Workers' Compensation Medical Status Questionnaire

Instructions

- The attached questionnaire, which has been approved by the North Carolina Industrial Commission, may be submitted by an employer/insurer paying compensation for an admitted workers' compensation claim to medical providers who have treated an employee for a work-related injury or condition.

- Medical providers are authorized by N.C. Gen. Stat. Sec. 97-25.6 to respond to these questions without an authorization from the employee.

- The medical provider may respond in any of the following ways:

    1. By providing appropriate responses on the attached questionnaire;

    2. By including appropriate responses in the medical notes; or

    3. By including appropriate responses in a letter.

- Medical providers need only respond to questions that are checked by the employer on the attached questionnaire.

- Medical providers are not required to answer questions for which they do not have sufficient information to formulate an opinion.

- Medical providers may charge, and the requesting employer/insurer shall pay, a reasonable fee not to exceed the current fee established under the NCIC fee schedule for CPT code 99080.

- Responses shall be provided to the employer or its insurer (or their designated agents or representatives, including the assigned rehabilitation professional), and to the employee or his/her representative simultaneously.

Medical Provider Work or Job Status Forms

- Medical providers may continue the practice of providing Work or Job Status Forms to the employee and the employer/insurer or assigned rehabilitation professional after each visit or when appropriate. This may be done without the express authorization of the employee.

Workers' Compensation Medical Status Questionnaire

Patient name:___________________________________ Today's date:_______________________________
Patient ID #:___________________________________ Date of injury:_____________________________
Employer:_______________________________________ Carrier:____________________________________
Treating physician:_____________________________ IC file:____________________________________

Please answer ONLY the checked questions.

_____ 1. Diagnosis/diagnoses:____
____

_____ 2. In your opinion, *did the job duties or work place incident*, as described by the patient, more likely than not (please check the one that, in your opinion, best applies):
_____ Have/has no relation to the current injury or condition;
_____ Cause or significantly contribute to the injury or condition;
_____ Aggravate, accelerate, or activate a preexisting condition; or
_____ Combine with other non-work related factors to bring about the current injury or condition.

_____ 3. Other medical conditions that are affected/exacerbated by the injury or condition:____________________
____
____

_____ 4. Reasonable and necessary treatment/treatment plan (to include: labs, medications, diagnostic images, tests, studies, referrals, physical therapy, etc.): ____
____
____

_____ 5. Prescribed medications for the injury or condition that would impair ability or judgment needed to perform certain jobs:____
____

_____ 6. At this time, given the patient's injury or condition, is the patient able to return to his/her job as provided in the attached job description: ☐ YES; ☐ NO. If "yes," please skip to question #9.

_____ 7. Work restricted to _________ hrs per day; _____ days per week. Anticipated time patient will be under such restrictions:____

_____ 8. Restrictions due to the injury or condition (check all that apply, specify pounds and frequency as appropriate, and explain):
☐ Lifting:__________________________________ ☐ Pushing/pulling_____________________________
☐ Bending/stooping:_________________________ ☐ Kneeling; squatting:________________________
☐ Twisting:_________________________________ ☐ Use of extremities:_________________________
☐ Standing:_________________________________ ☐ Walking:____________________________________
☐ Sitting:__________________________________ ☐ Repetitive motions:_________________________
☐ Driving:__________________________________ ☐ Vibrations:_________________________________
☐ Climbing:_________________________________ ☐ Splints/crutches/bandages:__________________
☐ Other conditions (e.g., dry work only; no heat exposure, etc.):_____________________________________
____

_____ 9. If patient has reached maximum medical improvement (MMI), what is the permanent impairment for the injury or condition? Body part:__________________; Percentage:_________%; MMI not reached______
Body part:__________________; Percentage:_________%; MMI not reached______

Physician signature:____Date:_________________________