## WYOMING WORKERS' COMPENSATION DIVISION HEALTH CARE PROVIDER INITIAL MEDICAL REPORT

Return to: 1510 E. Pershing Blvd., South Wing, Cheyenne, WY 82002 Workers Compensation is exempt from HIPAA regulations

## PLEASE PRINT

	An injury report must be on file before any benefits are paid to either the claimant or provider. WS § 27-14-502(c)						Claim Number: (If Known)				
	1. Employee's First Name		dle Initial:	Last Name		2. Employee Phone No.		o. 3. D	OB:	4. Sex:	
Patient	5. Street Address: City:		City:	State:		Zip:	6.WT	7.HT:	8. Employer Phone No.		
P	9. Name of Employer: 10. A			Address:			<b>-</b>	11.Employee Social Security Number			
	12. Date Injured: Hour: am pm l			13. Last Date Worked:			14a Has This Body Part Been Injured/Treated Before?  Yes No				
History	14b. If "Yes" State When and Describe:										
His	15. Employee's Statement of Cause of Injury or Illness (in First Person):										
	16. Describe Complaints (In First Person):										
	17. Findings of Examination:										
ation	18. ICD-(Code(s) (Required)										
Examination	19. Diagnosis (Written Description)										
E)	20. Is the Condition Requiring Treatment the Result of the Industrial Injury or Exposure Described on #15?  ☐ Yes ☐ No ☐ Undetermined:				If "No" Explain:						
ent	21. Date of First Treatment: Hour: am pm pm				22. Type of Treatment:						
Treatment	23. If Hospitalized, What H	If Claim Referred to Another Physician, Give Physician's Name and Address:									
Tre	23. If Hospitalized, What Hospital? Inpatient  Outpatient  Outpatient  24. If Claim Referred to Another Physician, Give Physician's Name and Address:										
	25. Is Condition Medically Stationary? Yes No Stationary? Yes No Stationary? Yes No Stationary? Yes Stationary?				ent Required? Yes No No t.				27. Will Injury Cause Permanent Impairment? Yes No		
Disposition	28. Does Injury Prevent Return to Regular Employment? Yes \( \subseteq \text{No} \subseteq \text{If "Yes" Estimate Time Loss:} \) 29. Date Released for Work:										
	Modified Employment: Yes ☐ No ☐ If "Yes" Explain Restrictions:										
Disp	30. Remarks or Outline of Proposed Treatment:										
	31. Are There Any Conditions That Would Retard or Prevent Recovery? Yes 🗌 No 🗎 If "Yes" What Are They?										
	32. Name and Type of Health Care Provider: (MD, DC, OD, etc)  33. Addre				s: 34. Phone No.:						
	35: Federal Tax ID Number: 36. Dat					37.	37. Health Care Provider's Original Signature:				