Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/Review Date:	FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth:	5. Social Security #:
6. Date of Accident:	7. Employer Name	8. Initial visit with this physician? ☐ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☐ **No change in Items 9 - 13d since last reported visit. If checked, GO TO SECTION II.**

10. **Injury/ Illness for which treatment is sought is:**
☐ **a) NOT WORK RELATED** ☐ **b) WORK RELATED** ☐ **c) UNDETERMINED as of this date**

11. **Has the patient been determined to have Objective Relevant Medical Findings?** Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ **a) NO** ☐ **b) YES** ☐ **c) UNDETERMINED as of this date**
If YES or UNDETERMINED, explain:

12. **Diagnosis(es):**

13. **Major Contributing Cause:** When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.
a) Is there a pre-existing condition contributing to the current medical disorder?
☐ **a_1) NO** ☐ **a_2) YES** ☐ **a_3) UNDETERMINED as of this date**
b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ **b_1) NO** ☐ **b_2) exacerbation** ☐ **b_3) aggravation** ☐ **b_4) UNDETERMINED as of this date**
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ **c_1) NO** ☐ **c_2) YES**
d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:
☐ **d_1) NO** ☐ **d_2) YES** **the reported medical condition?**
☐ **d_3) NO** ☐ **d_4) YES** **the treatment recommended (management/treatment plan)?**
☐ **d_5) NO** ☐ **d_6) YES** **the functional limitations and restrictions determined?**

SECTION II PATIENT CLASSIFICATION LEVEL

☐ 14. **LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.**

☐ 15. **LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment: physical reconditioning and functional restoration.**

☐ 16. **LEVEL III - Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.**

☐ 17. **LEVEL UNDETERMINED AS OF THIS DATE.**

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. **No clinical services indicated at this time. If checked, GO TO SECTION IV**

☐ 19. **No change in Items 20a - 20g since last report submitted. If checked, GO TO SECTION IV**

20. **The following proposed, subsequent clinical service(s) is/are deemed medically necessary.**
***** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. *****

☐ **a) Consultation with or referral to a specialist. Identify principal physician:**
Identify specialty & provide rationale:
☐ **a_1) CONSULT ONLY** ☐ **a_2) REFERRAL & CO-MANAGE** ☐ **a_3) TRANSFER CARE**

☐ **b) Diagnostic Testing: (Specify)**

☐ **c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:**
☐ **c_1)** Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ **c_2)** Physical Reconditioning (Level II Patient Classification)
☐ **c_3)** Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s):

☐ **d) Pharmaceutical(s) (specify):**

☐ **e) DME or Medical Supplies:**

☐ **f) Surgical Intervention - specify procedure(s):**
☐ **f_1)** In-Office:
☐ **f_2)** Surgical Facility:
☐ **f_3)** Injectable(s) (e.g. pain management):

☐ **g) Attendant Care:**

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Patient Name: **Soc.Sec.#:** **D/A:** **Visit/Review Date:**

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☐ **21** No functional limitations identified or restrictions prescribed as of the following date: _____.

☐ **22.** The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: _____. ***Use additional sheet if needed.***

☐ **23.** The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part . Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist>overhead			
☐ Pull			
☐ Push			
☐ Reach-overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐			
☐ Other			

COMMENTS:

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.

Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?

☐ **a)** YES, Date: _____ ☐ **b)** NO ☐ **c)** Anticipated MMI date: _____

☐ **d)** Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: **e)** ☐ Yes **f)** ☐ No

Comments:

25. _____ **%** Permanent Impairment Rating (body as a whole) **Body part/system:**

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):

☐ **a)** 1996 FL Uniform PIR Schedule ☐ **b)** Other, specify _____

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?

☐ **a)** YES ☐ **b)** NO ☐ **c)** Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time:

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient." *"I certify to any MMI / PIR information provided in this form."*

Physician Group: PARAMOUNT URGENT CARE **Date:**

Physician Signature: **Physician DOH License #:**

Physician Name: (print name) **Physician Specialty:** EMERGENCY MEDICINE

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: **Provider DOH License #:**

Provider Name: (print name) **Date:**