IMWCA

Patient Status Report

The *Patient Status Report* must be completed and returned to IMWCA after each appointment. This form can be downloaded from www.imwca.org.

Employee: _____ Employer: _____

This section must be completed by the city/county/28E personnel department before employee sees physician.

Please attach the employee's job description and physical requirements or list below:

_____
_____
_____
_____

Does the employer have light duty/return to work programs available? YES NO

_____ _____
Employer Signature (date signed) Title

This section must be completed by the treating physician.

Physician:_____

Address:_____
City:_____

Date employee was seen:_____ Date employee was injured: _____

Initial/interval history:

Rx:_____

Impression:_____
_____
_

Work related? YES NO UNDETERMINED

Disposition? Return to regular duties Date: _____
Return to duty with the following restrictions Date: _____

_____
_____

Off work

Restrictions apply to both work and non-work activities. Estimated disability: _____

Referral(s): _____

Next scheduled appointment: _____ Time employee released from appointment: _____

_____
Physician's signature (date signed)

Please fax or e-mail this completed form to: (978) 367-2862 or imwcaclaims@iowaleague.org