STATE OF CALIFORNIA

Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)

This form is required to be used for ratings prepared pursuant to the 1997 Permanent Disability Rating Schedule. It is designed to be used by the primary treating physician to report the initial evaluation of permanent disability to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary.

This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.

Patient:

Last Name _____ Middle Initial ____ First Name _____ Sex___ Date of Birth _____

Address _ _ City _ _ State _ _ Zip _

Occupation _ _ Social Security No. _____ Phone No._____

Claims Administrator/Insurer:

Name _____ Claim No. _____ Phone No._____

Address _ _ City _ _ State _ _ Zip _

Employer:

Name _____ Phone No. _

Address _ _ City _ _ State _ _ Zip

You must address each of the issues below. You may substitute or append a narrative report if you require additional space to adequately report on these issues.

Date of Injury_____ Last date _ _ Date of current _ _ Permanent & _

Date worked Date examination Date Stationary date Date

Description of how injury/illness occurred (e.g. Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):

Patient's Complaints:

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Relevant Medical History:

Objective Findings:

Physical Examination: (Describe all relevant findings; include any specific measurements indicating atrophy, range of motion, strength, etc.; include bilateral measurements - injured/uninjured - for upper and lower extremity injuries.)

Diagnostic tests results (X-ray/Imaging/Laboratory/etc.)

Diagnoses (List each diagnosis; ICD-9 code must be included) ICD-9

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

	Yes	No	Cannot Determine
Can this patient now return to his/her usual occupation?	☐	☐	☐
If not, can the patient perform another line of work?	☐	☐	☐

Subjective Findings: Provide your professional assessment of the subjective factors of disability, based on your evaluation of the patient's complaints, your examination, and other findings. List specific symptoms (e.g. pain right wrist) and their frequency, severity, and/or precipitating activity using the following definitions:

Severity: Minimal pain - an annoyance, causes no handicap in performance.
Slight pain - tolerable, causes some handicap in performance of the activity precipitating pain.
Moderate pain - tolerable, causes marked handicap in the performance of the activity precipitating pain.
Severe pain - precludes performance of the activity precipitating pain.

Frequency: Occasional - occurs roughly one fourth of the time.
Intermittent - occurs roughly one half of the time.
Frequent - occurs roughly three fourths of the time.
Constant - occurs roughly 90 to 100% of time.

Precipitating activity: Description of precipitating activity gives a sense of how often a pain is felt and thus may be used with or without a frequency modifier. If pain is constant during precipitating activity, then no frequency modifier should be used. For example, a finding of "moderate pain on heavy lifting" connotes that moderate pain is felt whenever heavy lifting occurs. In contrast, "intermittent moderate pain on heavy lifting" implies that moderate pain is only felt half the time when engaged in heavy lifting.

		Yes	No	Cannot determine
Pre-Injury Capacity	Are there any activities at home or at work that the patient cannot do as well now as could be done prior to this injury or illness?	☐	☐	☐

If yes, please describe pre-injury capacity and current capacity (e.g. used to regularly lift a 30 lb. child, now can only lift 10 lbs.; could sit for 2 hours, now can only sit for 15 mins.)

1.

2.

3.

4.

Preclusions/Work Restrictions

	Yes	No	Cannot determine
Are there any activities the patient cannot do?	☐	☐	☐

If yes, please describe all preclusions or restrictions related to work activities (e.g. no lifting more than 10 lbs. above shoulders; must use splint; keyboard only 45 mins. per hour; must have sit/stand workstation; no repeated bending). Include restrictions which may not be relevant to current job but may affect future efforts to find work on the open labor market (e.g. include lifting restriction even if current job requires no lifting; include limits on repetitive hand movements even if current job requires none).

1.

2.

3.

4.

5.

6.

Medical Treatment: Describe any continuing medical treatment related to this injury that you believe must be provided to the patient. ("Continuing medical treatment" is defined as occurring or presently planned treatment.) Also, describe any medical treatment the patient may require in the future. ("Future medical treatment" is defined as treatment which is anticipated at some time in the future to cure or relieve the employee from the effects of the injury.) Include medications, surgery, physical medicine services, durable equipment, etc.

Comments:

Apportionment:

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any physician who prepares a report addressing permanent disability due to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Sections 4663 and 4664 set forth below:

Labor Code Section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee

(a) Apportionment of permanent disability shall be based on causation.

(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards

(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

(c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

(A) Hearing.

(B) Vision.

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders.

(F) The lower extremities, including the hip joints.

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

	Yes	No
Is the permanent disability directly caused, by an injury or illness arising out of and in the course of employment?	☐	☐
Is the permanent disability caused, in whole or in part, by other factors besides this industrial injury or illness, including any prior industrial injury or illness?	☐	☐

If the answer to the second question is "yes," provide below: (1) the approximate percentage of the permanent disability that is due to factors other than the injury or illness arising out of and in the course of employment; and (2) a complete narrative description of the basis for your apportionment finding. If you are unable to include an apportionment determination in your report, state the specific reasons why you could not make this determination. You may attach your findings and explanation on a separate sheet.

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:

Medical Records:

Written Job Description:

Other:

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Primary Treating Physician (original signature, do not stamp)

I declare under penalty of perjury that this report is true and correct to the best of my knowledge, and that I have not violated Labor Code §139.3.

Signature: _____Cal. Lic. # : _____

Executed at: _____Date: _____

(County and State)

Name (Printed): _____Specialty: _____

Address: _____ City: _____ State: _____Zip:

Telephone: _____