

REASON FOR REPORT CIRCLE ONE INITIAL PROGRESS FINAL	M-1 PRACTITIONER'S REPORT STATE OF MAINE WORKERS' COMPENSATION BOARD Office of Medical/Rehabilitation Services	TYPE OF PRACTITIONER CIRCLE ONE MD DO DC LIST OTHER _____
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EMPLOYEE

EMPLOYER NAME:	EMPLOYEE LAST NAME:	FIRST NAME:	M.I.:
EMPLOYER MAILING ADDRESS & PHONE #:	ADDRESS - NUMBER AND STREET:		
INSURER NAME:	CITY:	STATE:	ZIP: HOME PHONE:
INSURER MAILING ADDRESS:	DATE OF INJURY:	SSN:	
PATIENT'S COMPLAINTS:			

PRACTITIONER

ICD-9 CODE: _____

IN MY OPINION, THIS PROBLEM IS WORK RELATED NOT WORK RELATED IS NOT YET IDENTIFIED AS TO CAUSE
HAVE DIAGNOSTIC TESTS BEEN PERFORMED? YES NO RESULTS: _____

DATE OF THIS EXAMINATION : ___ / ___ / ___ IS TREATMENT TO CONTINUE? YES NO

DATE PATIENT TO BE SEEN AGAIN: ___ / ___ / ___ ESTIMATED LENGTH OF TREATMENT? _____

TREATMENT PLAN: _____

LIST ANY MEDICATION PRESCRIBED FOR THIS DIAGNOSIS/CONDITION THAT WOULD PREVENT YOUR PATIENT FROM DRIVING
AND/OR WORKING SAFELY: _____

IF UNABLE TO WORK, ADVISE ESTIMATED DATE OF RETURN : ___ / ___ / ___ P.I. RATING : ___ / ___ / ___

WORK CAPACITY: REGULAR DUTY MODIFIED DUTY NO WORK CAPACITY

RESTRICTIONS	DESCRIBE:
YES/NO	

IS PERMANENT IMPAIRMENT EXPECTED? YES NO

HAS MMI BEEN REACHED? YES NO

SIGNATURE OF PRACTITIONER JOHN PADAVANO, DO 55 BAXTER BLVD. PORTLAND, ME 04101
PRINT NAME AND ADDRESS

TELEPHONE #: _____ NARRATIVES ATTACHED? YES NO