Form 123 Revised 2/92

PHYSICIAN'S INITIAL REPORT OF WORK INJURY OR OCCUPATIONAL DISEASE

This report must be filed persuant to rule R568-2-3-(A)

Industrial Commission - Industrial Accidents Division
160 East 300 South 3rd Floor, P.O. Box 146610, Salt Lake City, Utah 84114-6610
PLEASE PRINT OR TYPE

Insurance Company:

Address:

Do Not Use This Space
CLAIM NO.
POLICY NO.
Class Code.

PATIENT

1. Employee's First Name: Middle Initial: Last Name: | 2. Social Security No.: | 3. DOB: | 4. Sex:

5. Street Address: City: State: Zip: | 6. Phone No.: | 7. Ht.: | 8. Wt.:

9. Name of Employer: | 10. Address: | 11. Phone No.:

HISTORY

12. Date injured: Hour: AM ❑ PM ❑ | 13. Last Date Worked: | 14a. Has This Part Been Injured Before? ❑ yes ❑ no

14b. If "Yes" State When and Described:

15. Employee's Statement of Cause of Injury or Illness (In First Person):

16. Describe Complaints (In First Person):

EXAMINATION

17. Findings of Examination:

18. X-Rays? ❑ Yes ❑ No
Findings:

19. ICD-9 Codes:
__ __ __-__ __
__ __ __-__ __
__ __ __-__ __

20. Diagnosis (Written Description)

21. Is the Condition Requiring Treatment the Result of the Industrial Injury or Exposure Described? If "No" Explain:
❑ yes ❑ no ❑ undetermined

TREATMENT

22. Date of First Treatment: Hour: AM ❑ PM ❑ | 23. Type of Treatment:

24. If Hospitalized, What Hospital? ❑ In-Patient ❑ Out-Patient | 25. If Case Referred to Another Physician, Give Physician's Name and Address

DISPOSITION

26. Is Condition Medically Stationary? ❑ yes ❑ no | 27. Is Any Further Treatment Required? ❑ yes ❑ no If "Yes" Date of Next Visit and How Many Estimated? | 28. Will Injury Cause Permanent Impairment? ❑ yes ❑ no

29. Does Injury Prevent Return to Regular Employment? ❑ yes ❑ no If "Yes" Estimate Time Loss: | Modified Employment? ❑ yes ❑ no If "Yes Explain Restrictions: | 30. Date Released for Work:

31. Remarks of Outline of Proposed Treatment:

32. Are There Any Conditions That Would Retard or Prevent Recovery? ❑ yes ❑ no

33. Name of Physician and Degree: | 34. Address: | 35. Phone No.:

36. Federal Tax I.D. Number | 37. Date: | 38. Signature (Physicians Own Signature Please):

White: Industrial Commission **Yellow:** Employee **Pink:** Insurance Carrier **Goldenrod:** Physicians' File