WYOMING WORKERS' COMPENSATION DIVISION
HEALTH CARE PROVIDER INITIAL MEDICAL REPORT
Return to: 1510 E. Pershing Blvd., South Wing, Cheyenne, WY 82002

Workers Compensation is exempt from HIPAA regulations

PLEASE PRINT

An injury report must be on file before any benefits are paid to either the claimant or provider. WS § 27-14-502(c)

Claim Number: (If Known)

Patient

1. Employee's First Name	Middle Initial:	Last Name	2. Employee Phone No.	3. DOB:	4. Sex:

5. Street Address:	City:	State:	Zip:	6.WT	7.HT:	8. Employer Phone No.

9. Name of Employer:	10. Address:	11.Employee Social Security Number

History

12. Date Injured:	Hour:	am ☐ pm ☐	13. Last Date Worked:	14a Has This Body Part Been Injured/Treated Before? ☐ Yes ☐ No

14b. If "Yes" State When and Describe:

15. Employee's Statement of Cause of Injury or Illness (in First Person):

16. Describe Complaints (In First Person):

Examination

17. Findings of Examination:

18. ICD-(Code(s) (Required) ___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___ ___ . ___

19. Diagnosis (Written Description)

20. Is the Condition Requiring Treatment the Result of the Industrial Injury **or** Exposure Described on #15? ☐ Yes ☐ No ☐ Undetermined:	If "No" Explain:

Treatment

21. Date of First Treatment: Hour: am ☐ pm ☐	22. Type of Treatment:

23. If Hospitalized, What Hospital? Inpatient ☐ Outpatient ☐	24. If Claim Referred to Another Physician, Give Physician's Name and Address:

Disposition

25. Is Condition Medically Stationary? Yes ☐ No ☐	26. Is Any Further Treatment Required? Yes ☐ No ☐ If "Yes" Date of Next Visit.	27. Will Injury Cause Permanent Impairment? Yes ☐ No ☐

28. Does Injury Prevent Return to Regular Employment? Yes ☐ No ☐ If "Yes" Estimate Time Loss: Modified Employment: Yes ☐ No ☐ If "Yes" Explain Restrictions:	29. Date Released for Work:

30. Remarks or Outline of Proposed Treatment:

31. Are There Any Conditions That Would Retard or Prevent Recovery? Yes ☐ No ☐ If "Yes" What Are They?

32. Name and Type of Health Care Provider: (MD, DC, OD, etc)	33. Address:	34. Phone No.:

35: Federal Tax ID Number:	36. Date	37. Health Care Provider's Original Signature:

*This report satisfies the initial Health Care Provider report required by W. S. § 27-14-501(a)(b)