Treating Physician's Report (DWC Form PR-1)
Department of Industrial Relations - Division of Workers' Compensation

Check all applicable boxes:

Request for Authorization	☐	Progress Report	☐	Response to Request for Information	☐
Expedited Request for Authorization	☐	Change in Work Status	☐	Change in Patient's Condition	☐
Change in Treatment Plan	☐	Released from Care	☐	Other	☐

Patient Name (Last, First, Middle)

Date of Injury (MM/DD/YYYY)

Date of Birth (MM/DD/YYYY)

Claim Number

Employer

Physician Name

Practice Name

Contact Name

Address

City:

State

Zip Code

Telephone

Fax Number

E-mail

Specialty

State License Number

NPI Number

Primary Treating Physician Name (if different from above)

Claims Administrator

Address

City:

State

Zip Code

Contact Name

E-mail

Telephone

Fax Number

Patient Name

Signature and Included Sections

Section A: Request for Authorization ☐

Section B: Evaluation and Management Worksheet ☐

Section C: Work Status ☐

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Physician Signature

Date

Executed at

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: http://www.dir.ca.gov/od_pub/privacy.html.

Patient Name

SECTION A. Request for Authorization (If required; attach additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. List additional requests on a separate sheet if the space below is insufficient. For surgery requests, include full surgery orders (pre and post-op, if known). If request is to continue therapy, attach documentation of functional improvement.

Request for Medical Treatment (Non-Drug)

Diagnosis

Diagnosis Code (ICD-10)

Service/Good Requested

CPT/HCPCS Code

Is treatment consistent with Medical Treatment Utilization Schedule (MTUS) treatment guideline recommendation?

◯ Yes ◯ No

If no, attach citation/documentation. See California Code of Regulations, Title 8, section 9792.21.1(b)(1).

Request for Drug

Drug

◯ New Therapy ◯ Refill

Dose/Strength and Form

Frequency

Length of Therapy/#Refills

Quantity

Is medication an exempt drug on the MTUS Formulary and is use consistent with the recommendations of an MTUS treatment guideline?

Check box to request prospective review of an exempt drug ☐

◯ Yes ◯ No

If no, substantiate need for drug

Patient Name

Claims Administrator/Utilization Review Organization (URO) Response

Service/Good Requested

Drug Requested

Decision

Comments

Authorized Agent Name

Date

Signature

Telephone

Fax Number

E-mail

Authorization Number (if assigned)

Patient Name

SECTION B: Evaluation and Management Worksheet (continued) - Contains Private Healthcare Information

Primary Diagnosis		ICD-10	
Secondary Diagnosis		ICD-10	
Additional Diagnosis		ICD-10	

1. Chief Complaint(s) and Brief History (include subjective complaints)

2. Physical Examination (objective findings)

3. Current Treatment Plans including Medication (list all medications, dose, and frequency)

4. Outcomes to include Functional Improvements and Activities of Daily Living (ADL; note positive/negative/no changes related to treatment)

- **ADL Goal for next visit/treatment period (explain):**

5. Disability Status:

Patient Name

SECTION B: Evaluation and Management Worksheet - Contains Private Healthcare Information (continued)

6. Secondary Physician Reports (if applicable; discuss and, if appropriate, incorporate findings)

7. Discussion (indicate assessment)

8. Treatment Plan

If physician is requesting authorization for treatment, complete Section A; Request for Authorization, indicating the treatment(s), reference to treatment guidelines, and explanation as to how treatment follows the MTUS. Indicate whether any prescription for medication or supplies must be dispensed as written.

Continue same treatment plan (see prior reports and RFA as needed)	☐	Discharge from care	☐
Change in treatment plan – see Request for Authorization	☐	Dispense prescription as written	☐

Comments

Patient Name

SECTION C: Work Status
Employers may only receive Section B (Work Status) as other sections contain private healthcare information.

1. Patient has been instructed to

Return to full duty without restrictions ☐ Date

Patient is unable to return to work in any capacity for the indicated period. ☐ Date to Date

State reason

Return to work with the following work restrictions ☐ Restrictions below in hours unless otherwise indicated

a. Lift/Carry Restrictions - Pounds

Lift/Carry Restrictions

Lift/Carry Restriction - Height (state if applicable)

b. Standing

c. Walking

d. Sitting

e. Climbing

f. Forward Bending

g. Kneeling

h. Crawling

i. Twisting

j. Keyboarding

k. Grasping ☐ Right ☐ Left ☐ Bilateral Hours

l. Pushing/Pulling ☐ Right ☐ Left ☐ Bilateral Hours

Other (explain)

Patient Name

SECTION C: Work Status (continued)
Employers may only receive Section B (Work Status) as other sections contain private healthcare information.

How long will the work restrictions apply?

Medication: Is this employee currently prescribed medication for use during working hours that may affect alertness, ability to respond to an emergency, and/or ability to do their job:

☐ Yes

☐ No

If yes, describe the nature of the reaction(s)

2. Patient Status

Anticipate date of return to full duty with no limitations or restrictions.	☐	Date	
Anticipate date of return to modified duty with limitations or restrictions.	☐	Date	
Anticipate date of maximum medical improvement and permanent works restrictions (if applicable).	☐	Date	
Date of next visit.	☐	Date	
Date discharged from care.	☐	Date	