



North Dakota Workforce
Safety & Insurance

MCM – INITIAL EVALUATION

RETURN TO WORK DIVISION

SFN 53205 (08/2014)

1600 EAST CENTURY AVENUE, SUITE 1

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BISMARCK ND 58506-5585

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TTY (hearing impaired) 1-800-366-6888

Fraud and Safety Hotline 1-800-243-3331

www.WorkforceSafety.com

Date of Report	Injured Worker	Claim Number
Date of Injury	Date of Birth	

CASE SUMMARY

Date of Interview	Type of Interview <input type="checkbox"/> Telephonic <input type="checkbox"/> Face-to Face Location:
Individuals Present	
Diagnosis/ICD-9 Code	

DISCLAIMER

I will be asking you numerous questions during this MCM Initial Evaluation interview process. The information obtained will be used as a tool by WSI to assist with the management of your claim. If, during the interview, you feel uncomfortable answering any of the questions posed, you may decline to respond. If you have any questions of me during this process, such as the reasoning behind a specific question, please feel free to ask me.

Injured worker was read and understands the above disclaimer
 Yes No

INTRODUCTION

Ethnic Background	
Physical Appearance (<i>pale, weak, obese, etc.</i>)	
Sensorium (<i>alert, confused, cooperative, etc.</i>)	
FROI/C1 signed (<i>if no, why</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No	Verbal acceptance of case management services <input type="checkbox"/> Yes <input type="checkbox"/> No
Role of Medical Case Manager reviewed with injured worker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	

DESCRIPTION AND MECHANISM OF INDUSTRIAL INJURY (as reported by injured worker):

CURRENT MEDICAL STATUS:

CURRENT PHYSICIANS

Doctor	Specialty	Next Appointment	Purpose/Treatment
Treating Physician:			
Family Physician:			

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CURRENT MEDICATIONS

Drug	Dosage/Frequency of Use	Prescribing Doctor	Side Effects

Drug Allergies

Narcotic Contract Yes No N/A

Prior medications used over the past 3 years:

COMMENTS:

CURRENT DIAGNOSTIC TESTING

DIAGNOSTIC TESTS	DATE PERFORMED	RESULTS

COMMENTS:

CURRENT AND PAST HEALTH CONDITIONS (If appropriate, complete a body system review)

Disorders	No	Yes	Medication	Treating MD	Comments
Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures/type/frequency	<input type="checkbox"/>	<input type="checkbox"/>			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>			
Migraine	<input type="checkbox"/>	<input type="checkbox"/>			
Tension	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus	<input type="checkbox"/>	<input type="checkbox"/>			
Concussion/brain injury	<input type="checkbox"/>	<input type="checkbox"/>			
Vertigo/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>			
Balance Disturbance	<input type="checkbox"/>	<input type="checkbox"/>			
Numbness	<input type="checkbox"/>	<input type="checkbox"/>			
Black-outs	<input type="checkbox"/>	<input type="checkbox"/>			

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Tremors	<input type="checkbox"/>	<input type="checkbox"/>			
Memory Difficulties/Lapses	<input type="checkbox"/>	<input type="checkbox"/>			
Speech Difficulties/Lapses	<input type="checkbox"/>	<input type="checkbox"/>			
Endocrine Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Diet Controlled	<input type="checkbox"/>	<input type="checkbox"/>			
Oral Medications	<input type="checkbox"/>	<input type="checkbox"/>			
Insulin	<input type="checkbox"/>	<input type="checkbox"/>			
Cardiac/Heart Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>			
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Coronary Artery Bypass	<input type="checkbox"/>	<input type="checkbox"/>			
Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>			
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Valve Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Rhythm Irregularity	<input type="checkbox"/>	<input type="checkbox"/>			
Respiratory/Lung Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
COPD	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
SOB	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>			
Excessive Snoring	<input type="checkbox"/>	<input type="checkbox"/>			
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>			
Dental/Gum Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Dentures	<input type="checkbox"/>	<input type="checkbox"/>			
Urinary/Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Frequency/Urgency	<input type="checkbox"/>	<input type="checkbox"/>			
Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/>			
Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>			
GI Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Frequent Heartburn	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Abdominal Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>			
Frequent N/V	<input type="checkbox"/>	<input type="checkbox"/>			
Notable Change in Bowel Characteristics	<input type="checkbox"/>	<input type="checkbox"/>			

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Visual Correction	<input type="checkbox"/>	<input type="checkbox"/>			
Contacts	<input type="checkbox"/>	<input type="checkbox"/>			
Corrective Lenses	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
Bone/Joint Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Fracture	<input type="checkbox"/>	<input type="checkbox"/>			
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>			
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			
Soft Tissue Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Sprain	<input type="checkbox"/>	<input type="checkbox"/>			
Crush	<input type="checkbox"/>	<input type="checkbox"/>			
Laceration/Contusion	<input type="checkbox"/>	<input type="checkbox"/>			
Prosthetic	<input type="checkbox"/>	<input type="checkbox"/>			
Skin Disorders/Changes	<input type="checkbox"/>	<input type="checkbox"/>			
Drainage	<input type="checkbox"/>	<input type="checkbox"/>			
Bruising/Discoloration	<input type="checkbox"/>	<input type="checkbox"/>			
Non-healing Wounds	<input type="checkbox"/>	<input type="checkbox"/>			
Scars	<input type="checkbox"/>	<input type="checkbox"/>			
Swelling/Redness	<input type="checkbox"/>	<input type="checkbox"/>			
Incisions	<input type="checkbox"/>	<input type="checkbox"/>			
Ear, Nose, & Throat Conditions	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>			
Mental Health Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Depression	<input type="checkbox"/>	<input type="checkbox"/>			
Anxiety/Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>			
Mood Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
Previous Hospitalizations/Surgeries	<input type="checkbox"/>	<input type="checkbox"/>			
Other Health Conditions	<input type="checkbox"/>	<input type="checkbox"/>			

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

Have you ever had a prior out-of-state work related injury? No Yes (Has ISO report been run?)

If yes, please explain (Date, State, Body Part)

Have you had surgery related to the work injury?

No Yes If yes, indicate date and type of surgery.

Is surgery planned?

No Unknown Yes If yes, indicate date, type, and physician.

OTHER INFORMATION

Dominant Hand <input type="checkbox"/> Right <input type="checkbox"/> Left	Height (feet & inches)	Current Weight	Pre-injury Weight
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Additional Comments:

COMMENTS:

CURRENT FUNCTIONAL STATUS		<i>Limitations from injury as reported by the injured worker</i>	
	No	Yes	Comments
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	
Bending	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	
Driving	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	
Independent with activities of daily living? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, has home health assessment been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No			

COMMENTS/CONCERNS:

CURRENT ORTHOPEDIC/MOBILITY/DME			
	No	Yes	Comments
Problems with Mobility	<input type="checkbox"/>	<input type="checkbox"/>	
Prosthetic	<input type="checkbox"/>	<input type="checkbox"/>	
Braces/Splints	<input type="checkbox"/>	<input type="checkbox"/>	
Corset/Sling	<input type="checkbox"/>	<input type="checkbox"/>	
Crutches	<input type="checkbox"/>	<input type="checkbox"/>	
Walker	<input type="checkbox"/>	<input type="checkbox"/>	
Cane	<input type="checkbox"/>	<input type="checkbox"/>	
Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

DESCRIPTION OF HOME ENVIRONMENT/ARCHITECTURAL BARRIERS (if no problems, can be stated as such)	
Do you live in a <input type="checkbox"/> House <input type="checkbox"/> Mobile Home <input type="checkbox"/> Apartment <input type="checkbox"/> Other	
Home Accessibility/Needs (Wheelchair accessibility, bathroom accessibility, safety concerns): <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, explain:	
Do you feel safe in your environment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PAIN INVENTORY/ASSESSMENT		
Location (narrative):		
Intensity: Injured worker rates the pain using pain scale 1-10 (1) least pain (10) worst pain		
Present	Worst Pain Gets	Best Pain Gets
Characteristics: (use injured worker's own words, i.e. prick, ache, burn, throb, pull, sharp)		
What makes pain better?		
What makes pain worse?		

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SOCIAL FAMILY CIRCUMSTANCES	
Indicate your living arrangements: <input type="checkbox"/> alone <input type="checkbox"/> with someone	If with someone, who? <input type="checkbox"/> Husband/Wife/Significant Other <input type="checkbox"/> Children <input type="checkbox"/> Other Relatives <input type="checkbox"/> Friend(s), Roommate
If with someone, is this individual available to provide support and assistance to you? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	
Are there any family or social issues which may impact recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	
Do you use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
Do you consume alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
Do you use illicit / recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
Have you been convicted of a misdemeanor or felony? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
Do you have any religious/spiritual beliefs that may impact your medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	

EDUCATIONAL/VOCATIONAL INFORMATION			
	No	Yes	Where/When/Comments
High School Diploma	<input type="checkbox"/>	<input type="checkbox"/>	
Last Grade Completed			
GED	<input type="checkbox"/>	<input type="checkbox"/>	
University/College Education	<input type="checkbox"/>	<input type="checkbox"/>	
Degree	<input type="checkbox"/>	<input type="checkbox"/>	
Vocational Training/Schooling	<input type="checkbox"/>	<input type="checkbox"/>	
License/Certifications	<input type="checkbox"/>	<input type="checkbox"/>	
Are Licenses/Certificates Current	<input type="checkbox"/>	<input type="checkbox"/>	

	No	Yes	Comments
Language Preference	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to Read	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to Write	<input type="checkbox"/>	<input type="checkbox"/>	
Interpreter Required	<input type="checkbox"/>	<input type="checkbox"/>	

EMPLOYMENT INFORMATION			
Current Employer	Occupation		
Are you legally able to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you working now? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other			
If yes, please indicate the following: <input type="checkbox"/> Full time <input type="checkbox"/> Part Time <input type="checkbox"/> With restrictions <input type="checkbox"/> Without restrictions Comments (identify restrictions):	If no, why?	If not working, when was your last day of employment (MM/DD/YYYY)	
Are you self-employed or do you have a home-based business? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:			
Have you ever participated in a FCA/FCE to address physical capabilities/work restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when (MM/DD/YYYY)	
Do you own a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Driver's License <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, State/Type/Restrictions	If no, when is IW eligible to obtain license?

HOBBIES AND INTERESTS:

	No	Yes	Branch of Service/Special Training	Years Served/Discharge Date
Military Service	<input type="checkbox"/>	<input type="checkbox"/>		
Service Connected Disability	<input type="checkbox"/>	<input type="checkbox"/>		

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MOTIVATIONAL/BEHAVIORAL

Injured worker's apparent behavior/mood

Has your physician provided you with an explanation of your current problem and treatment plan? Yes No
 If yes, please provide a brief outline of your problem/treatment plan.

Injured worker verbalizes compliance with current treatment: Yes No

Comment:

Has your physician discussed length of recovery and the impact it will have on your return to current employment? Yes No

Comment:

What are your employment goals?

What do you feel you are capable of doing at your workplace?

FINANCIAL

Present financial concerns? Yes No

COMMENTS ABOUT FINANCIAL CONCERNS:

Medicare/Medicaid Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you applied for or you receiving SSDI? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a medical insurance policy / policies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a short-term or longer term disability plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		

COMMENTS ABOUT MEDICAL INSURANCE:

ADDITIONAL COMMENTS:

CASE MANAGEMENT/NURSING ASSESSMENT

PROBLEMS IDENTIFIED:

CASE MANAGEMENT RECOMMENDATIONS:

Medical Case Manager:

Phone Number:
Fax Number: