PHYSICIAN UPDATE FORM

Following ***each*** office visit, please complete and fax this form to 724-934-1609 or scan/email to WC-claims@mrmtrust.com.

Patient to complete:

Patient Name: _____ Date of Injury: _____

Date of Birth: _____

How did injury occur? _____

_____

I authorize the release of the following information to my employer, insurance carrier and medical case manager.

Patient Signature: _____ Date: _____

The following information is to be completed by the treating physician:

Diagnosis: _____

Return to pre-injury without restrictions? Yes _____ No _____

The employee can return to work without the following restrictions:
( ) Sedentary work: Lifting 10# maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, small tools. There may be some walking required to carry out the job but walking and standing are required only occasionally.

( ) Light work: Lifting 20# maximum with frequent lifting and/or carrying objects weighting up to 10# even though the weight lifted may be a negligible amount, a job is in this category when it involves sitting most of the time with a moderate degree of pushing and pulling of arm or leg controls.

( ) Medium work: Lifting a 50# maximum with frequent lifting and/or carrying of objects weighing up to 25#.

( ) Heavy work: Lifting 100# maximum with frequent lifting and/or carrying of objects weighing up to 50#.

Additional restrictions: _____

Effective return to work date: _____

If patient cannot return to work, what is the anticipated return to work date: _____

Treatment recommendations: _____

Diagnostic testing: _____

Next office visit: _____

Physician: _____ Date: _____

Name of Provider/Facility (PLEASE PRINT): _____

Address: _____