State of California
Division of Workers' Compensation

Additional pages attached ☐

# PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ Other:

**Patient:**
Last ________________________________First _______________________M.I.______________Sex _______
Address_________________________________City_______________________ State ______Zip___________
Date of Injury_______________ Date of Birth_____________________
Occupation___________________________SS # _____-_____-________ Phone (___)____________________
**Claims Administrator:**
Name_______________________________________________ Claim
Number_______________________________
Address_____________________________________City_____________________ State______Zip____________
Phone (___)____________________________________ FAX (______)

_____________________________________

**Employer name:** Employer Phone ( )

The information below must be provided. You may use this form or you may substitute or append a narrative report.

**Subjective complaints:**

**Objective findings**: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

**Diagnoses:**
1. ______________________________________________________________ ICD-9 ____________________
2. ______________________________________________________________ ICD-9 ____________________
3. ______________________________________________________________ICD-9 ____________________

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**Treatment Plan:** (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any **changes** in treatment plan? If so, why?

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**Work Status:** This patient has been instructed to:

☐ Remain off-work until__________.

☐ Return to *modified* work on________________________ with the following limitations or restrictions

(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

☐ Return to full duty on ___________________with no limitations or restrictions.

**Primary Treating Physician:** (original signature, do not stamp) Date of exam: _________________

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: __________________________________
Name:_________________________________________ Specialty: ________________________________
Address:_______________________________________ Phone:___________________________________