

1. I.D. NUMBER

PHYSICIANS INITIAL REPORT

MAIL TO EMPLOYER'S SERVICE REP.

2. CLAIM NUMBER

3. NAME OF EMPLOYER		PATIENT INFORMATION				
		4. NAME OF INJURED WORKER FIRST MIDDLE LAST		5. WORKER'S TELEPHONE NO.		
		6. MAILING ADDRESS		7. SOCIAL SECURITY NO.		
3A. NAME OF EMPLOYER'S SERVICE REPRESENTATIVE		8. CITY STATE ZIP		9. DATE OF BIRTH		
Tribal First 4313 6th Ave. SE, Ste. A Lacey, WA 98503		10. DATE OF INJURY	11. TIME (AM/PM)	12. SEX	13. MARITAL STATUS/ DEPENDANTS	
		14. WORKER STATEMENT OF INCIDENT				
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		15. SIGNATURE			16. DATE	
A. ICDM-9 CODE	B. DIAGNOSIS - SPECIFY RIGHT/LEFT					
		20. ANSWER TO THE BEST OF YOUR KNOWLEDGE				
		20A. HAS WORKER EVER BEEN TREATED FOR PRESENT OR SIMILAR CONDITIONS? YES <input type="checkbox"/> NO <input type="checkbox"/>		20C. WILL ANY PRE-EXISTING CONDITION COMPLICATE TREATMENT OR RETARD RECOVERY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
		20B. IS THERE ANY PRE-EXISTING IMPAIRMENT OF THE AREA INJURED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20D. IS THE CONDITION DIAGNOSED THE RESULT OF THE INCIDENT DESCRIBED ON A MORE PROBABLE THAN NOT BASIS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
		21. TREATMENT PROVIDED/ORDERED		22. EMPLOYEE INFORMATION		
18. ARE THERE OBJECTIVE FINDINGS TO SUPPORT THIS DIAGNOSIS <input type="checkbox"/> NO <input type="checkbox"/> YES, SPECIFY		A.) TYPE		A.) CAN THIS WORKER RETURN TO REGULAR WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO, WHEN _____		
		DRUGS RX'D <input type="checkbox"/> YES <input type="checkbox"/> NO		B.) CAN THIS WORKER RETURN TO LIGHT DUTY? <input type="checkbox"/> YES <input type="checkbox"/> NO, WHEN _____		
		CHIROPRACTIC / OSTEOPATH ADJUSTMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		C.) WHAT RESTRICTIONS ARE PLACED ON RTW? LIFTING _____ BENDING _____		
		CASTED <input type="checkbox"/> YES <input type="checkbox"/> NO		STANDING _____ SITTING _____		
		SUTURED <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER _____		
		SURGERY <input type="checkbox"/> YES <input type="checkbox"/> NO		D.) ESTIMATE TIME LOSS IN DAYS: _____		
		HOSPITALIZED <input type="checkbox"/> YES <input type="checkbox"/> NO				
		WHERE? _____				
		B.) IF FURTHER TREATMENT NEEDED, DATE OF NEXT VISIT _____				
19A. REFERRED FOR DIAGNOSIS STUDIES (X-RAY) <input type="checkbox"/> NO <input type="checkbox"/> YES, SPECIFY		23. REFERRED TO ADDRESS				
		DR. _____				
		CITY STATE ZIP PHONE				
19B. REFERRED FOR DIAGNOSIS STUDIES (LAB) <input type="checkbox"/> NO <input type="checkbox"/> YES, SPECIFY		LICENSED PHYSICIAN MUST SIGN BEFORE REPORT IS ACCEPTED			DO NOT SEND THIS FORM TO LABOR & INDUSTRIES	
		24. SIGNATURE				
19C. OTHER STUDIES & FINDINGS		25. PHONE		26. DATE		
		27. PHYSICIAN NAME (PRINT OR TYPE)				
		28. ADDRESS				
		ZIP				
19D. REMARKS		30. IRS ACCOUNT #				