DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

MEDICAL TREATMENT FORM

P.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? ☐ Yes ☐ No

11. HOSPITALIZATION?

☐ Yes ☐ No IF "YES," PROVIDE NAME AND ADDRESS OF HOSPITAL _____

Admission Date _____ _____

Discharge Date _____ _____

12. PHYSICAL REHABILITATION PRESCRIBED? ☐ Yes ☐ No	13. REFERRAL TO ANOTHER DOCTOR? ☐ Yes ☐ No IF "YES," NAME AND ADDRESS

RETURN TO WORK INFORMATION

14. DATE LOST TIME BEGAN FROM WORK _____ ☐ RELEASED TO RTW WITHOUT PHYSICAL RESTRICTIONS ☐ RELEASED TO RTW WITH PHYSICAL RESTRICTIONS ☐ PERMANENT RESTRICTIONS ☐ TEMPORARY RESTRICTIONS – DURATION	15. DATE RELEASED TO RETURN TO WORK _____ DESCRIBE THE RESTRICTIONS

16. IS ADDITIONAL MEDICAL TREATMENT NEEDED? ☐ Yes ☐ 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. ☐ Yes ☐ 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."