Doctor's Initial Report

C-4

State of New York - Workers' Compensation Board

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

A. Patient's Information

1. Name: _____ (Last / First / MI) 2. Social Security #: _____

3. Home phone #: (____)_____ 4. WCB Case # (if known):_____ 5. Carrier Case #:_____

6. Mailing address:_____ (Number and Street / City / State / Zip Code)

7. Date of injury/onset of illness: ____/____/____ 8. Date of Birth: ____/____/____ 9. Gender: ☐ Male ☐ Female

10. On the date of injury/illness what was the patient's job title or description: _____

11. On the date of injury/illness what were the patient's usual work activities:_____

_____

12. Patient's Account #:_____

B. Employer Information

1. Employer when injury occurred: _____ (Company/Agency Name) 2. Phone #: (____)_____

3. Employer Address: _____ (Number and Street / City / State / Zip Code)

C. Doctor's Information

1. Your name: _____ (Last / First / MI) 2. WCB Authorization #: _____

3. WCB Rating Code:_____ 4. Federal Tax ID #: _____ The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: _____ (Number and Street / City / State / Zip Code)

6. Billing group or practice name:_____

7. Billing address: _____ (Number and Street / City / State / Zip Code)

8. Office phone #: (____)_____ 9. Billing phone #: (____)_____ 10. Treating Provider's NPI #:_____

11. You are a (*check one*): ☐ Physician ☐ Podiatrist ☐ Chiropractor

D. Billing Information

1. Employer's insurance carrier: _____ 2. Carrier Code #: W_____

3. Insurance carrier's address:_____ (Number and Street / City / State / Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD9 Code:	ICD9 Descriptor:
(1) _____	_____
(2) _____	_____
(3) _____	_____
(4) _____	_____

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

Patient's Name: _____ Date of injury/onset of illness: ____/____/____
Last First MI

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$	$	$

E. History

1. Based on the patient's history, where and how did the injury/illness happen: _____

2. How did you learn about the injury/illness (*check one*): ☐ Patient ☐ Medical Records ☐ Other(*specify*): _____

3. Did another health provider treat this injury/illness including hospitalizaton and/or surgery? ☐ Yes ☐ No If yes, give details:

4. Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☐ No If yes, when: _____

F. Exam Information

1. Date(s) of Examination: _____

2. Patient's subjective complaints: *Check all that apply and identify specific affected body part(s).*

☐ Numbness/Tingling _____ ☐ Swelling _____
☐ Pain _____ ☐ Weakness _____
☐ Stiffness _____ ☐ Other (*specify*) _____

3. Type/nature of injury: *Check all that apply and identify specific affected body part(s).*

☐ Abrasion _____ ☐ Infectious Disease _____
☐ Amputation _____ ☐ Inhalation Exposure _____
☐ Avulsion _____ ☐ Laceration _____
☐ Bite _____ ☐ Needle Stick _____
☐ Burn _____ ☐ Poisoning/Toxic Effects _____
☐ Contusion/Hematoma _____ ☐ Psychological _____
☐ Crush Injury _____ ☐ Puncture Wound _____
☐ Dermatitis _____ ☐ Repetitive Strain Injury _____
☐ Dislocation _____ ☐ Spinal Cord Injury _____
☐ Fracture _____ ☐ Sprain/Strain _____
☐ Hearing Loss _____ ☐ Torn Ligament,Tendon or Muscle _____
☐ Hernia _____ ☐ Vision Loss _____
☐ Other (*specify*) _____

Patient's Name: _____ (Last) _____ (First) _____ (MI) Date of injury/onset of illness: ____/____/____

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- ☐ None at present
- ☐ Bruising _____
- ☐ Burns _____
- ☐ Crepitation _____
- ☐ Deformity _____
- ☐ Edema _____
- ☐ Hematoma/Lump/Swelling _____
- ☐ Joint Effusion _____
- ☐ Laceration/Sutures _____
- ☐ Pain/Tenderness _____
- ☐ Scar _____
- ☐ Other findings: _____
- ☐ Neuromuscular Findings:
  - ☐ Abnormal/Restricted ROM
    - ☐ Active ROM _____
    - ☐ Passive ROM _____
  - ☐ Gait _____
  - ☐ Palpable Muscle Spasm _____
  - ☐ Reflexes _____
  - ☐ Sensation _____
  - ☐ Strength (Weakness) _____
  - ☐ Wasting/Muscle Atrophy _____

5. Describe any diagnostic test(s) rendered at this visit: _____

6. Describe any treatment(s) rendered at this visit: _____

7. Describe prognosis for recovery: _____

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No

If yes, list and describe: _____

G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☐ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? _____%
5. Describe findings and relevant diagnostic test results: _____

H. Plan of Care

1. What is your proposed treatment? _____

2. Medication(s):(a) list medications prescribed: _____

   (b) list over-the-counter medications advised: _____

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:

Patient's Name:_____ Date of injury/onset of illness:_____/_____/_____
Last First MI

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:

- ☐ CT Scan
- ☐ EMG/NCS
- ☐ MRI (Specify):_____
- ☐ Labs (Specify):_____
- ☐ X-rays (Specify):_____
- ☐ Other (Specify):_____

Referrals:

- ☐ Chiropractor
- ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in _____
- ☐ Other (Specify):_____

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair
☐ Other (specify): _____

Important: *Form C-4 AUTH should be used to request any special medical service costing over $1000* or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

5. When is the patient's next follow-up appointment?
☐ Within a week ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 7-8 weeks ☐ _____months ☐ Return as needed

I. Work Status

1. Has the patient missed work because of the injury/illness? ☐ Yes ☐ No If yes, date patient first missed work:_____/_____/_____
Is the patient currently working? ☐ Yes ☐ No If yes, did the patient return to: ☐ usual work activities ☐ limited work activities
2. Can the patient return to work? (*check only one*):

a. ☐ The patient cannot return to work because (explain):_____

b. ☐ The patient can return to work without limitations on _____/_____/_____

c. ☐ The patient can return to work with the following limitations (check all that apply) on _____/_____/_____

- ☐ Bending/twisting
- ☐ Climbing stairs/ladders
- ☐ Environmental conditions
- ☐ Kneeling
- ☐ Lifting
- ☐ Operating heavy equipment
- ☐ Operation of motor vehicles
- ☐ Personal protective equipment
- ☐ Sitting
- ☐ Standing
- ☐ Use of public transportation
- ☐ Use of upper extremities
- ☐ Other (explain):_____

Describe/quantify the limitations:_____

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's return to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name_____ Specialty_____

Board Authorized Health Care Provider signature:

_____ / /
Name Signature Specialty Date