

REASON FOR REPORT CIRCLE ONE INITIAL PROGRESS FINAL	M-1 PRACTITIONER'S REPORT STATE OF MAINE WORKERS' COMPENSATION BOARD Office of Medical/Rehabilitation Services	TYPE OF PRACTITIONER CIRCLE ONE MD DO DC LIST OTHER _____
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EMPLOYEE

EMPLOYER NAME:		EMPLOYEE LAST NAME:		FIRST NAME:		M.I.:	
EMPLOYER MAILING ADDRESS & PHONE #:		ADDRESS - NUMBER AND STREET:					
INSURER NAME:		CITY:		STATE:	ZIP:	HOME PHONE:	
INSURER MAILING ADDRESS:		DATE OF INJURY:		SSN:			
PATIENT'S COMPLAINTS:							

PRACTITIONER

ICD-9 CODE: _____

IN MY OPINION, THIS PROBLEM IS WORK RELATED NOT WORK RELATED IS NOT YET IDENTIFIED AS TO CAUSE HAVE DIAGNOSTIC TESTS BEEN PERFORMED? YES NO RESULTS: _____

DATE OF THIS EXAMINATION : ___ / ___ / ___ IS TREATMENT TO CONTINUE? YES NO

DATE PATIENT TO BE SEEN AGAIN: ___ / ___ / ___ ESTIMATED LENGTH OF TREATMENT? _____

TREATMENT PLAN: _____

LIST ANY MEDICATION PRESCRIBED FOR THIS DIAGNOSIS/CONDITION THAT WOULD PREVENT YOUR PATIENT FROM DRIVING AND/OR WORKING SAFELY: _____

IF UNABLE TO WORK, ADVISE ESTIMATED DATE OF RETURN : ___ / ___ / ___ P.I. RATING : ___ / ___ / ___

WORK CAPACITY: REGULAR DUTY MODIFIED DUTY NO WORK CAPACITY

RESTRICTIONS	DESCRIBE:
YES/NO	

IS PERMANENT IMPAIRMENT EXPECTED? YES NO

HAS MMI BEEN REACHED? YES NO

 SIGNATURE OF PRACTITIONER
 TELEPHONE #: _____

 PRINT NAME AND ADDRESS
 NARRATIVES ATTACHED? YES NO