

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION MEDICAL REPORT

\_\_\_\_ Initial  
\_\_\_\_ Interim  
\_\_\_\_ Final

**FAILURE TO SUBMIT THIS REPORT TO THE INSURER WILL JEOPARDIZE PAYMENT OF FEES**

Employee Name (First) (Middle) (Last)				Employee's Phone Number		Social Security Number	
Employee's Street Address		City	State	Zip	Date of Injury		
Employer				Insurer			
Address				Address			
City	State	Zip	Phone	City	State	Zip	Phone

1. Date disability began		2. Date of first treatment		3. Services authorized by ____ Employer ____ Dr. ____ Other	
4. Patient's history					
5. Findings from examination					
6. Describe diagnosis				ICD-9 Code	
7. Describe the treatment					
8. Prognosis					
9. Date of maximum recovery		10. Doctors estimate of length of disability		11. Catastrophic Case Management recommended	
12. Date discharged as cured		13. Date patient stopped treatment without an order		14. Date patient refused treatment	
15. a. Date patient able to return to work without restrictions _____ b. Date patient able to return to work with restrictions _____ c. List any restrictions _____				16. Hospital name and address if hospitalized	
17. Does employee have any permanent disability? ____ Yes ____ No If any vision or hearing loss, see other side of form. If yes, specify the part of body _____ Percentage based upon AMA Guides _____ %					
Date of Service	CPT Code	Medical and Surgical Services and Drug (Itemize)	Units	Amount	
18. Doctor's Name and Address			19. Doctor's FEI/SSN		

By \_\_\_\_\_  
(Signature of Doctor) (Date) (Phone)

**FILE THREE (3) COPIES WITH INSURER OR SELF-INSURER (PLEASE TYPE)**

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to \$10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

IF EMPLOYEE HAS ANY LOSS OF VISION OR HEARING, PLEASE GIVE THE AMOUNT OF DISABILITY

VISION READ ON UNCORRECTED VISUAL ACUITY		HEARING	Left ear	_____ 500	_____ 1K	_____ 2K
_____ right eye	_____ left eye		Right ear	_____ 500	_____ 1K	_____ 2K

By: \_\_\_\_\_  
(Signature of Doctor) (Date)