

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

Check the box(es) 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 Form PR-3 or IMC Form 81556.

<input type="checkbox"/> Periodic Report (required 45 days after last report)	<input type="checkbox"/> Change in treatment plan	<input type="checkbox"/> Released from care
<input type="checkbox"/> Change in work status	<input type="checkbox"/> Need for referral or consultation	<input type="checkbox"/> Response to request for information
<input type="checkbox"/> Change in patient's condition	<input type="checkbox"/> Need for surgery or hospitalization	<input type="checkbox"/> Other:

**Patient:**

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Injury \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Claims Administrator:**

Name \_\_\_\_\_ Claim Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

**Employer name:**

Employer Phone (\_\_\_\_) \_\_\_\_\_

The information below must be provided. You may use this form or you may substitute or append a narrative report.

**Subjective complaints:**

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

**Diagnoses:**

1. \_\_\_\_\_ ICD-9 \_\_\_\_\_  
2. \_\_\_\_\_ ICD-9 \_\_\_\_\_  
3. \_\_\_\_\_ ICD-9 \_\_\_\_\_

**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 § 139.3.

Signature: \_\_\_\_\_ Cal. Lic. # \_\_\_\_\_  
Executed at: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Next report due no later than \_\_\_\_\_