

# ATTENTION!

INJURED WORKERS -

1. HAVE YOUR DOCTOR FILL OUT THIS QUESTIONNAIRE.

2. HAVE YOUR DOCTOR MAIL THE COMPLETED QUESTIONNAIRE TO US AT LEAST FIVE (5) DAYS BEFORE THE MEDIATION CONFERENCE OR BRING THE COMPLETED QUESTIONNAIRE TO THE MEDIATION CONFERENCE

THANK YOU -

WORKERS' COMPENSATION ADMINISTRATION

**STATE OF NEW MEXICO  
WORKERS' COMPENSATION ADMINISTRATION  
FORM LETTER TO HEALTH CARE PROVIDER**

**TO: HEALTH CARE PROVIDER**

**RE: Worker:\_\_\_\_\_WCA No.:**

**DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Attached is a release of medical information by the Worker/Patient. The information requested in this letter is necessary to evaluate the Worker's legal claims. By promptly completing these forms, you speed the process of evaluation, including whether medical bills should be paid by the Insurance Carrier. Please answer all questions which you believe to be pertinent. Your answers must be based upon reasonable medical probability.**

- 1. Who referred Worker to you for treatment?**
- 2. Date of Worker's most recent visit or treatment:**
- 3. What is your diagnosis of the condition(s) for which you have treated the Worker?**
  
- 4. In your opinion, are the conditions or complaints for which you have treated the Worker causally related to an on-the-job injury? Yes\_\_ No  
Date of Injury:**
  
- 5. Is the Worker suffering from a disease that, in your opinion, is related to employment?  
Yes\_\_ No\_\_ Date of occurrence:**
- 6. Indicate the period of time the Worker has been unable to work:**
- 7. Is Worker able to return to work? Yes\_\_ No  
Any restrictions?\_\_\_\_\_ If no, when  
do you anticipate a return to work?**
- 8. Has the Worker reached the date after which further recovery from, or lasting improvement to, an injury can no longer be reasonably anticipated (MMI)?  
Yes\_\_ No\_\_ Date of MMI:**
- 9. If the Worker has reached MMI, please indicate your opinion as to the percentage of the Worker's anatomical or functional abnormality existing after the date of MMI:  
a) Percentage of impairment, if any:**

b) Whole body or body part: \_\_\_\_\_ c)  
Indicate which edition of AMA Guides used:

10. Has a Physical Capacities Assessment or Functional Capacity Evaluation been performed? Yes\_\_ No  
Was the evaluation performed by a licensed physical therapist or occupational therapist? Yes\_\_ No
11. Can the Worker:
- a) Lift over 50 pounds occasionally or up to 50 pounds frequently? Yes\_\_ No
  - b) Lift up to 50 pounds occasionally or up to 25 pounds frequently? Yes\_\_ No
  - c) Lift up to 20 pounds occasionally or up to ten pounds frequently, and either walk or stand to a significant degree, or sit most of the time with a degree of pushing and pulling arm or leg controls or both? Yes\_\_ No
  - d) Lift up to ten pounds occasionally or up to five pounds frequently, and occasionally walk or stand to carry out job duties? Yes\_\_ No
- Comments:
12. Please describe any other restrictions on Worker's activities not covered above:
13. Other \_\_\_\_\_ remarks:
14. Have you made any referrals to other health care providers, hospitals or institutions? Yes\_\_ No\_\_ If yes, provide the name:
15. Please attach a copy of any unpaid bills.

The maximum allowable fee for this form is \$45.00. The fee for copying of medical records and reports for the first ten (10) pages is \$10.00, and \$.20 cents for each additional page.

I hereby swear and affirm that the foregoing responses or opinions are true and correct, to a reasonable medical probability, on pain and penalty of perjury.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Printed Name of Physician

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

( ) \_\_\_\_\_

\_\_\_\_\_  
Telephone Number

**SEND COMPLETED FORM TO:**

**Workers' Compensation Administration, P. O. Box 27198, Albuquerque, NM 87125-7198**