Reset Form

PHYSICIAN'S REPORT

State Form 2118 (R4 / 8-11)

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204-2753
Telephone: (317) 232-3808

* This agency is requesting disclosure of your Social Security number in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

INSTRUCTIONS: Page 1 of this form is for the examination; page 2 is for Permanent Partial Impairment (PPI).

PATIENT INFORMATION

Social Security number *	Name of injured employee	Age	Sex ☐ Male ☐ Female
Address *(number and street, city, state, and ZIP code)*			
Name of employer			Date of this report (*month, day, year*)
Address *(number and street, city, state, and ZIP code)*			

ACCIDENT INFORMATION

Date of injury (*month, day, year*)	Time of injury / illness / exposure	☐ AM ☐ PM
Briefly describe accident / exposure as reported by worker		

PHYSICIAN'S FINDINGS - *Please attach causation.*

State objective findings of injury / illness / exposure

Ability to work

☐ Unable to work beginning _____ until _____. ☐ Able to work with restrictions beginning _____ until _____. ☐ Able to work full duty effective _____.

Is this the only cause of patient's condition? *(If No, state contributing causes)*

☐ Yes ☐ No

In your opinion, are the worker's current symptoms a result of the injury described above? ☐ Yes ☐ No	If no, did the injury aggravate, exacerbate, or accelerate a pre-existing condition? ☐ Yes ☐ No

Has normal recovery been delayed for any reason? *(If Yes, please explain)*

☐ Yes ☐ No

Medical status ☐ Maximum Medical Improvement (MMI) ☐ Disabled	If MMI, date achieved *(month, day, year)*

If disabled, type:

☐ Partial but temporary ☐ Totally but temporary ☐ Totally and permanent

ATTENDING PHYSICIAN TREATMENT

Date of your first treatment (*month, day, year*)	Who engaged your services?

Describe treatment given or ordered by you

Was patient treated by a previous physician? *(If Yes, by whom, give name)* ☐ Yes ☐ No			Date treated (*month, day, year*)
Was patient hospitalized? ☐ Yes ☐ No	Name of hospital	Date of admission (*month, day, year*)	Date of discharge (*month, day, year*)

Is further treatment needed? *(If Yes, please explain)*

☐ Yes ☐ No

(Check one)

Patient ☐ was ☐ will be able to resume regular work on _____ (*month, day, year*).

(Check one)

Patient ☐ was ☐ will be able to resume light duty work on _____ (*month, day, year*). *Please explain any restrictions below.*

If there is permanent impairment as a result of this injury / illness / exposure, please give body part affected, degree of impairment and other pertinent information. *(If there is an amputation to the hand or the foot, please indicate the point of amputation on one of the diagrams below.)*

☐ Thumb _____%	☐ Toe, Great _____%	☐ Hand below elbow _____%	☐ Loss of vision to <1/10 normal _____%
☐ Finger 1 _____%	☐ Toe 2 _____%	☐ Arm above elbow _____%	☐ Loss of eye _____%
☐ Finger 2 _____%	☐ Toe 3 _____%	☐ Foot below knee _____%	☐ Hearing, left or right _____%
☐ Finger 3 _____%	☐ Toe 4 _____%	☐ Leg below knee _____%	☐ Hearing, both ears _____%
☐ Finger 4 _____%	☐ Toe 5 _____%	☐ Spine _____%	☐ Testicle loss, one _____%
			☐ Testicle loss, both _____%

To calculate the PPI amount, multiply the degree value by the percentage of loss. Multiply the result by the appropriate dollar amount for the date of injury. If an amputation, double the value.

Remarks: *(Use this section for an independent medical examination report or give any information of value not included above i.e. history, prognosis, or work restrictions of the patient.)*

Is this report submitted as an independent medical examination? ☐ Yes ☐ No

Is further treatment necessary? *(If necessary, please explain response in the remarks section above. Supplemental reports may be submitted with this form.)* ☐ Yes ☐ No

Signature of physician	Date (*month, day, year*)
Printed name of physician	Telephone number ( )

Address of physician *(number and street, city, state, and ZIP code)*

PPI rating provided according to _____ Ed. AMA guidelines.