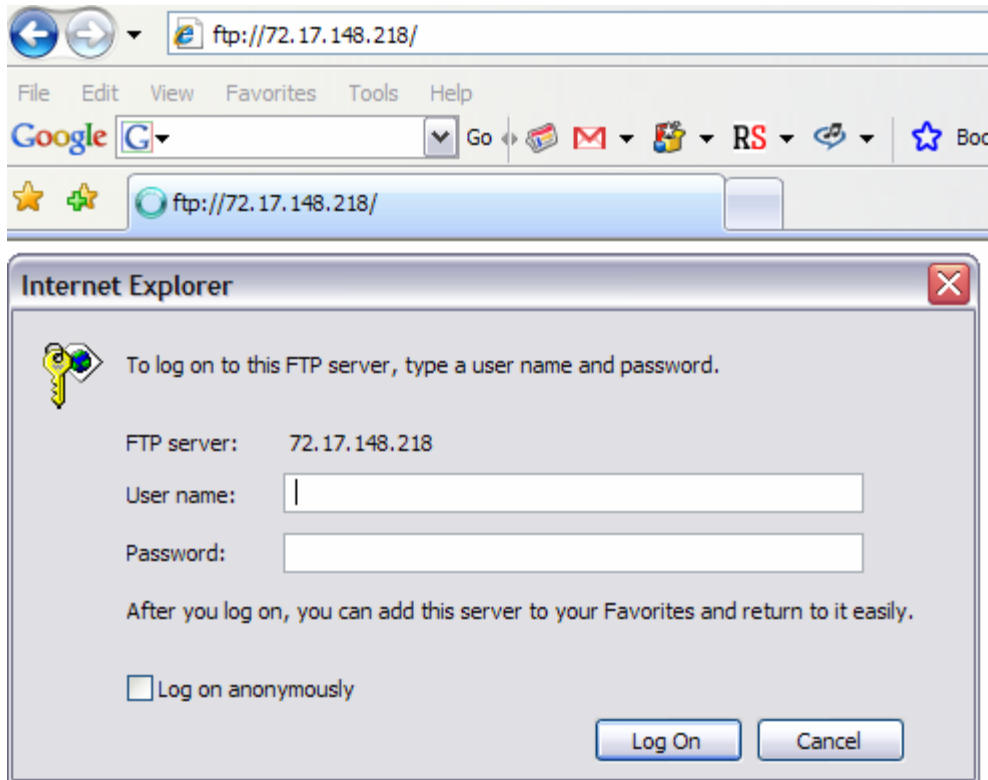
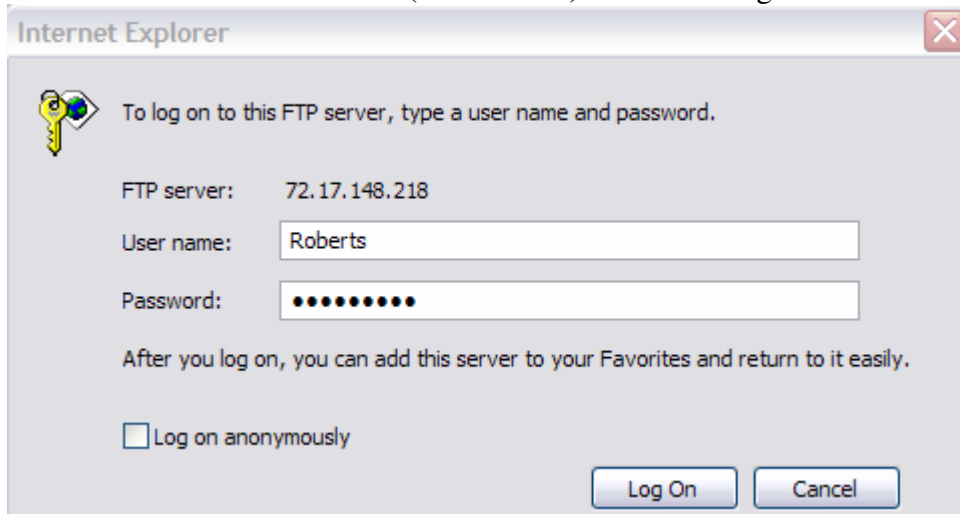


## Client Remote Access

- From a Web browser, type the FTP server IP address (ex:72.17.148.218), the Dialog box below will appear



- Enter Username and Password (ex: RobertS) then click Log On



- Click the Download folder for Read only files

## FTP root at 72.17.148.218

To view this FTP site in Windows Explorer, click **Page**, and then click **Open FTP Site in Windows Explorer**.

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03/28/2008 10:38AM      Directory [Download](#)

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- Click on the filename (Test 1.doc), to open, save or print the file



Connecting...

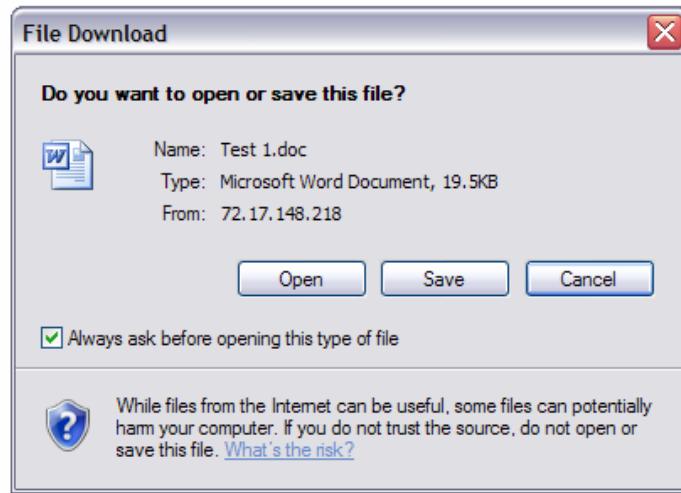
## FTP directory /Download/ at 72.17.148.218

To view this FTP site in Windows Explorer, click **Page**, and then click **Open FTP Site in Windows Explorer**.

[Up to higher level directory](#)

10/15/2007 09:58PM

19,968 [Test 1.doc](#)



Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1		
BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3		
NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.		
1. Insurer Name:	2. Visit/Review Date:	FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth:	5. Social Security #:
6. Date of Accident:	7. Employer Name	8. Initial visit with this physician? <input type="checkbox"/> a) NO <input type="checkbox"/> b) YES
SECTION I CLINICAL ASSESSMENT / DETERMINATIONS		
9. <input type="checkbox"/> No change in Items 9 - 13d since last reported visit. If checked, GO TO SECTION II.		
10. Injury/ Illness for which treatment is sought is: <input type="checkbox"/> a) NOT WORK RELATED <input type="checkbox"/> b) WORK RELATED <input type="checkbox"/> c) UNDETERMINED as of this date		
11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable. <input type="checkbox"/> a) NO <input type="checkbox"/> b) YES <input type="checkbox"/> c) UNDETERMINED as of this date If YES or UNDETERMINED, explain: _____		
12. Diagnosis(es): _____		
13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11. a) Is there a pre-existing condition contributing to the current medical disorder? <input type="checkbox"/> a <sub>1</sub> ) NO <input type="checkbox"/> a <sub>2</sub> ) YES <input type="checkbox"/> a <sub>3</sub> ) UNDETERMINED as of this date b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition? <input type="checkbox"/> b <sub>1</sub> ) NO <input type="checkbox"/> b <sub>2</sub> ) exacerbation <input type="checkbox"/> b <sub>3</sub> ) aggravation <input type="checkbox"/> b <sub>4</sub> ) UNDETERMINED as of this date c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient? <input type="checkbox"/> c <sub>1</sub> ) NO <input type="checkbox"/> c <sub>2</sub> ) YES d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for: <input type="checkbox"/> d <sub>1</sub> ) NO <input type="checkbox"/> d <sub>2</sub> ) YES the reported medical condition? <input type="checkbox"/> d <sub>3</sub> ) NO <input type="checkbox"/> d <sub>4</sub> ) YES the treatment recommended (management/treatment plan)? <input type="checkbox"/> d <sub>5</sub> ) NO <input type="checkbox"/> d <sub>6</sub> ) YES the functional limitations and restrictions determined?		
SECTION II PATIENT CLASSIFICATION LEVEL		
<input type="checkbox"/> 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.		
<input type="checkbox"/> 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment: physical reconditioning and functional restoration.		
<input type="checkbox"/> 16. LEVEL III -Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.		
<input type="checkbox"/> 17. LEVEL UNDETERMINED AS OF THIS DATE.		
SECTION III MANAGEMENT / TREATMENT PLAN		
<input type="checkbox"/> 18. No clinical services indicated at this time. If checked, GO TO SECTION IV		
<input type="checkbox"/> 19. No change in Items 20a - 20g since last report submitted. If checked, GO TO SECTION IV		
<input type="checkbox"/> 20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary. <b>*** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES ***</b>		
<input type="checkbox"/> a) Consultation with or referral to a specialist. Identify principal physician: _____ Identify specialty & provide rationale: <input type="checkbox"/> a <sub>1</sub> ) CONSULT ONLY <input type="checkbox"/> a <sub>2</sub> ) REFERRAL & CO-MANAGE <input type="checkbox"/> a <sub>3</sub> ) TRANSFER CARE		
<input type="checkbox"/> b) Diagnostic Testing: (Specify) _____		
<input type="checkbox"/> c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below: <input type="checkbox"/> c <sub>1</sub> ) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation. <input type="checkbox"/> c <sub>2</sub> ) Physical Reconditioning (Level II Patient Classification) <input type="checkbox"/> c <sub>3</sub> ) Interdisciplinary Rehabilitation Program (Level III Patient Classification) Specific instruction(s): _____		
<input type="checkbox"/> d) Pharmaceutical(s) (specify): _____		
<input type="checkbox"/> e) DME or Medical Supplies: _____		
<input type="checkbox"/> f) Surgical Intervention - specify procedure(s): _____ <input type="checkbox"/> f <sub>1</sub> ) In-Office: _____ <input type="checkbox"/> f <sub>2</sub> ) Surgical Facility: _____ <input type="checkbox"/> f <sub>3</sub> ) Injectable(s) (e.g. pain management): _____		
<input type="checkbox"/> g) Attendant Care: _____		

■ Finish