



STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813
INSTRUCTION SHEET FOR FORM WC-2 PHYSICIAN'S REPORT

Instructions

Please completely fill out the WC-2 PHYSICIAN'S REPORT FORM.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail, In-Person, or via Fax

Oahu	Kauai	Maui
Princess Keelikolani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaii 96813 Mailing Address: P.O. Box 3769 Honolulu, Hawaii 96812-3769 Phone: (808) 586-9161 Fax: (808) 586-9219	3060 Eiwa Street, Room 202 Lihue, Hawaii 96766 Phone: (808) 274-3351 Fax: (808) 274-3355	2264 Aupuni Street #2 Wailuku, Hawaii 96793 Phone: (808) 984-2072 Fax: (808) 984-2071
Hawaii	West Hawaii	
75 Aupuni Street, Room 108 Hilo, Hawaii 96720 Phone: (808) 974-6464 Fax: (808) 974-6460	Ashikawa Building 81-990 Halekii Street, Room 2087 Kealakakua, Hawaii 96750 If Mailing, Please Mail to This Address: P.O. Box 49, Kealakakua, Hawaii 96750 Phone: (808) 322-4808 Fax: (808) 322-4813	

STATE OF HAWAII
DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISIONWC-2 PHYSICIAN'S REPORT
NOTE: COMPLETE THE FILLABLE-DARK SHADED BLOCKS

CASE NUMBER
DATE RECEIVED

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 SSN PASSPORT	IDENTIFICATION NUMBER	DATE OF INJURY/ILLNESS (I/I)	DATE OF FIRST TREATMENT	IF PATIENT DECEASED, GIVE DATE	
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
1. ARE YOU THE ATTENDING PHYSICIAN? NO YES					
2. HAS THE PATIENT BEEN BURNED?					
3. IS THERE A POSSIBILITY OF OTHER DISFIGUREMENT?					
4. DO YOU THINK PHYSICAL REHABILITATION WILL BE NECESSARY? NO YES					
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 <u>ALL</u> 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。
CHUUKESSE	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.