ATTENDING DOCTOR'S FINAL REPORT

☐ Worker's Comp ☐ Private Pay ☐ Group Ins. ☐ Other _____

Employee: _____ Employer: _____

Date of Injury: _____ Date of Final Exam: _____ Claim # _____

1. Current Diagnosis: _____

_____

2. Subjective Complaints: _____

_____

3. Status:
   - ☐ Currently under rehabilitative care.
   - ☐ Currently under periodic care to relieve recurrent symptoms.
   - ☐ Currently under preventative maintenance care.
   - ☐ Patient was self-dismissed from care pre-maturely as of _____
   - ☐ Patient has fully recovered to a pre-injury status as of _____
   - ☐ Patient has reached a permanent and stationary status as of _____
   - ☐ Other _____
4. Prognosis:
   - ☐ Patient has no residual impairment.
   - ☐ Patient has partial impairment of _____
   - ☐ Patient has total impairment of _____
   - ☐ Other _____
5. Disability:
   - ☐ Patient has lost no time from work due to this condition.
   - ☐ Patient has/will return to work on (date) _____
     - ☐ Full time
     - ☐ Part time; specify hours per day/week: _____
     - ☐ Modified Work. Specify restrictions: _____

     _____
     - ☐ Patient is permanently precluded from engaging in his/her usual occupation. Specify activity restrictions:

     _____

     _____
6. Evaluate patient's response to date: _____

   _____
7. Future treatment needed; indicate nature, extent and duration of future care: _____

   _____

   _____
8. Comments: _____

   _____
9. Disability Evaluation Attached ☐ Yes ☐ No
10. Final Billing Attached ☐ Yes ☐ No

Doctor's Name _____ Phone _____

Address _____

Signature _____ Date _____

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