PHYSICIAN'S VISIT REPORT

PLEASE FAX THIS FORM TO: 410-583-5455
FAX DICTATION AS SOON AS IT IS COMPLETED
If you have any questions, please call Michael Lane at 484-581-2803
Mail all bills to UCIC (c/o SISCO) P.O. Box 42737, Baltimore, MD 21284

Name_____ DOB / / Employer_____

Visit Date Time_____ Provider_____

Synopsis

Are your findings and diagnosis consistent with history and type of injury?	□ Yes	□ No	□ Unsure
Is work relationship established?	□ Yes	□ No	□ Unsure
Are there any current conditions that may affect patient's status/recovery?	□ Yes	□ No	□ Unsure

Current Diagnosis_____

Patient's Status Regarding This Injury:

□ Fully Recovered
□ Regular Duty
□ Has Reached Maximum Medical Improvement
□ May Return to Regular Work_____
□ May Return to Restricted Work_____
□ Unable to Work Until_____

The Employee is capable of performing: □ Sedentary □ Light □ Medium □ Heavy

Circle the degree of limitation where applicable

Lifting	None	10 lb.	20 lb.	50 lb.	Other	lb.
Carrying	None	10 lb.	20 lb.	50 lb.	Other	lb.
Bending	None	Occasional	Frequent	Constant		
Squatting	None	Occasional	Frequent	Constant		
Kneeling	None	Occasional	Frequent	Constant		
Climbing	No Fixed Stairs		No Ladders			
Reaching	Not with left		Not with right			
Grasping	Not with left		Not with right			
Pushing/Pulling	Not with left		Not with right			

Comments:_____

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Studies/Treatment Ordered_____ Facility/Date/Time_____

Next Appointment Date/Time_____