Horizon
Horizon Casualty Services, Inc.

Horizon Casualty Services, Inc.
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Workers' Compensation Patient Treatment Plan Form

Case Manager: ______________________________ Date of Service: ____/____/_____

Patient Information

Claim Number: ____________________ Claimant Name: ______________________________

Employer: ______________________________ Date of Injury: ____/____/_____

Current Medications: ____________________ Allergies: ______________________________

Treatment Plan

Diagnosis #1: ____________________ Diagnosis #2: ____________________

If today is the first time you provided treatment to this employee for this date of injury, please state the employee's description of the accident:

____

Subjective Findings: ______________________________

Objective Findings: ______________________________

Assessment: ______________________________

Treatment Plan Recommendations: ______________________________

The following questions must be answered:

☐ **YES** ☐ **NO:** Is the injury/ illness the result of a work related incident or condition of employment? In the space provided, please address if and how present complaints are causally related to original work injury.

____

☐ **YES** ☐ **NO:** Does the employee report a pre-existing injury to same body parts? If yes, state body part(s):

____

Projected MMI date: ____/____/_____ **Return to office date:** ____/____/_____

SPECIFIC WORK RESTRICTIONS (MUST BE COMPLETED/Please check where applicable)

- ☐ **No restrictions of job activities required.** **RTW date:** ____/____/_____
- ☐ **No work. If out of work, projected return to work date:** ____/____/_____
- ☐ **Sedentary Work:** Lifting up to 10 lbs. Maximum. Sit primarily with small amount of standing and walking.
- ☐ **Light Work:** Lifting up to 20 lbs. Maximum and/or carry 10 lbs. Frequently. May walk or stand as needed. May push/pull with arms alone, and/or legs & feet.
- ☐ **Light Medium Work:** Lifting up to 50 lbs. of force occasionally, and/or up to 20 lbs. of force frequently.
- ☐ **Heavy Work:** Exerting up to 100 lbs. of force occasionally, and/or in excess of 50 lbs. of force frequently.
- ☐ **Very Heavy Work:** Exerting in excess of 100 lbs. of force occasionally, and/or in excess of 50 lbs. of force frequently.
- ☐ **Can Drive** ☐ **Can drive up to** ______ **hrs.** ☐ **Can not drive**
- ☐ **Can do keyboarding up to** ______ **hrs.**
- ☐ **PERMANENT RESTRICTIONS** ☐ **TEMPORARY RESTRICTIONS**

Please print and sign physician name: ______________________________

Physician phone number: ______________________________ Tax ID#____________________

Please refer to your Horizon Casualty Services Physician and Healthcare Professional Office Manual for details regarding services requiring pre-certification and all other policies and procedures.

Horizon Casualty Services is an independent Licensee of the Blue Cross and Blue Shield Association