PRINT CLEAR

State of California
Division of Workers' Compensation

Additional pages attached ☐

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

Check the boxes 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 Forms PR-3 or PR-4.

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ 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?

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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:_____