐ Normal	☐ Abnormal	Neck	☐ Normal	☐ Abnormal
Weight	☐ Normal	☐ Abnormal	Thoracic	☐ Normal	☐ Abnormal
Abdomen	☐ Normal	☐ Abnormal	Lumbosacral	☐ Normal	☐ Abnormal
Chest/Lungs	☐ Normal	☐ Abnormal	Heart	☐ Normal	☐ Abnormal
Ear, Eyes, Nose	☐ Normal	☐ Abnormal	Appearance/ Mental Status	☐ Normal	☐ Abnormal
Throat, Mouth					

X-Ray Taken? ☐ Yes ☐ No Findings Available? ☐ Yes ☐ No Attached? ☐ Yes ☐ No

X-Ray Date and Diagnosis: _____

Labs Completed? ☐ Yes ☐ No Results Available? ☐ Yes ☐ No Attached? ☐ Yes ☐ No

3. TREATMENT *Use additional paper, if necessary.*

3a. Describe treatment rendered.

3b. If further treatment is required, specify treatment plan/estimated duration.

3c. If hospitalized as inpatient, give hospital name and location.

Date Admitted

Estimated Stay

3d. Treatment plan.

- ☐ Diagnostic tools/tests _____
- ☐ Procedures _____
- ☐ Therapy _____
- ☐ Medications _____
- ☐ Supplies _____
- ☐ Other _____

3e. Does the claimant need diagnostic tests or referrals?

☐ Yes ☐ No

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): _____

All referrals, high-cost diagnostic procedures, x-rays, MRI's physical therapy, occupational therapy, work hardening, surgery, and pain management **MUST BE PRE-APPROVED**. Contact the Program to initiate pre-certification. Pre-certification is **NOT** required for physician office visits, durable medical equipment and routine laboratory testing.

3f. Prognosis for recovery:

3g. Assistive device prescribed for this claimant: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair

☐ Other (specify): _____

FORM 3S – PHYSICIAN’S SUPPLEMENTAL REPORT

Claimant Name: _____

Claim No.: _____

4. MAXIMUM MEDICAL IMPROVEMENT (MMI)

- ☐ Patient has reached MMI Date of MMI _____
- ☐ Patient is not at MMI, but is anticipated to be at MMI in/on _____
- ☐ MMI date is unknown at this time because _____

4a. Maintenance care after MMI ☐ Yes ☐ No If yes, specify care: _____

5. PERMANENT MEDICAL IMPAIRMENT (REQUIRED AT DISCHARGE OR RELEASE *PRO RE NATA*)

- ☐ No permanent impairment ☐ Permanent Impairment (Attach completed Form 3M and include supporting narrative)
- ☐ Anticipate permanent impairment ☐ Permanent Impairment not known at this time
(attach narrative explaining basis)

6. WORK STATUS

(i) Is patient able to work? ☐ Yes ☐ No

If yes, ☐ Without restrictions ☐ With restrictions until _____

Is patient able to perform sedentary work? ☐ Yes ☐ No

If no, Patient is unable to work from _____ to _____ and _____

- ☐ can return to Regular work on _____ , _____
- ☐ can return to Modified work on _____ , or _____
- ☐ ability to return to Regular or Modified work is dependent on next medical evaluation, which is scheduled for _____

6a. Limitations/Restrictions: ☐ No Restrictions ☐ Temporary Restrictions ☐ Permanent Restrictions

- | | |
|---|--|
| ☐ Lifting (maximum weight in pounds) _____ lbs. | ☐ Walking _____ hours per day |
| ☐ Repetitive lifting _____ lbs. | ☐ Standing _____ hours per day |
| ☐ Carrying _____ lbs. | ☐ Sitting _____ hours per day |
| ☐ Pushing/Pulling _____ lbs. | ☐ Crawling _____ hours per day |
| ☐ Pinching/Gripping ☐ Yes ☐ No | ☐ Kneeling _____ hours per day |
| ☐ Reaching away from body ☐ Yes ☐ No | ☐ Squatting _____ hours per day |
| ☐ Overhead reaching ☐ Yes ☐ No | ☐ Climbing _____ hours per day |
| ☐ Repetitive Motion Restriction ☐ Yes ☐ No | ☐ Driving _____ hours per day |
| ☐ Other _____ | |

7. DOCTOR’S OPINION

7a. Is the claimant’s injury/illness causally related to his/her work activities? Explain. _____

Physician’s Signature: _____ License/Reg#: _____

Return this form to **ORM by email, regular mail or fax** to the address below.

Office of Risk Management

**One Judiciary Square, 441 Fourth Street, NW, Suite 800 South
Washington, D.C. 20001**

Email: wcsecure@dc.gov

Fax: (202) 535-1130