

**M-1
DIAGNOSTIC MEDICAL REPORT
MAINE WORKERS' COMPENSATION BOARD**

EMPLOYER NAME:	EMPLOYER MAILING ADDRESS:		
INSURER NAME:	INSURER MAILING ADDRESS:		
THIRD PARTY ADMINISTRATOR (IF APPLICABLE):	CLAIM NUMBER (IF KNOWN):	THIRD PARTY ADMINISTRATOR MAILING ADDRESS (IF APPLICABLE):	
EMPLOYEE NAME:	SSN (last 4 digits only): XXX-XX-	DOB:	DATE OF INJURY:

PATIENT COMPLAINTS: _____

DATE OF THIS EXAMINATION : _____ INITIAL PROGRESS FINAL

DIAGNOSIS: _____

IN MY OPINION, THIS DIAGNOSIS IS WORK RELATED NOT WORK RELATED NOT YET IDENTIFIED AS TO CAUSE

HAVE DIAGNOSTIC TESTS BEEN PERFORMED? YES NO IF YES, LIST: _____

TREATMENT TO CONTINUE? YES IF YES, DATE TO BE SEEN AGAIN: _____ NO IF NO, PATIENT AT MMI? YES NO

ESTIMATED LENGTH OF TREATMENT _____ DAYS WEEKS MONTHS

TREATMENT PLAN (CHECK ALL THAT APPLY): REST MEDICATION EXERCISE

MEDICAL REFERRALS: THERAPY (LIST): _____ SURGERY (LIST): _____ OTHER (LIST): _____

OFFICE PROCEDURES: CAST STRAPPING OTHER (LIST): _____

DOES TREATMENT PLAN INCLUDE MEDICATION THAT WOULD PREVENT THE PATIENT FROM DRIVING AND/OR WORKING SAFELY? YES NO
IF YES, LIST MEDICATIONS: _____

WORK CAPACITY: REGULAR DUTY NO WORK CAPACITY IF CHECKED, ESTIMATED DATE OF RETURN : _____

MODIFIED WORK (DESCRIBE RESTRICTIONS BELOW) IF CHECKED, ESTIMATED LENGTH OF RESTRICTIONS? _____

BODY PARTS:	RIGHT	LEFT	UPPER	LOWER	ACTIVITY/USE OF:	NEVER	MINIMAL	MODERATE	NORMAL
<input type="checkbox"/> HEAD					LIFT/CARRY > LBS				
<input type="checkbox"/> NECK <input type="checkbox"/> THORAX					WALKING				
<input type="checkbox"/> BACK <input type="checkbox"/> FLANK					STANDING				
<input type="checkbox"/> SPINE					STAIR CLIMBING				
<input type="checkbox"/> ABDOMEN					SITTING				
<input type="checkbox"/> SHOULDER					STOOP/BEND				
<input type="checkbox"/> HUMERUS					KNEEL/CRAWL				
<input type="checkbox"/> FOREARM <input type="checkbox"/> WRIST					PUSH/PULL				
<input type="checkbox"/> HAND <input type="checkbox"/> FINGERS					VIBRATORY TOOLS				
<input type="checkbox"/> PELVIS <input type="checkbox"/> HIP					REPETITIVE ACTIVITIES				
<input type="checkbox"/> FEMUR <input type="checkbox"/> KNEE					KEYBOARD USE				
<input type="checkbox"/> LEG <input type="checkbox"/> ANKLE									
<input type="checkbox"/> FOOT <input type="checkbox"/> TOES									
<input type="checkbox"/> OTHER _____									

PERMANENT IMPAIRMENT EXPECTED? YES NO IF YES, PERMANENT IMPAIRMENT RATING _____ % OR NOT YET AVAILABLE

SIGNATURE OF HEALTH CARE PROVIDER

PRINT NAME

ADDRESS

TELEPHONE #

DIAGNOSTIC MEDICAL REPORT (FORM M-1)

Pursuant to 39-A M.R.S.A. §208(2)(A)(B) & (C) and Workers' Compensation Board Rule Chapter 5, a diagnostic medical report (Form M-1) must be completed by the health care provider and submitted to the employer/insurer and employee as follows:

- **Initial:** within 5 business days from the completion of a medical examination or within 5 business days from the date notice of injury is given to the employer, whichever is later. A health care provider may charge a fee for completing the initial M-1, however payment of fees for completion of the form may be withheld and/or penalties may be assessed for failure to complete and submit the report within 5 business days.
- **Progress:** if ongoing medical treatment is being provided, every 30 days.
- **Final:** within 5 working days of the termination of treatment, except that only an initial report must be submitted if the health care provider treated the employee on a single occasion.

Except for the header information, the remainder of **the M-1 form MUST be completed by the health care provider**. This information is vital to the administration of the claim and the employee's return to work.

The attachment of narratives is optional; however, an employer/insurer may request, at any time (for a fee), medical information concerning the condition of the employee for which compensation is sought. The health care provider shall respond within 10 business days from receipt of the request. Pursuant to 39-A M.R.S.A. §208(1) a medical release is not necessary if the information pertains to an injury claimed to be compensable under the Act (whether or not the claim is controverted/denied).

PLEASE NOTE: THE M-1 FORM IS NOT SUBMITTED TO THE BOARD.