STATE OF HAWAII
DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

| CASE NUMBER |
|---|
| |
| DATE RECEIVED |
| |

# WC-2 PHYSICIAN'S REPORT

**NOTE: COMPLETE THE FILLABLE-DARK SHADED BLOCKS**

**TYPE OF REPORT**

☐ FIRST ☐ FIRST & FINAL ☐ FINAL ☐ INTERIM ☐ CONSULTING ☐ RATING

**PATIENT INFORMATION - SECTION 1**

| PATIENT NAME – LAST | FIRST | M.I. | SUFFIX |
|---|---|---|---|
| | | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| EMAIL ADDRESS | PHONE NUMBER |
|---|---|
| | ( ) – |

| IDENTIFICATION TYPE | IDENTIFICATION NUMBER | DATE OF INJURY/ILLNESS (I/I) | DATE OF FIRST TREATMENT | IF PATIENT DECEASED, GIVE DATE |
|---|---|---|---|---|
| ☐ SSN ☐ PASSPORT | | | | |

**EMPLOYER - SECTION 2**

| REGISTERED EMPLOYER NAME | DBA |
|---|---|
| | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| EMPLOYER POINT OF CONTACT (POC) | PHONE NUMBER | EMAIL ADDRESS |
|---|---|---|
| | ( ) – | |

**WC INSURANCE CARRIER AND ADJUSTER - SECTION 3**

| CARRIER | CARRIER ID | CARRIER CASE NUMBER |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| NAME OF ADJUSTING COMPANY | ADJUSTER NAME |
|---|---|
| | |

| EMAIL ADDRESS | PHONE NUMBER | ADJUSTER ID NUMBER |
|---|---|---|
| | ( ) – | |

**PHYSICIAN INFORMATION - SECTION 4**

| NAME OF PHYSICIAN | PHONE NUMBER | EMAIL ADDRESS |
|---|---|---|
| | ( ) – | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| | NO | YES |
|---|---|---|
| 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? | ☐ | ☐ |

A. STATE IN PATIENT'S OWN WORDS WHERE AND HOW THE INJURY/ILLNESS OCCURRED - Please continue in Supplemental Section (SS) if additional space is needed.

B. GIVE ACCURATE DESCRIPTION AND EXTENT OF INJURY/ILLNESS - Specify ALL parts of the body involved and state objective findings. Please continue in Supplemental Section if additional space is needed.

MULTIPLE BODY PARTS? ☐ NO ☐ YES

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| # | SIDE OF INJURY/ILLNESS | | PART(S) OF BODY | DISFIGUREMENT | BURN |
|---|---|---|---|---|---|
| 1. | ☐ LEFT ☐ RIGHT | ☐ FRONT ☐ BACK | | ☐ NO ☐ YES | ☐ NO ☐ YES |
| 2. | ☐ LEFT ☐ RIGHT | ☐ FRONT ☐ BACK | | ☐ NO ☐ YES | ☐ NO ☐ YES |
| 3. | ☐ LEFT ☐ RIGHT | ☐ FRONT ☐ BACK | | ☐ NO ☐ YES | ☐ NO ☐ YES |
| 4. | ☐ LEFT ☐ RIGHT | ☐ FRONT ☐ BACK | | ☐ NO ☐ YES | ☐ NO ☐ YES |
| 5. | ☐ LEFT ☐ RIGHT | ☐ FRONT ☐ BACK | | ☐ NO ☐ YES | ☐ NO ☐ YES |

C. IS INJURY/ILLNESS MENTIONED ABOVE THE ONLY CAUSE OF PATIENT'S CONDITION? ☐ YES ☐ NO - State contributing causes. Please continue in SS if space needed.

D. WHO ENGAGED YOUR SERVICES? - Please continue in SS if space needed.

E. IS FURTHER TREATMENT REQUIRED? ☐ NO ☐ YES - How long?

F. WERE X-RAYS TAKEN? ☐ NO ☐ YES

IF YES, BY WHOM? - Please continue in SS if additional space is needed.

DATE(S)

G. X-RAY DIAGNOSIS - Please continue in Supplemental Section if additional space is needed.

H. WAS PATIENT TREATED BY ANYONE ELSE? ☐ NO ☐ YES

IF YES, BY WHOM? - Please continue in SS if additional space is needed.

DATE(S)

WAS PATIENT HOSPITALIZED? ☐ NO ☐ YES

DATE OF ADMISSION

DATE OF DISCHARGE

NAME OF HOSPITAL

ADDRESS

CITY

STATE

ZIP CODE

I. DESCRIBE SUBSEQUENT TREATMENT TO BE PROVIDED BY YOU - Please continue in Supplemental Section if additional space is needed.

DID I/I RESULT IN DISABILITY FOR WORK? ☐ NO ☐ YES

DATE DISABILITY BEGAN

PATIENT ☐ WAS ABLE TO RESUME WORK ☐ WILL BE ABLE TO RESUME WORK

TYPE OF WORK ☐ REGULAR WORK ☐ LIGHT WORK

DATE RESUME(D) WORK ON

PATIENT STOPPED TREATMENT WITHOUT ORDERS ON

PATIENT DISCHARGED AS CURED ON

J. DOES PATIENT HAVE ANY DEFECT OR DISFIGUREMENT? ☐ NO ☐ YES - Describe below. Include scars, discolorations, deformities, etc. Please continue in Supplemental Section if additional space is needed.

K. FINAL DIAGNOSIS - Please continue in Supplemental Section if additional space is needed.

PHYSICIAN SIGNATURE

NAME OF PHYSICIAN

DATE

CASE NUMBER

**SUPPLEMENTAL - SECTION 5**

A. STATE IN PATIENT'S OWN WORDS WHERE AND HOW THE INJURY/ILLNESS OCCURRED (continued from Section 4.A)

B. GIVE ACCURATE DESCRIPTION AND EXTENT OF INJURY/ILLNESS (continued from Section 4.B)

C. IS INJURY/ILLNESS MENTIONED ABOVE THE ONLY CAUSE OF PATIENT'S CONDITION? IF NO, STATE CONTRIBUTING CAUSES (continued from Section 4.C)

D. WHO ENGAGED YOUR SERVICES? (continued from Section 4.D)

E. IS FURTHER TREATMENT REQUIRED? IF YES, HOW LONG? (continued from Section 4.E)

F. WERE X-RAYS TAKEN? IF YES, BY WHOM? (continued from Section 4.F)

G. X-RAY DIAGNOSIS (continued from Section 4.G)

H. WAS PATIENT TREATED BY ANYONE ELSE? IF YES, BY WHOM? (continued from Section 4.H)

I. DESCRIBE SUBSEQUENT TREATMENT TO BE PROVIDED BY YOU (continued from Section 4.I)

J. DOES PATIENT HAVE ANY DEFECT OR DISFIGUREMENT? IF YES, DESCRIBE BELOW. INCLUDE SCARS, DISCOLORATIONS, DEFORMITIES, ETC. (continued from Section 4.J)

K. FINAL DIAGNOSIS (continued from Section 4.K)

| | |
|---|---|
| ENGLISH | This document contains important information. If you need language assistance at no cost to you, please contact us by telephone or in person immediately. |
| ILOKANO | Daytoy nga dokumento ket addaan ti importante nga impormasyon. No masapul mo ti mangipatarus nga libre, pangngaasim ta awagan na kami ti telepono wenno umay na kami kitaen nga daras. |
| TAGALOG | Ang dokumentong ito ay naglalaman ng importanteng impormasyon. Kung nangangailangan kayo ng libreng tulong para maintindihan ito, mangyaring makipag-ugnay sa amin sa pamamagitan ng telepono o makipagkita kagaad sa amin. |
| CHINESE SIMPLIFIED | 此文件有重要信息。如果您需要免费的语言协助服务，请您立刻给我们打电话或来我们办公室请求帮助。 |
| CHINESE TRADITIONAL | 此文件有重要信息。如果您需要免費的語言協助服務，請您立刻給我們打電話或來我們辦公室請求幫助。 |
| SPANISH | Este documento contiene información importante. Si necesita los servicios de un intérprete sin costo alguno para usted, por favor llame de inmediato por teléfono o contacte con alguna persona de nuestra oficina. |
| JAPANESE | この書類には重要な情報が含まれています。無償で日本語の支援を受けたい場合は、早急に電話あるいは直接窓口にて申込を行ってください。 |
| CHUUKESE | Mei auchea met masowan ei taropwe. Ika pwe ke mochen aninis ren noumw chon chiaku esap kamo, kose mochen kokori kich won tengwa ika fen pusin chuto rech. |
| MARSHALLESE | Ilo pepa in ewor melele ko aorok. Ne kwoj aikuj jiban na ukok ilo ejjelok wonen, jouj im kokkeitaak kem ilo talboon ak ilo wobij e ien eo emakaaj tata. |
| KOREAN | 이 문서는 중요한 정보가 포함되어 있습니다. 무료로 언어 도움이 필요하시면, 바로 전화 하시거나 오셔서 상담하십시오. |
| VIETNAMESE | Tài liệu này bao gồm các thông tin quan trọng. Nếu bạn cần hỗ trợ ngôn ngữ miễn phí, xin vui lòng đến gặp trực tiếp chúng tôi hoặc liên lạc qua điện thoại ngay lập tức. |