MOHAWK
SELF INSURANCE

# Medical Update MSI -8

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

Date Patient was seen (M/D/Y):_____

Patient's current medical condition (diagnosis): _____
_____
_____

Do you believe this patient is capable of returning to work in her/his own occupation at this time? No:_____ Yes:_____, if so when (M/D/Y)? _____

Does the patient have any physical restrictions that need to be considered?
No: _____ Yes:_____, if so please identify these restrictions: _____
_____
_____
_____
_____

What is the current treatment plan for this patient? (type of treatment, duration, prescribed medication)_____
_____
_____
_____
_____

Investigations & Referrals (ex: X-ray, CT scan, MRI, EMG, Ultrasound, other): _____
_____
_____

Does the patient have a follow-up appointment, if so when (M/D/Y): _____

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

Please forward this form to Mohawk Self Insurance via Fax: 450-638-9974 to the attention of the MSI Claims Officer.