Print Form | Reset Form

State of California

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 ☐ Release 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

Patient last name: | Patient first name: | MI

Patient Street Address/PO Box | Patient City | State | Zip Code | Sex

Occupation | Phone Number | Date of Birth

Claims Administrator

Date of Injury

Claims Administrator Name | Claim number

Claims Administrator Street Address/ | Claims Administrator City | State | Zip Code

Phone Number | Fax Number | Employer Name | Phone Number

Subjective Complaints (The information below must be provided. You may use this form or you may substitute or append a narrative report):

Objective findings: *(Include significant physical examination, laboratory, imaging, or other diagnostic findings.)*

Diagnoses:

1.		ICD-10		7.		ICD-10	
2.		ICD-10		8.		ICD-10	
3.		ICD-10		9.		ICD-10	
4.		ICD-10		10.		ICD-10	
5.		ICD-10		11.		ICD-10	
6.		ICD-10		12.		ICD-10	

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?

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 section 139.3.

Physician signature _____ Cal. License Number: _____

Executed at: _____ Date *(mm/dd/yyyy)*: _____

Physician Name _____ Specialty: _____

Physician address: _____ Phone Number _____

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: http://www.dir.ca.gov/od_pub/privacy.html.