

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)**

Note: This form is required to be used for ratings prepared pursuant to the 2005 Permanent Disability Rating Schedule and the AMA Guides to the Evaluation of Permanent Impairment (5th Ed.) It 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.

**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 \_\_\_\_\_

Treating Physician:

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

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

Date of Injury \_\_\_\_\_ Last date worked \_\_\_\_\_ Permanent & Stationary \_\_\_\_\_ Date of current examination \_\_\_\_\_  
*Date* *Date* *Date* *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:

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**Relevant Medical History:**

**Objective Findings:**

**Physical Examination:** Describe all relevant findings as required by the AMA Guides, 5th Edition. Include any specific measurements indicating atrophy, range of motion, strength, etc. Include bilateral measurements - inured/uninjured - for injuries of the extremities.

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

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

ICD-9

1.		
2.		
3.		
4.		

**Impairment Rating:**

Report the whole person impairment (WPI) rating for each impairment using the AMA Guides, 5th Edition, and explain how the rating was derived. List tables used and page numbers.

Impairment	WPI%	Table #(s).	Page #(s)
<u>Explanation</u>			
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<u>Explanation</u>			
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**Pain assessment:**

If the burden of the worker's condition has been increased by pain-related impairment in excess of the pain component already incorporated in the WPI rating under Chapters 3-17 of the AMA Guides, 5<sup>th</sup> Edition, specify the additional whole person impairment rating (up to 3% WPI) attributable to such pain. For excess pain involving multiple impairments, attribute the pain in whole number increments to the appropriate impairments. The sum of all pain impairment ratings may not exceed 3% for a single injury.

**Apportionment:**

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any Physician who prepares a report addressing permanent disability due to a claim to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Sections 4663 and 4664 set forth below:

**Labor Code section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee**

- (a) Apportionment of permanent disability shall be based on causation.
  
- (b) Any Physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.
  
- (c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to see treatment or evaluation in accordance with this division in order to make the final determination.
  
- (d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

**Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards**

- (a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.
  
- (b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

(c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

A) Hearing..

(B) Vision.

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders. (F) The lower extremities, including the hip joints.

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

	Yes	No
Is the permanent disability directly caused, by an injury or illness arising out of and in the course of employment?	<input type="checkbox"/>	<input type="checkbox"/>
Is the permanent disability caused, in whole or in part, by other factors besides the industrial injury or illness, including any prior industrial injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to the second question is "yes," provide below: (1) the approximate percentage of the permanent disability that is due to factors other than the injury or illness arising out of and in the course of employment; and (2) a complete narrative description of the basis for your apportionment finding. If you are unable to include an apportionment determination in your report, state the specific reasons why you could not make this determination. You may attach your findings and explanation on a separate sheet.

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**Future Medical Treatment:** Describe any continuing medical treatment related to this injury that you believe must be provided to the patient. ("Continuing medical treatment" is defined as occurring or presently planned treatment.) And describe any medical treatment the patient may require in the future. ("Future medical treatment" is defined as treatment which is anticipated at some time in the future to cure or relieve the employee from the effects of the injury.) Include medications, surgery, physical medicine services, durable equipment, etc.

**Comments:**

**Functional Capacity Assessment:**

**Note: The following assessment of functional capacity is to be prepared by the treating physician, solely for the purpose of determining a claimant's ability to return to his or her usual and customary occupation, and will not to be considered in the permanent disability rating.**

Limited, but retains MAXIMUM capacities to LIFT (including upward pulling) and/or CARRY:

10 lbs.  20 lbs.  30 lbs.  40 lbs.  50 or more lbs.

FREQUENTLY LIFT and/or CARRY:

10 lbs.  20 lbs.  30 lbs.  40 lbs.  50 or more lbs.

OCCASIONALLY LIFT and/or CARRY:

10 lbs.  20 lbs.  30 lbs.  40 lbs.  50 or more lbs.

STAND and/or WALK a total of:

- Less than 2 HOURS per 8 hour day
- Less than 4 HOURS per 8 hour day
- Less than 6 HOURS per 8 hour day
- Less than 8 HOURS per 8 hour day

SIT a total of:

- Less than 2 HOURS per 8 hour day
- Less than 4 HOURS per 8 hour day
- Less than 6 HOURS per 8 hour day
- Less than 8 HOURS per 8 hour day

PUSH and/or PULL (including hand or foot controls):

- UNLIMITED
- LIMITED (Describe degree of limitation)

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ACTIVITIES ALLOWED:

	Frequently	Occasionally	Never
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fingering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe in what ways the impaired activities are limited:

Environmental restrictions (e.g. heights, machinery, temperature extremes, dust, fumes, humidity, vibration etc.)

Can this patient now return to his/her usual occupation? Yes  No

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

Medical Records:

Written Job Description:

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Other:

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**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: \_\_\_\_\_