

MEDICAL REPORT

		Interim	Final	File Number
Name		Address		
Occupation	Age	Marital Status		Phone Number
First examination at		on		19

EVIDENCE OF prior injuries	prior disease	temporary impairment of faculties by alcohol or drugs at the time of first examination

First aid or other prior treatment received from:

Other inquiries for information concerning patient received from:

PATIENT'S ACCOUNT OF INJURY (Place and manner of occurrence)	Date	Time

DESCRIPTION OF INJURY(IES)

TREATMENT Given at _____ on (specify dates)		
Surgical treatment, if any		
Other treatment prescribed	No. of sutures required	
X-ray and findings		
Sent <input type="checkbox"/> home or <input type="checkbox"/> hospital	Name of Hospital	Date discharged

PROGNOSIS		PERMANENCY OF INJURY (Degree of permanent impairment)	
		Estimate Disability from date of accident	
		Total disability weeks	Partial disability weeks
Amount of account to date \$	Amount of final account \$	Signature	Date
		M.D.	