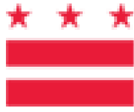

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 3 - PHYSICIAN'S REPORT

For Help and Information, call (202) 727-8600

Completion and submission of this form is required to file a claim for benefits with the Public Sector Workers' Compensation Program (PSWCP). This form must be returned to the PSWCP within ten (10) calendar days of an examination of the injured employee.

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 Report Completed:** ____________

1. **DESCRIBE HOW THE INCIDENT HAPPENED. Patient to complete this portion, if able to do so.** Otherwise, physician please complete immediately. *Use additional paper, if necessary.*

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

FORM 3 – PHYSICIAN'S REPORT

Claimant Name: ______________________ **Claim No.:** __________

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

3a. History of work related injury/illness reported by patient? ☐ Yes ☐ No If "yes," explain.

3b. History of previous injuries or pre-existing conditions reported by patient? ☐ Yes ☐ No If "yes," list conditions.

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

4a. Physical Examination Summary:

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 Throat, Mouth	☐ Normal	☐ Abnormal	Appearance/ Mental Status	☐ Normal	☐ Abnormal

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

X-Ray Diagnosis: ______________________________

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

4b. Describe mechanism of injury:

5. **WORK-RELATED DIAGNOSIS.** (*If occupational illness, specify etiologic agent and duration of exposure.*) *Use additional paper, if necessary. Chemical or toxic compounds involved?* ☐ Yes ☐ No

5b. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☐ Yes ☐ No If "no," explain.

5c. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ No If "yes," explain.

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

6a. Describe treatment rendered.

6b. If further treatment is required, specify treatment plan/estimated duration.

FORM 3 – PHYSICIAN'S REPORT

Claimant Name: ______________________ **Claim No.:** __________

6c. If hospitalized as inpatient, give hospital name and location.	Date Admitted	Estimated Stay

6d. Treatment plan.
☐ Diagnostic tools/tests ______________________
☐ Procedures ______________________
☐ Therapy ______________________
☐ Medications ______________________
☐ Supplies ______________________
☐ Other ______________________

6e. 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, MRIs 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.

6f. Prognosis for recovery:

6g. Assistive device prescribed for this claimant: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair
☐ Other (specify): ______________________

7. **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 ______________________
____

7a. Maintenance care after MMI ☐ Yes ☐ No If yes, specify care:______________________
____

8. **PERMANENT MEDICAL IMPAIRMENT (REQUIRED AT DISCHARGE OR RELEASE PRN)**
☐ No permanent impairment ☐ Permanent Impairment (attach completed Form 3M and include supporting narrative)
☐ Anticipate permanent impairment ☐ Permanent Impairment not known at this time.

9. **WORK STATUS**
(i) Is patient able to work? ☐ Yes ☐ No
If yes, ☐ Without restrictions ☐ With restrictions until ____/____/____.
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 ____/____/____.

FORM 3 – PHYSICIAN'S REPORT

Claimant Name: ______________________ **Claim No.:** __________

9a. 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 ____

____

10. **DOCTOR'S OPINION**

10a. Is the claimant's injury/illness causally related to his/her work activities? ☐ Yes ☐ No Explain basis for answer.

10b. For a recurrence claim, state the original work-place injury/illness and diagnosis. Provide the causal relationship between the present diagnosed condition(s) and the original work-place injury/illness.

10c. Are the patient's complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No Explain basis for answer.

Physician's Signature:________________________ License/Reg#: ________________

Return this form to **ORM/PSWCP by mail, in person, e-mail or fax**. You may return the form in person, weekdays between 8:30 a.m. and 5:00 p.m., or by mail to the following address. You will need photo identification to enter the building:

Office of Risk Management
One Judiciary Square
441 Fourth Street, NW, Suite 800 South
Washington, D.C. 20001
E-mail: dcclaims@corvel.com
Fax: (866) 539-9712