



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

MEDICAL TREATMENT FORMP.O. Box 58
Jefferson City, MO 65102-0058
www.labor.mo.gov/DWC**INJURY NUMBER**

NOTE: THIS FORM MUST BE TYPED OR HAND PRINTED IN BLACK INK.

INJURED WORKER INFORMATION

1. NAME OF INJURED PERSON Last First		2. SOCIAL SECURITY NUMBER - -	3. DATE OF INJURY
4. NAME OF EMPLOYER			
5. NAME OF INSURANCE CARRIER			
6. DESCRIPTION OF HOW INJURY OCCURRED AS RELATED BY INJURED PERSON _____			
7. DATE OF FIRST TREATMENT		8. BODY PART	

TREATMENT INFORMATION

9. DESCRIBE TREATMENT GIVEN BY YOU		10. DID EMPLOYEE HAVE SURGERY? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. HOSPITALIZATION? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES," PROVIDE NAME AND ADDRESS OF HOSPITAL _____ Admission Date _____ Discharge Date _____		
12. PHYSICAL REHABILITATION PRESCRIBED? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. REFERRAL TO ANOTHER DOCTOR? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES," NAME AND ADDRESS _____	

RETURN TO WORK INFORMATION

14. DATE LOST TIME BEGAN FROM WORK _____ <input type="checkbox"/> RELEASED TO RTW WITHOUT PHYSICAL RESTRICTIONS <input type="checkbox"/> RELEASED TO RTW WITH PHYSICAL RESTRICTIONS <input type="checkbox"/> PERMANENT RESTRICTIONS <input type="checkbox"/> TEMPORARY RESTRICTIONS – DURATION _____		15. DATE RELEASED TO RETURN TO WORK _____ DESCRIBE THE RESTRICTIONS _____	
16. IS ADDITIONAL MEDICAL TREATMENT NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES," PROGNOSIS _____			17. NEXT APPOINTMENT DATE
18. DOCTOR'S RATING IF ANY: _____ % (percentage) OF THE _____ (body part) AT THE _____ (week level).			
19. TOTAL COST OF MEDICAL \$ _____ IS THE FINAL COST. <input type="checkbox"/> Yes <input type="checkbox"/> No			

PHYSICIAN INFORMATION

20. PHYSICIAN NAME (Type or Print) Last First		21. LICENSE NUMBER	
22. PHYSICIAN ADDRESS	CITY	STATE	ZIP CODE
23. PHYSICIAN SIGNATURE	24. TELEPHONE NUMBER () -		25. DATE

ATTACH A BRIEF NARRATIVE WITH THE FINAL REPORT, IF APPROPRIATE.

The Division defines a "brief narrative" as the following "not to exceed a maximum of five (5) pages describing the course of treatment, the diagnosis, the evaluation for permanent injury and the need for future medical treatment, if any."