

SELF-INSURERS MEDICAL PROGRESS REPORT / SIF-IO

Date: _____

PATIENT: _____ CLAIM NUMBER: _____

EMPLOYER: _____ DATE OF INJURY: _____

INJURY/ACCEPTED CONDITION:

Our last report from you covers treatment through _____

1. Are you still treating this patient for this injury? Yes () No ()

Date of last treatment: _____

2. Please list your diagnosis, clinical findings, complaint, and treatment since last report. If progress is delayed, please explain.

3. Will further treatment be necessary? Yes () No ()

4. Is worker released for work? Yes () No ()

If yes, give date: _____

Regular Work () Modified Work () If modified, give limitations.

5. If not released, estimate length of further disability:

Days: _____ Weeks: _____ Months: _____

6. Is inability to work due solely to the industrial condition? Yes () No ()

7. Is the worker's condition medically fixed? Yes () No ()

If yes, give date: _____

8. Will any permanent impairment result from this injury? Undetermined () Yes () No ()

If undetermined, please explain:

If yes, will you accomplish the necessary report, or would you prefer to refer patient to another physician for examination and report? _____

9. Remarks: _____

Signature: _____ Date: _____

Physicians Name: _____

Physicians Address: _____

RETURN TO: Adjudicator
Washington Hospital Services, PO Box 19557, Seattle, WA 98109