GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 3-S - PHYSICIAN'S SUPPLEMENTAL REPORT

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

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:

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 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 devised prescribed for this claimant: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair
☐ Other (specify): _____

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 required worksheets and 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			

☐ Other _____

_____

7. **DOCTOR'S OPINION**

7a. Is the claimant's injury/illness causally related to his/her work activities? ☐ Yes ☐ No If "yes," explain.

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

Return this form to **ORM by email, regular mail, fax or in person**. 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
c/o CorVel Corporation
One Judiciary Square
441 Fourth Street, NW, Suite 800 South
Washington, D.C. 20001

Email: dcclaims@corvel.com
FAX: (866) 539-9712