



INITIAL VISIT MEDICAL STATUS REPORT

(To be completed by physician)

Please complete and return to _____ -.

Patient's Name: _____

Patient's Address: _____

Name of Employer: _____ Date of Accident or Illness: ____/____/____

Patient's description of how accident or exposure occurred: _____

Name of Medical Facility: _____ Date of Visit: _____

Diagnosis: _____

New Injury/Illness

Existing Condition

Recommended work status:

May return to full duty beginning: ____/____/____

May return to modified duty beginning: ____/____/____

- What restrictions have been placed on the employee/patient?

- Does condition preclude travel to and from work? Yes No

- Anticipate return to full duty beginning: ____/____/____

Unable to work at this time

- Anticipate return to modified duty beginning: ____/____/____

- Anticipate return to full duty beginning: ____/____/____

Physician's Comments (Please note any contributing factors, prior injuries and pre-existing conditions): _____

Follow-Up Appointment with: _____ Date: ____/____/____ Time: _____ am/pm

Physician Name (please print): _____ Phone #: _____

Physician Signature: _____