

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

- o 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: _____
Patient ID #: _____
Employer: _____
Treating physician: _____

Today's date: _____
Date of injury: _____
Carrier: _____
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: _____