MOHAWK
SELF INSURANCE

Physician's Report MSI-3

SECTION A
Patient's Information

Patient's Name: _____

Date of Birth (M/D/Y): _____

Patient's Occupation: _____

SECTION B
Physician Information

Physician Name: _____

Date of Examination (M/D/Y):_____

Diagnosis/Working Diagnosis:

Part of Body Injured: _____

Diagnosis: _____

_____

SECTION C: Please indicate the patient's status and task limitations in relation to the diagnosis

Please check one:

☐ No Limitation ☐ No Return to Work (rationale required) ☐ Return to Work with Limitations

Explanation: _____
_____
_____
_____

Please provide a referral to other treatment modalities (diagnostics specialist, surgery, physio, occupational rehabilitee, work conditioning, Functional Capacity Evaluation, etc..)

Medication Prescribed: _____

Date of Next visit: _____

Physician Signature: _____ Date (M/D/Y): _____