§9785.2. Form PR-2 “Primary Treating Physician’s Progress Report.”

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
- 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)
- Signature:
- Cal. Lic. #
- Executed at:
- Date:
- Name:
- Specialty:
- Address:
- Phone:

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: ___________________________

DWC Form PR-2 (Rev. 4/4/04 5/03)

(Use additional pages, if necessary)