STATE OF HAWAII

DEPARTMENT OF LABOR AND INDUSTRIAL

RELATIONS DISABILITY COMPENSATION DIVISION

Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

PHYSICIAN'S REPORT

# Note: PLEASE DO NOT WRITE IN SHADED BLOCKS

1

First

2

First & Final

3

Final

4

Interim

5

Consulting

6

Rating

Case Number

Date this report received

Mo. / Day / Yr.

# 

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| Employer Name and Address | | Carrier’s Name and Address | |
| Patient’s Name and Address | | Your Name, Address and Telephone No. | |
| Patient’s Social Security Number | | Physician’s ID | |
| Date of Injury/Illness Mo. / Day / Yr. | Date of First Treatment Mo. / Day / Yr. | | If patient expired, give date Mo. / Day / Yr. |

1. Are you the attending physician?
2. Has the patient been burned?
3. Is there a possibility of other disfigurement?
4. Do you think physical rehabilitation will be necessary?
5. Do you think medical rehabilitation will be necessary?

Yes No

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| State in patient’s own words where and how the accident occurred: |
| Give accurate description and extent of injury: specify all parts of the body involved and state objective findings. |
| Is accident mentioned above the only cause of patient’s condition? Yes / No. If no, state contributing causes. |
| Who engaged your services? |
| Were X-Rays taken? No / Yes. If Yes, then by whom? Include date(s). |
| X-Ray Diagnosis: |
| Was patient hospitalized? No / Yes  Date of admission:  Date of Discharge:  Name and Address of Hospital: |
| Did accident result in disability for work? Yes / No. Date disability began: |
| Patient stopped treatment without orders on:  Patient discharged as cured on: |
| **[ Paste the body of the RateFast note here ]** |