

SUMMARY OF MEDICAL RECORD – INDUSTRIAL ACCIDENT
(Please attach additional pages if necessary)

Petitioner's Name: _____ Date of Industrial Accident: _____
Employer's Name: _____

1. Diagnosis and Cause

Please identify each and every medical problem caused petitioner by the industrial accident at issue.

2. Preexisting Causes

Does the petitioner suffer from a pre-existing medical condition that contributed to the medical problems identified by you in your answer to question No. 1 as caused by the industrial accident at issue? **Yes** **No**

If yes, please explain:

3. Work Release/Medical Stability

Have you released the petitioner from work as the result of the medical problems caused by the industrial accident at issue? **Yes** **No**

If yes, on what date? _____

Have you released the petitioner to work with medically prescribed functional limitations ("light duty") as the result of the medical problems caused by industrial accident at issue? **Yes** **No**

If yes, on what date? _____ If yes, describe in detail the functional limitations?

Have you released the petitioner to return to work with no restrictions? **Yes** **No**

If yes, on what date? _____

Is the petitioner medically stable (stabilization means that the period of healing has ended and the condition of the petitioner will not materially improve) with respect to the medical problems caused by the industrial accident at issue? **Yes** **No**

If yes, on what date (please identify separately a specific date of medical stability for each medical problem if more than one caused by the industrial accident at issue.)

4. Permanent Impairment

If the petitioner is medically stable, what is the percentage of permanent impairment, based upon Utah Code §34A-2-412 or the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition" as modified by "Utah's 2006 Impairment Guides," that is attributable to the medical problem caused by the industrial accident at issue? _____

Does the petitioner have medically prescribed permanent functional restrictions as the result of the medical problem caused by the industrial accident at issue? **Yes** **No**

If yes, please describe in detail:

5. Medical Treatment.

What treatment has been provided to date that was necessary to treat the petitioner's medical condition(s) caused by the industrial accident at issue?

What necessary medical treatment are you currently recommending to treat the petitioner's medical condition(s) caused by the industrial accident at issue?

6. Permanent Total Disability Cases.

If you found that the petitioner is permanently and totally disabled, please describe in detail each and every medically prescribed functional restriction on petitioner's activities and the specific medical problem causing the restriction.

Dated this _____ day of _____, 20_____.

Physician's Name (please print)

Physician's Specialty

Physician's Signature

Physician's Street Address

Physician's City/State/Zip

Physician's Telephone Number