

§9785.2. Form PR-2 "Primary Treating Physician's Progress Report."

State of California
Division of Workers' Compensation

Additional pages attached

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

Check the box(es) 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 Form PR-3 or IMC Form 81556.

- Periodic Report (required 45 days after last report) Change in treatment plan Released from care Discharged
- Change in work status Need for referral or consultation Response to request for information
- Info. requested by _____
- Change in patient's condition Need for surgery or hospitalization 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?)

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: _____

Next report due no later than _____

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Note: Authority Cited: Sections 139.5, 4061.5, 4603.2, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4061.5, 4600, 4603.2 and 4636, Labor Code.