STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)

This form is designed to be used by the primary treating physician to report the initial evaluation of permanent disability to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary or has reached maximum medical improvement.

This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.

Patient:

Last Name_____ Middle Initial ____ First Name _____Sex ____ Date of Birth _____
Address _____City _____State _____ Zip _____
Occupation _____ Social Security Number _____ Phone No. _____

Claims Administrator/Insurer:

Name _____ Phone Number _____
Address _____ _ City _____ State _____ Zip _____ _

Employer:

Name _____ _ Phone Number _____
Address _____ _ City _____ State _____ Zip _____

You must address each of the issues below. Use of the form below is optional. You may substitute or append a narrative report if you require additional space to adequately report on these issues.

Injury/ Illness Date of Injury/ Onset of Illness _____ Date Last date worked _____ Date Date of current examination _____ Date

Description of how injury/illness occurred (e.g. Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):

Patient's Complaints:

Relevant Medical History:

Objective Findings:

Physical Examination: (Describe all relevant findings; include any specific measurements indicating atrophy, range of motion, strength, etc.; include bilateral measurements - injured/uninjured - for upper and lower extremity injuries.)

Diagnostic tests results (X-ray/Imaging/Laboratory/etc.)

Diagnoses (List each diagnosis; ICD-9 code must be included) ICD-9

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

	Yes	No	Cannot determine
Did work cause or contribute to the injury or illness?	☐	☐	☐
Apportionment: Are there pre-existing impairments/disabilities that contribute to permanent disability? If Yes, append narrative to describe cause and extent of pre-existing disability; describe any documentation of pre-existing disability.	☐	☐	☐
Can this patient now return to his/her usual occupation?	☐	☐	☐
If not, can the patient perform another line of work?	☐	☐	☐

Subjective Findings: Provide your professional assessment of the subjective factors of disability, based on your evaluation of the patient's complaints, your examination, and other findings. List specific symptoms (e.g. pain right wrist) and their frequency, severity, and/or precipitating activity using the following definitions:

Severity: Minimal pain (Min) - an annoyance, causes no handicap in performance. Slight pain (Slt) - tolerable, causes some handicap in performance of the activity precipitating pain. Moderate pain (Mod) - tolerable, causes marked handicap in the performance of the activity precipitating pain. Severe pain (Sev) - precludes performance of the activity precipitating pain.
Frequency: Occasional (Occ) - occurs roughly one fourth of the time. Intermittent (Int) - occurs roughly one half of the time. Frequent (Fre) - occurs roughly three fourths of the time. Constant (Con) - occurs roughly 90 to 100% of time.
Precipitating activity: Precipitating activity gives a sense of how often a pain is felt and thus is often provided in lieu of frequency, e.g. slight pain in back on heavy lifting, or slight-to-moderate pain in knee when standing or walking more than six hours per day. Can be used in conjunction with frequency if pain is less than constant while engaging in the precipitating activity. For example, intermittent slight pain on bending would be felt approximately 50% of time while actually engaged in bending.

Symptom	**Frequency** (Mark X at any spot)	**Severity** (Mark X at any spot.)	**Precipitating Activity**
_____	|----|----|----|----|----|----| Occ Int Fre Con	|----|----|----|----|----|----| Min Slt Mod Sev	_____
_____	|----|----|----|----|----|----| Occ Int Fre Con	|----|----|----|----|----|----| Min Slt Mod Sev	_____
_____	|----|----|----|----|----|----| Occ Int Fre Con	|----|----|----|----|----|----| Min Slt Mod Sev	_____
_____	|----|----|----|----|----|----| Occ Int Fre Con	|----|----|----|----|----|----| Min Slt Mod Sev	_____

Pre-Injury Capacity Are there any activities at home or at work that the patient cannot do as well now as could be done prior to this injury or illness?

Yes ☐ No ☐ Cannot determine ☐

If yes, please describe pre-injury capacity and current capacity (e.g. used to regularly lift 30 lb. child, now can only lift 10 lbs.; could sit for 2 hours, now can only sit for 15mins.)

1.
2.
3.
4.

Preclusions/Work Restrictions

	Yes	No	Cannot determine
Are there any activities the patient cannot do?	☐	☐	☐

If yes, please describe all preclusions or restrictions related to work activities (e.g. no lifting more than 10 lbs. above shoulders; must use splint; keyboard only 45 mins. per hour; must have sit/stand workstation; no repeated bending). Include restrictions which may not be relevant to current job but may affect future efforts to find work on the open labor market (e.g. include lifting restriction even if current job requires no lifting; include limits on repetitive hand movements even if current job requires none).

1.
2.
3.
4.
5.
6.

Future Medical Treatment: Describe any medical treatment related to this injury that you believe the patient may require in the future. Include medications, surgery, physical medicine services, durable equipment, etc.

Comments:

List any other physicians who contributed information used in this report:

A. Name _____ Specialty _____

B. Name _____ Specialty _____

C. Name _____ Specialty _____

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:

Medical Records

Personnel Records

Written Job Description

Any other, please describe:

Primary Treating Physician (original signature, do not stamp)

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 §139.3.

Signature : _____ Cal. Lic. # : _____

Executed at : _____ Date: _____

(County and State)

Name (Printed) : _____ Specialty: _____

Address : _____ _____ City: _____ State: _____ Zip : _____

Telephone: _____

Print

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