Workers’ Compensation Medical Status Questionnaire

Instructions

• The attached questionnaire, which has been approved by the North Carolina Industrial Commission, may be submitted by an employer/insurer paying compensation for an admitted workers’ compensation claim to medical providers who have treated an employee for a work-related injury or condition.

• Medical providers are authorized by N.C. Gen. Stat. Sec. 97-25.6 to respond to these questions without an authorization from the employee.

• The medical provider may respond in any of the following ways:
  1. By providing appropriate responses on the attached questionnaire;
  2. By including appropriate responses in the medical notes; or
  3. By including appropriate responses in a letter.

• Medical providers need only respond to questions that are checked by the employer on the attached questionnaire.

• Medical providers are not required to answer questions for which they do not have sufficient information to formulate an opinion.

• Medical providers may charge, and the requesting employer/insurer shall pay, a reasonable fee not to exceed the current fee established under the NCIC fee schedule for CPT code 99080.

• Responses shall be provided to the employer or its insurer (or their designated agents or representatives, including the assigned rehabilitation professional), and to the employee or his/her representative simultaneously.

Medical Provider Work or Job Status Forms

  o Medical providers may continue the practice of providing Work or Job Status Forms to the employee and the employer/insurer or assigned rehabilitation professional after each visit or when appropriate. This may be done without the express authorization of the employee.
**Workers’ Compensation Medical Status Questionnaire**

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>Today’s date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID #:</td>
<td>Date of injury:</td>
</tr>
<tr>
<td>Employer:</td>
<td>Carrier:</td>
</tr>
<tr>
<td>Treating physician:</td>
<td>IC file:</td>
</tr>
</tbody>
</table>

Please answer ONLY the checked questions.

1. Diagnosis/diagnoses:

2. In your opinion, *did the job duties or work place incident*, as described by the patient, more likely than not (please check the one that, in your opinion, best applies):
   - Have/has no relation to the current injury or condition;
   - Cause or significantly contribute to the injury or condition;
   - Aggravate, accelerate, or activate a preexisting condition; or
   - Combine with other non-work related factors to bring about the current injury or condition.

3. Other medical conditions that are affected/exacerbated by the injury or condition:

4. Reasonable and necessary treatment/treatment plan (to include: labs, medications, diagnostic images, tests, studies, referrals, physical therapy, etc.):

5. Prescribed medications for the injury or condition that would impair ability or judgment needed to perform certain jobs:

6. At this time, given the patient’s injury or condition, is the patient able to return to his/her job as provided in the attached job description:  ☐ YES;  ☐ NO.  If “yes,” please skip to question #9.

7. Work restricted to _________ hrs per day; _____ days per week. Anticipated time patient will be under such restrictions:

8. Restrictions due to the injury or condition (check all that apply, specify pounds and frequency as appropriate, and explain):
   - Lifting:
   - Pushing/pulling
   - Bending/stooping:
   - Kneeling; squatting:
   - Twisting:
   - Use of extremities:
   - Standing:
   - Walking:
   - Sitting:
   - Repetitive motions:
   - Driving:
   - Vibrations:
   - Climbing:
   - Splints/crutches/bandages:
   - Other conditions (e.g., dry work only; no heat exposure, etc.):

9. If patient has reached maximum medical improvement (MMI), what is the permanent impairment for the injury or condition? Body part: ___________; Percentage: _________%; MMI not reached
   
   Body part: ___________; Percentage: _________%; MMI not reached

Physician signature: ____________________________ Date: ____________________________