North Dakota Workforce Safety & Insurance

CONTRACTED NURSE CASE MANAGEMENT INITIAL EVALUATION

RETURN TO WORK DIVISION
SFN 53205 (01/2020)

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SECTION 1 – *Injured employee*

Claim number	Injured employee's (First name)	(Last name)
Preferred name	Date of injury	Date of birth

Diagnosis/ICD code(s)	Accepted body part(s)
Date of initial evaluation	Method of evaluation ☐ Telephone ☐ Face-to-face ☐ Other

Individuals present

Preferred language	Interpreter required ☐ Yes ☐ No	Release of information on file ☐ Yes ☐ No

Statement
The information obtained from you and your medical file will be used by WSI to assist with the management of your claim. If you have any questions or are uncomfortable with anything during this interview, let me know.

Injured employee was read and understands the above statement?
☐ Yes ☐ No

SECTION 2 – *Medical*

Description of injury (as reported by the injured employee)

Current medical status/current treatment plan (as reported by the injured employee)

Current medical status/current treatment plan (summary of WSI medical documents)

Has the provider discussed the length of recovery and the impact it will have on return to work?
☐ Yes ☐ No

If yes, explain

Comments

Current providers

Provider name	Specialty	Facility name	Next appointment

Claim number	Injured employee's (First name)	(Last name)

Current medications

Drug	Dosage/frequency of use	Reason for taking/side effects	Prescribing provider

Allergies

☐ No known medication allergies

Narcotic contract? ☐ Yes ☐ No	Preferred pharmacy	Address and/or telephone number

Pain assessment

Location of pain

Pain rating using pain scale 0-10 (0 least pain and 10 worst pain)

Current pain rating	Worst pain rating	Best pain rating

Describe pain (Example: burn, ache, throb, pull, sharp)

What makes the pain better?

What makes the pain worse?

Diagnostic tests

Test performed	Date performed	Results

Comments

Current and past health conditions

Neurological

	Yes	No	Provider	Comments (If yes, explain)
Headaches/migraines	☐	☐		

Claim number	Injured employee's (First name)	(Last name)

Neurological				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Brain injury/concussion	☐	☐		
Vertigo/dizziness	☐	☐		
Balance disturbance	☐	☐		
Seizures	☐	☐		
Black-outs/fainting	☐	☐		
Numbness	☐	☐		
Stroke	☐	☐		
Tremors	☐	☐		
Memory problems	☐	☐		
Speech problems	☐	☐		

Endocrine				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Diabetes	☐	☐		
Thyroid	☐	☐		

Cardiac				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
High blood pressure	☐	☐		
Heart attack	☐	☐		
Angina/chest pain	☐	☐		
Congestive heart failure	☐	☐		
Bleeding or clotting disorder	☐	☐		

Respiratory/Lung				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Asthma	☐	☐		
Shortness of breath	☐	☐		
Chronic cough	☐	☐		
Emphysema/COPD	☐	☐		
Sleep apnea	☐	☐		

Urinary/kidney				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Bladder problems	☐	☐		
Kidney problems	☐	☐		

Gastrointestinal (GI)				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Constipation/diarrhea	☐	☐		
Abdominal pain	☐	☐		
Heartburn	☐	☐		
Nausea/vomiting	☐	☐		

Musculoskeletal				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Fractures	☐	☐		
Sprain/strain	☐	☐		

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Musculoskeletal				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Crush injury	☐	☐		
Joint replacement	☐	☐		
Osteoporosis	☐	☐		
Arthritis	☐	☐		

Skin				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Drainage	☐	☐		
Bruising/discoloration	☐	☐		
Swelling	☐	☐		
Non-healing wounds	☐	☐		
Lacerations	☐	☐		
Incisions	☐	☐		
Scars	☐	☐		
Rash	☐	☐		

Head, eyes, ears, nose, throat (HEENT)				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Glasses/contacts	☐	☐		
Double vision	☐	☐		
Change in vision	☐	☐		
Hearing loss	☐	☐		
Dental issues/gum disease	☐	☐		

Mental health				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Depression	☐	☐		
Anxiety/panic disorder	☐	☐		
Drug/alcohol dependency	☐	☐		
Mood Disorder	☐	☐		
Eating Disorder	☐	☐		

Previous hospitalizations				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Previous hospitalizations/surgeries	☐	☐		

Other health conditions				
	Yes	**No**	**Provider**	**Comments (If yes, explain)**
Cancer	☐	☐		
Infectious diseases	☐	☐		
Autoimmune	☐	☐		
Other	☐	☐		

Have you ever been involved in a motor vehicle accident that required treatment?
☐ Yes ☐ No

If yes, explain

Have you ever had a prior work-related injury?
☐ Yes ☐ No

Claim number	Injured employee's (First name)	(Last name)

If yes, explain

If yes, have you ever had a functional capacity evaluation?
☐ Yes ☐ No

If yes, explain

Comments

Other information

Physical appearance

Dominant hand	Height (feet & inches)	Current weight (pounds)
☐ Right ☐ Left		

SECTION 3 – *Social/family/home environment*

Where are you currently living?
☐ House ☐ Mobile home ☐ Apartment ☐ Other Explain

What is your living arrangement?
☐ Alone ☐ With someone

If with someone, who?
☐ Husband/wife/significant other ☐ Children ☐ Friend/roommate ☐ Other

Is there someone available to provide support and assistance to you?
☐ Yes ☐ No

If yes, explain

Are you independent with activities of daily living?	Do you feel safe in your home?
☐ Yes ☐ No	☐ Yes ☐ No

Do you have home accessibility/safety concerns (wheelchair accessibility, bathroom accessibility, bedroom location, stairs)?

Do you have family or social issues which may impact recovery?
☐ Yes ☐ No

If yes, explain

Do you have religious/spiritual beliefs that may impact your medical treatment?
☐ Yes ☐ No

If yes, explain

Do you have any hobbies or interests?
☐ Yes ☐ No

If yes, explain

What is your typical day or daily activities?

Do you participate in physical activity or exercise?
☐ Yes ☐ No

If yes, explain

Do you own a vehicle?
☐ Yes ☐ No

Do you have a current driver's license?	If yes, state/restrictions	If no, when are you eligible to obtain a license?
☐ Yes ☐ No		

Do you use tobacco products? ☐ Yes ☐ No ☐ Decline	If yes, how often, how long, what kind
Do you consume alcoholic beverages? ☐ Yes ☐ No ☐ Decline	If yes, how often, how long, what kind
Do you use illicit or recreational drugs? ☐ Yes ☐ No ☐ Decline	If yes, how often, how long, what kind
Have you ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No ☐ Decline	Comments

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SECTION 4 – *Physical limitations (as reported by the injured employee)*

	Comments
Reaching	
Bending	
Kneeling	
Lifting	
Driving	
Walking	
Standing	
Sitting	

SECTION 5 – *Durable Medical Equipment*

Assistive devices

	Yes	**No**	**Description**
Braces/splints	☐	☐	
Sling/corset	☐	☐	
Crutches	☐	☐	
Walker	☐	☐	
Cane	☐	☐	
Wheelchair	☐	☐	
Prosthetic	☐	☐	
Other	☐	☐	

SECTION 6 – *Employment*

Are you currently working? ☐ Yes ☐ No	If yes, ☐ Full-time ☐ Part-time
Employer	Occupation
If no, explain	What is the last day you worked?
What are your current physical capabilities/work restrictions as defined by a health care provider?	
What are your employment goals?	
If you returned to work today, what do you feel you are capable of doing at your workplace?	
Do you have a home-based business or second employer? ☐ Yes ☐ No	Are you legally able to work in the United States? ☐ Yes ☐ No
Comments	

SECTION 7 – *Education*

What is your level of education? ☐ GED ☐ High school diploma ☐ Degree ☐ Other	Comments
Do you have the ability to read/write? ☐ Yes ☐ No	
Have you taken vocational training or college courses? ☐ Yes ☐ No	
Do you have any license/certifications? ☐ Yes ☐ No	Are the licenses/certifications current? ☐ Yes ☐ No
Are you or have you served in the military? ☐ Yes ☐ No	If yes, any service-connected physical disability? ☐ Yes ☐ No
Comments	

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SECTION 8 – *Financial*
Do you have any present financial concerns? ☐ Yes ☐ No
Do you have a medical insurance policy? ☐ Yes ☐ No
Do you have a short term or long-term disability plan? ☐ Yes ☐ No
Have you applied for, are you eligible for or are you receiving social security disability or social security retirement benefits? ☐ Yes ☐ No
Comments

SECTION 9 – *Case management plan/recommendations*		
Problems/barriers identified		
Plan/recommendations		
Nurse case manager		Date
Telephone number	Email address	Fax number