

1 I.D. NUMBER

PHYSICIANS INITIAL REPORT

2 CLAIM NUMBER

MAIL TO EMPLOYER'S SERVICE REP.

TULALIP TRIBES OF WASHINGTON  
ATTN: DEAN HENRY/CHRISTINA DICK  
6700 TOTEM BEACH RD.  
MARYSVILLE WA 98271

3a NAME OF EMPLOYER'S SERVICE REPRESENTATIVE

WARD/TRIBAL FIRST  
4313 6TH AVENUE SE, SUITE A  
LACEY, WA 98503

EMPLOYER'S TELEPHONE NO. EMPLOYER'S SERVICE REP PHONE  
1-877-777-8039

Physician — START HERE

17 Date patient first seen by you for this injury/condition

a ICDM-9 CODE b Diagnosis - Specify Right / Left

18 Are there objective findings to support this diagnosis  
 No  Yes, Specify

19a Referred for Diagnostic Studies (X-Ray)  
 No  Yes, Specify

b Referred for Diagnostic Studies (Lab)  
 No  Yes, Specify

c Other Studies & Findings

d Remarks

**PATIENT INFORMATION**

4 NAME OF INJURED WORKER: FIRST MIDDLE LAST 5 WORKER'S TELEPHONE NO.

6 MAILING ADDRESS 7 SOCIAL SECURITY NUMBER

8 CITY STATE ZIP CODE 9 DATE OF BIRTH

10 DATE OF INJURY 11 TIME A.M. P.M. 12 SEX 13 MARITAL STATUS / DEPENDENTS

14 Worker Statement of Incident

15 Signature 16 Date

20 Answer to the best of your knowledge

a HAS WORKER EVER BEEN TREATED FOR PRESENT OR SIMILAR CONDITION? YES NO

b IS THERE ANY PRE-EXISTING IMPAIRMENT OF THE AREA INJURED? YES NO

c WILL ANY PRE-EXISTING CONDITION COMPLICATE TREATMENT OR RETARD RECOVERY? YES NO

d IS THE CONDITION DIAGNOSED THE RESULT OF THE INCIDENT DESCRIBED ON A MORE PROBABLE THAN NOT BASIS? YES NO

21 Treatment Provided / Ordered

a) Type YES NO

Drugs Rx'd

Chiropractic / osteopath adjustment

Casted

Sutured

Surgery

Hospitalized

Where? \_\_\_\_\_

b) If further treatment needed, date of next visit \_\_\_\_\_

22 Employment Information

a) Can this Worker return to regular work? Yes  No  When \_\_\_\_\_

b) Can this Worker return to light duty? Yes  No  When \_\_\_\_\_

c) What restrictions are placed on RTW?  
Lifting \_\_\_\_\_ Bending \_\_\_\_\_  
Standing \_\_\_\_\_ Sitting \_\_\_\_\_  
Other \_\_\_\_\_

d) Estimate Time Loss in Days:

23 Referred to: Address  
Dr. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Licensed Physician must sign before report is accepted  
24 Signature

25 Phone 26 Date

27 Physician Name (Print or Type)

28 Address

Zip

30 IRS Account #

DO NOT SEND THIS FORM TO  
LABOR & INDUSTRIES