North Dakota Workforce Safety & Insurance

MCM – INITIAL EVALUATION

RETURN TO WORK DIVISION

SFN 53205 (08/2014)

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

CASE SUMMARY

Date of Interview	Type of Interview ☐ Telephonic ☐ 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 *(pale, weak, obese, etc.)*	
Sensorium *(alert, confused, cooperative, etc.)*	
FROI/C1 signed *(if no, why)* ☐ Yes ☐ No	Verbal acceptance of case management services ☐ Yes ☐ No

Role of Medical Case Manager reviewed with injured worker ☐ Yes ☐ No ☐ 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:			

Claim Number	Injured Worker

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	☐	☐			
Seizures/type/frequency	☐	☐			
Headaches	☐	☐			
Migraine	☐	☐			
Tension	☐	☐			
Sinus	☐	☐			
Concussion/brain injury	☐	☐			
Vertigo/Dizziness	☐	☐			
Balance Disturbance	☐	☐			
Numbness	☐	☐			
Black-outs	☐	☐			

Claim Number	Injured Worker

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

Claim Number	Injured Worker

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

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 ☐ Right ☐ Left	Height (feet & inches)	Current Weight	Pre-injury Weight

Claim Number	Injured Worker

Additional Comments:

COMMENTS:

CURRENT FUNCTIONAL STATUS ***Limitations from injury as reported by the injured worker***

	No	Yes	Comments
Reaching	☐	☐	
Bending	☐	☐	
Kneeling	☐	☐	
Lifting	☐	☐	
Driving	☐	☐	
Walking	☐	☐	
Standing	☐	☐	
Sitting	☐	☐	

Independent with activities of daily living? ☐ Yes ☐ No
If no, has home health assessment been completed? ☐ Yes ☐ No

COMMENTS/CONCERNS:

CURRENT ORTHOPEDIC/MOBILITY/DME

	No	Yes	Comments
Problems with Mobility	☐	☐	
Prosthetic	☐	☐	
Braces/Splints	☐	☐	
Corset/Sling	☐	☐	
Crutches	☐	☐	
Walker	☐	☐	
Cane	☐	☐	
Wheelchair	☐	☐	
Other	☐	☐	

DESCRIPTION OF HOME ENVIRONMENT/ARCHITECTURAL BARRIERS ***(if no problems, can be stated as such)***

Do you live in a ☐ House ☐ Mobile Home ☐ Apartment ☐ Other

Home Accessibility/Needs (Wheelchair accessibility, bathroom accessibility, safety concerns): ☐ Yes ☐ No
If yes, explain:

Do you feel safe in your environment? ☐ Yes ☐ 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?

Claim Number	Injured Worker

SOCIAL FAMILY CIRCUMSTANCES

Indicate your living arrangements: ☐ alone ☐ with someone	If with someone, who? ☐ Husband/Wife/Significant Other ☐ Children ☐ Other Relatives ☐ Friend(s), Roommate

If with someone, is this individual available to provide support and assistance to you? ☐ Yes ☐ No Comments:

Are there any family or social issues which may impact recovery? ☐ Yes ☐ No Comments:

Do you use tobacco products? ☐ Yes ☐ No	Comments
Do you consume alcoholic beverages? ☐ Yes ☐ No	Comments
Do you use illicit / recreational drugs? ☐ Yes ☐ No	Comments
Have you been convicted of a misdemeanor or felony? ☐ Yes ☐ No	Comments

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

EDUCATIONAL/VOCATIONAL INFORMATION

	No	Yes	Where/When/Comments
High School Diploma	☐	☐	
Last Grade Completed			
GED	☐	☐	
University/College Education	☐	☐	
Degree	☐	☐	
Vocational Training/Schooling	☐	☐	
License/Certifications	☐	☐	
Are Licenses/Certificates Current	☐	☐	

	No	Yes	Comments
Language Preference	☐	☐	
Ability to Read	☐	☐	
Ability to Write	☐	☐	
Interpreter Required	☐	☐	

EMPLOYMENT INFORMATION

Current Employer	Occupation

Are you legally able to work in the United States? ☐ Yes ☐ No

Are you working now? ☐ Yes ☐ No ☐ Other

If yes, please indicate the following: ☐ Full time ☐ Part Time ☐ With restrictions ☐ 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? ☐ Yes ☐ No
If yes, describe:

Have you ever participated in a FCA/FCE to address physical capabilities/work restrictions? ☐ Yes ☐ No	If yes, when (MM/DD/YYY)

Do you own a vehicle? ☐ Yes ☐ No	Current Driver's License ☐ Yes ☐ 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	☐	☐		
Service Connected Disability	☐	☐		

Claim Number	Injured Worker

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? ☐ Yes ☐ No	Have you applied for or you receiving SSDI? ☐ Yes	Do you have a medical insurance policy / policies? ☐ Yes ☐ No
Do you have a short-term or longer term disability plan? ☐ Yes ☐ No		

COMMENTS ABOUT MEDICAL INSURANCE:

ADDITIONAL COMMENTS:

CASE MANAGEMENT/NURSING ASSESSMENT

PROBLEMS IDENTIFIED:

CASE MANAGEMENT RECOMMENDATIONS:

Medical Case Manager:

Phone Number:
Fax Number: