

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

Check the boxes 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 Forms PR-3 or PR-4.

- Periodic Report (Required 45 days after last report) Change in treatment plan Release From Care
Change in work status Need for referral or consultation Response to request for information
Change in patient's condition Need for surgery or hospitalization Request for authorization
Other

Patient

Patient last name: Patient first name: MI

Patient Street Address/PO Box Patient City State Zip Code Sex

Occupation Phone Number Date of Birth

Claims Administrator Date of Injury

Claims Administrator Name Claim number

Claims Administrator Street Address/ Claims Administrator City State Zip Code

Phone Number Fax Number Employer Name Phone Number

Subjective Complaints (The information below must be provided. You may use this form or you may substitute or append a narrative report):

Large empty box for subjective complaints.

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

Large empty box for objective findings.

Diagnoses:

- 1. ICD-10 7. ICD-10
2. ICD-10 8. ICD-10
3. ICD-10 9. ICD-10
4. ICD-10 10. ICD-10
5. ICD-10 11. ICD-10
6. ICD-10 12. ICD-10

**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:

Remain off-work until \_\_\_\_\_

Return to *modified* work on \_\_\_\_\_ with the following limitations or restrictions. (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

Return to full duty on \_\_\_\_\_ with no limitations or restrictions.

**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 section 139.3.

Physician signature \_\_\_\_\_

Cal. License Number: \_\_\_\_\_

Executed at: \_\_\_\_\_

Date (mm/dd/yyyy): \_\_\_\_\_

Physician Name \_\_\_\_\_

Specialty: \_\_\_\_\_

Physician address: \_\_\_\_\_

Phone Number \_\_\_\_\_

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: [http://www.dir.ca.gov/od\\_pub/privacy.html](http://www.dir.ca.gov/od_pub/privacy.html).