SUPPLEMENTAL REPORT

Insurance Company _____

Address _____

Employee Name _____ Date of Injury _____

Claim No. _____ Adjustor _____

Employer _____

Treatment for the month of _____

DIAGNOSIS (ICD-9-CM codes) _____

_____

_____

EXTENT OF INJURY: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

PRESENT STATUS: ☐ Acute ☐ Chronic ☐ Flare-up ☐ Aggravation ☐ Improving
☐ Condition resolved (pre-injury) ☐ Permanent & Stationary

PROGNOSIS: ☐ Excellent ☐ Fair ☐ Good ☐ Probable residual

TREATMENT: ☐ Manipulation ☐ Ultrasound ☐ Diathermy ☐ Traction
☐ Massage ☐ Corrective exercises ☐ Electrical stimulation
☐ Orthotics ☐ Wet heat ☐ Cryotherapy ☐ Hydrotherapy
☐ Infrared ☐ Other _____

FURTHER TREATMENT RECOMMENDED DURING THE NEXT MONTH:
☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 times ☐ 6 times
☐ 7 times ☐ 8 times ☐ 9 times ☐ 10 times ☐ 11 times ☐ 12 times
Then re-evaluation.

DISABILITY STATUS: ☐ Working Date returned to work _____
☐ Temporary total disability Date estimated to return to work _____
☐ Permanent and Stationary
☐ Other _____

REMARKS: _____
_____
_____
_____
_____
_____
_____

Doctor's name typed _____ Date _____

Address _____

Doctor's Signature _____

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