Department of Workforce Development
Worker's Compensation Division
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MEDICAL REPORT ON INDUSTRIAL INJURY

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

PATIENT	WC Claim Number	Employee Name	
	Employee Social Security Number*	Employee Address	
	Injury Date	Employer Name	Insurance Company
HISTORY	History as described by patient:		
DIAGNOSIS (Please be as detailed as possible)			
PERMANENT DISABILITY (Describe permanent elements of disability, such as limitation of motion, pain, weakness, etc., and describe effect on working ability.)	What amputation present?	Comparative x-rays taken? ☐ Yes ☐ No	Stump: ☐ hardy or ☐ tender
	Has permanent disability resulted? ☐ Yes ☐ No	Date of Last Exam	Has healing period ended? ☐ Yes ☐ No / Patient discharged? ☐ Yes ☐ No
	Description of permanent disability (Record finger motion losses on reverse.)		
	Was surgery performed as a result of accident? ☐ Yes ☐ No If Yes, state type of surgery:		
	If healing has not ended, what is minimum permanent disability expected?		
PRIOR DISABILITY	What previous disability?		
PROGNOSIS	Prognosis:		
	Date injured was or will be able to return to a limited type of work: State any limitations:		
	Date injured was or will be able to return to full-time work subject only to permanent limitations:		
	What further treatment should be given?		
Additional comments, if any:			
Date	City	Physician or Chiropractor Signature (in own writing)	
	Phone Number ( ) -	Typed or Printed Name	

WKC-16 (R. 06/2017)

Employee Name	Employee Social Security Number

Instructions for finger injuries

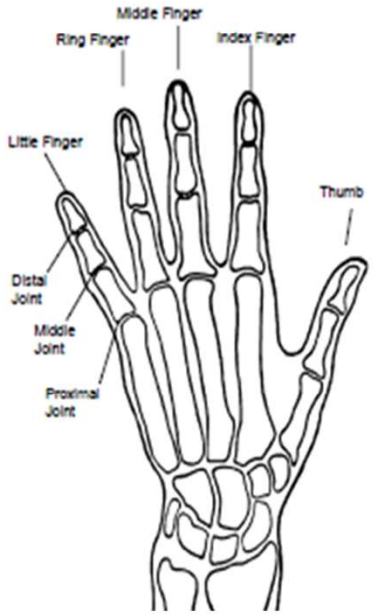
Please use statutory terms in referring to fingers, such as thumbs, index, middle, ring, and little fingers, and distal, middle, and proximal joints. Where there is limitation of motion, list separately the normal range of motion in degrees, the "degrees" loss of flexion, and the "degrees" loss of extension for each joint of each finger. The Worker's Compensation Division will evaluate the loss of use due to loss of motion of the fingers.

Where there are other elements of disability of the fingers, such as deformity, weakness, pain, or lack of endurance, give your opinion on the percentage loss of use as compared to amputation for such elements of disability and specify the joint at which such loss is estimated.

Digit	Joint	Angle Ext./Flex	Normal Range of Motion	Degrees Loss Extension	Degrees Loss Flexion	Estimate % loss of use for additional factors at joint involved and reason for additional allowance
Thumb	Dist					
	Prox					
Index	Dist					
	Mid					
	Prox					
Mid	Dist					
	Mid					
	Prox					
Ring	Dist					
	Mid					
	Prox					
Little	Dist					
	Mid					
	Prox					

CIRCLE HAND INVOLVED: Right Left

DOMINANT HAND: Right Left



See DWD 80.32 & 80.33 for guides to evaluation for amputations, restrictions of motion, ankylosis, sensory loss, and surgical results for disability to the hip, knee, ankle, toes, shoulder, elbow, wrist, fingers and back.

If fingertip amputation is present, submit comparative x-rays or a statement indicating whether the bone loss was less than one-third, between one-third and two-thirds, or more than two-thirds of the distal phalanx.

If amputation is below the distal joint, submit comparative x-rays.

PHYSICIAN'S REPORT ON EYE INJURIES

Refer to Ind. 80.26, Loss of vision; determination

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PATIENT

WC Claim Number	Employee Name
Social Security Number*	Employee Address

HISTORY

Injury Date	Employer Name	Insurance Company Name
Date of First Treatment	Date of Last Treatment or Exam	Which eye is injured? ☐ Right ☐ Left ☐ Both

If only one eye is injured, is the other eye affected? ☐ Yes ☐ No If yes, explain

NATURE OF INJURY AND DIAGNOSIS

Please be as detailed as possible

Is physical condition of the eyes stationary? ☐ Yes ☐ No If no, explain:	1) Did cataract form as a result of injury? ☐ Yes ☐ No 2) If cataract formed, was lens removed? ☐ Yes ☐ No 3) Has there been a surgical implant of lens? ☐ Yes ☐ No	Danger of further impairment? ☐ Yes ☐ No If yes, explain:
Have all adequate and reasonable operations been attempted? ☐ Yes ☐ No		

CENTRAL VISUAL READINGS

Distance ⟶ Use Snellen test letters or characters up to 20/800.

Near ⟶ Use AMA Reading Card up to 14/560.

IMPORTANT: PLEASE FILL OUT EACH LINE COMPLETELY FOR EACH EYE

	After Injury					Pre-existing before injury, including presbyopia and other conditions clearly not the result of the injury.			
	Without Correction		With Correction			Without Correction		With Correction	
	Distance	Near	Distance	Near		Distance	Near	Distance	Near
Right					Right				
Left					Left				

PRIOR DISABILITY

Did the employee wear glasses for pre-existing subnormal vision? ☐ Yes ☐ No

Is there a record or positive indication of pre-existing subnormal vision? ☐ Yes ☐ No If yes, Explain:

Is the remaining impairment due to the injury? ☐ Yes ☐ No Explain:

BINOCULAR VISION

Is there absence of useful binocular vision? ☐ Yes ☐ No

Explain cause:
If a result of the injury, what is the percentage of additional permanent disability?

Is there any diplopia present? ☐ Yes ☐ No

If yes, this should be plotted in the chart at the right by placing an X in each square in which diplopia is found. The test is to be made with any industrially useful correction applied.

Was such correction used? ☐ Yes ☐ No

Industrial Motor Field Chart

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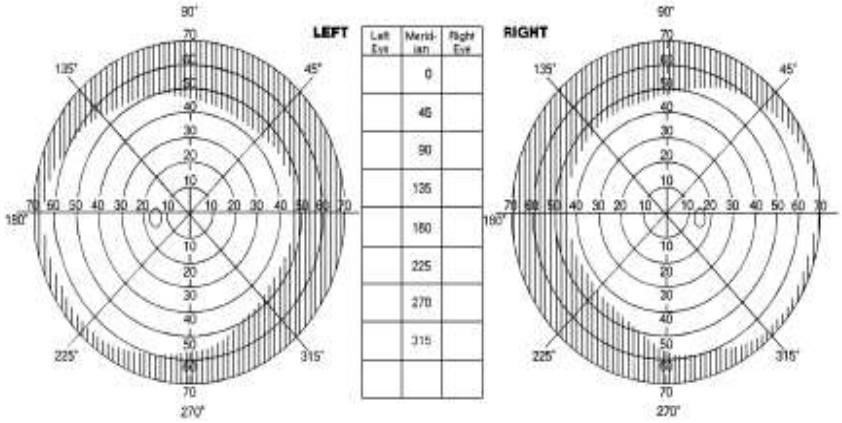
FIELD VISION

Field vision taken without correction if possible using a white test object which subtends one degree and a standard perimeter with a radius of 12.9 inches (330 mm). The test object shall measure 0.223 inches (5.8 mm).

Is there any loss of the field of vision? ☐ Yes ☐ No Is it the result of the injury? ☐ Yes ☐ No

If so, indicate on the charts and table below. **Sketch impaired area. Sketch areas of any scotomata.**



Left Eye	Meridian	Right Eye
	0	
	45	
	90	
	135	
	180	
	225	
	270	
	315	

When did the last trace of inflammation disappear from the eye?

Date able to return to work:

OTHER FUNCTIONS

Certain ocular disabilities are not covered in the foregoing sections, such as disturbance of accommodation, of color vision, of adaptation to light and dark, metamorphosia, entropion, ectropion, lagophthalmos, epiphora, and muscle disturbances not included under diplopia. Is any such disability present? **If so, explain under "Remarks" below, stating whether it results from the injury, what it is, which eye, or whether both eyes are affected, and your percentage estimate of the impairment of the eye or eyes for industrial use.**

Remarks:

Doctor Signature: _____ Date Signed:
(Required in doctor's own handwriting)

Address: