Entered ☐

United Occupational Medicine
Workers' Compensation PPO Patient Management Record

Provider: Upon completion of the information below, please fax (607) 762-2433 or toll-free (866) 234-8753.

★ *REQUIRES COMPLETION BY PROVIDER.*

Provider Name & Location (Please Print)			Appointment Date: ____/____/____ Time ____:____ am/pm
Patient Name:	SS #:	ICD-9 Code: ★	Injury Date: ____/____/____ Initial Visit Date: ____/____/____
★ Office Procedure Codes - (CPT4):			
★ Diagnosis:			Employer:
Patient Description of Injury:			
★ Treatment Rendered:			

CPT CODING INFORMATION

★ **Patient Profile** ☐ New Patient ☐ Established Patient **Type of Visit** ☐ Brief ☐ Limited ☐ Intermediate ☐ Comprehensive

RECOMMENDATIONS

★ Patient may return to work full duty. ☐ YES ☐ NO

★ First Day of Disability____/___/___	Is Patient Working? ☐ YES ☐ NO	Is the patient disabled from regular duties? ☐ YES ☐ NO
★ Disability: ☐ NONE ☐ TOTAL ☐ **Partial Disability** please ✔ ❍ mild ❍ moderate ❍ marked	Has patient reached Maximal Medical Improvement? ☐ YES ☐ NO	**If no, when will the patient be seen again?** Date:_____/_____/_____ Time:__________

★ Functional Work Capabilities:

___ **NO** Bending Stooping Twisting Squatting Kneeling Lifting Pushing Pulling Climbing Crouching Over Head Work Repetitive Wrist Motion

___ One Hand/One Arm Work (Right or Left)

___ May Lift Up To _____ lbs. ☐ occasionally (33%) ☐ frequently (66%) ☐ continuously (100%) of work day

___ May Pinch/Grip ☐ occasionally (33%) ☐ frequently (66%) ☐ continuously (100%) of work day

___ Other

FOLLOW-UP CARE

★ Referral & Authorization Requests:

★ Comments/Justification:

★ **The injury is causally related to work.** ☐ **Yes** ☐ **No** **I hereby certify that the aforementioned information is true and correct to the best of my knowledge.**

★ ________________________________ Date: ____/____/____

Signature of Provider ***(PHYSICIAN ONLY)**

UOM CASE MANAGER USE ONLY

Date & Time of Company Notification: Date:_____/_____/_____ Time:___:_____

Spoke With (Name): Comments: ____________________

Returned To Work ☐ YES ☐ NO **Case Manager Signature:**

DATE & TIME FAXED TO EMPLOYER_____________________________

DATE & TIME FAXED TO CARRIER _____________________________