§ 9785.2. Treating Physician's Progress Report

State of California
Division of Workers' Compensation

Treating Physician's Progress Report (DWC Form PR-2)

Date of Report:
Provider Name:

Attachments: ☐ Request for Authorization ☐ Other
Rendering Provider is: ☐ Primary Treating Physician (PTP) ☐ Secondary Treating Physician

Section A: Routing

1. Send document to those listed below (as applicable).

Claims Administrator Name and Address:

Phone Number:
Fax Number:

Primary Treating Physician Name and Address:

Phone Number:
Fax Number:

Optional Addressee:

Phone Number:
Fax Number:

Patient Name and Claim Information
Patient Name:
Date of Birth:
Date of Injury:
Employer:
Claim Number:

Provider Name and Information
Provider Name:
Practice Name:
Address:
City/State/Zip Code:
Phone Number:
Fax Number:

Provider Specialty:
Provider State License Number:
National Provider ID Number:
Name of Medical Provider Network (MPN) (if available):

2. Check the boxes that indicate why you are submitting a report at this time. Check all that apply.

☐ Periodic Report	☐ Change in Treatment Plan	☐ Release from Care
☐ Change in Work Status	☐ Request for Authorization	☐ Transfer Care To:
☐ Response to Request for Information	☐ Change in Patient's Condition	☐ Other:

3. Sections included in this report:

☐ Section B: Evaluation and Management Worksheet
☐ Section C: Work Status
☐ Other

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 section 139.3.

Provider Signature: _____ Date: _____

Executed at: _____

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Patient Name:
Provider Name:
Date of Visit:

Section B: Evaluation and Management Worksheet

Contains Private Healthcare Information

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1. **Chief Complaint(s) and Interval History (Subjective Complaints):**

2. **Physical Examination (Objective):**

3. **Other Information Reviewed (includes consultations, records, laboratory, radiology, and diagnostic testing):**

4. **Assessment/Diagnosis (include co-morbidities and complications):**

Primary Diagnosis:	ICD-9
Secondary Diagnosis:	ICD-9
Additional Diagnosis:	ICD-9
Additional Diagnosis:	ICD-9

5. **Discussion (indicate assessment in this space):**

6. **Plan:**
If physician is requesting authorization for treatment, indicate the treatment(s), what is to be treated, justification, and reference to treatment guidelines. Indicate whether any prescription for medication or supplies must be dispensed as written. This information must be indicated in the Request for Authorization for Medical Treatment (DWC Form RFA) to specify requested treatment.

- ☐ Continue same treatment plan (see prior reports).
- ☐ Change in treatment plan – see attached Request for Authorization for Medical Treatment (DWC Form RFA).
- ☐ Discharge from care.
- ☐ Dispense prescription as written.

7. **Length of Visit**
If more than 50% of visit time involves counseling and/or coordination of care, then time may determine level of E&M services. Total face-to-face time (min.): ____Counseling/coordination of care time (min.):____

Patient Name:
Provider Name:
Date of Visit:

Section C: Work Status

Employers may only receive Section A (Routing Document) and Section C (Work Status) as other sections contain private healthcare information.

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1. The Patient has been instructed to:

Date: _____
Date: _____

☐ Return to full duty without restrictions.
☐ Return to work with the following work restrictions:
(List all specific, functional restrictions, i.e., standing, sitting, bending, lifting, etc.)

Date: _____

to

Date: _____

☐ Patient is unable to return to work in any capacity for the indicated period.
State reason:

2. Patient Status:

Date: _____
Date: _____

☐ Anticipate date of return to full duty with no limitations or restrictions.
☐ Anticipated date of maximum medical improvement and permanent restrictions.

Date: _____
Date: _____

☐ Date of next visit.
☐ Date discharged from care.