North Dakota Workforce Safety & Insurance

CONTRACTED NURSE CASE MANAGEMENT INITIAL EVALUATION

RETURN TO WORK DIVISION
SFN 53205 (09/2024)

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SECTION 1 – *Injured employee*

Claim number	Injured employee's (First name)	(Last name)
Date of initial evaluation		

SECTION 2 – *Medical*

Description of injury (as reported by the injured employee)

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

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

If yes, explain

Current providers

Provider name	Specialty	Facility name	Next appointment

Current medications

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

Pain assessment

Location/description 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

What makes the pain worse?

What makes the pain better?

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

Diagnostic tests

Test performed	Date performed	Results

Previous hospitalizations/surgeries

Year	Reason	Facility/provider	Additional comments

Current and past health conditions

Neurological

	Yes	No	Comments (If yes, explain)
Headaches/migraines	☐	☐	
Brain injury/concussion	☐	☐	
Vertigo/dizziness/balance problems	☐	☐	
Seizures	☐	☐	
Numbness/tingling/weakness	☐	☐	
Memory/speech difficulties	☐	☐	

Endocrine

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

Cardiac

	Yes	No	Comments (If yes, explain)
High blood pressure	☐	☐	
Heart disease	☐	☐	
Chest pain/shortness of breath	☐	☐	
Arrhythmia	☐	☐	

Respiratory/Lung

	Yes	No	Comments (If yes, explain)
Asthma	☐	☐	
Shortness of breath/chronic cough	☐	☐	
Emphysema/COPD	☐	☐	
Sleep apnea	☐	☐	

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

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

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

Skin			
	Yes	**No**	**Comments (If yes, explain)**
Redness/drainage	☐	☐	
Bruising/discoloration	☐	☐	
Swelling	☐	☐	
Incisions/lesions	☐	☐	
Rash	☐	☐	

Head, eyes, ears, nose, throat (HEENT)			
	Yes	**No**	**Comments (If yes, explain)**
Vision problems/change	☐	☐	
Hearing problems/change	☐	☐	
Dental problems/change	☐	☐	
Other	☐	☐	

Mental health			
	Yes	**No**	**Comments (If yes, explain)**
Depression	☐	☐	
Anxiety/panic disorder	☐	☐	
Substance use disorder	☐	☐	
Insomnia/sleep disorder	☐	☐	
Other	☐	☐	

Other health conditions			
	Yes	**No**	**Comments (If yes, explain)**
Cancer	☐	☐	
Bleeding/clotting disorder	☐	☐	
Autoimmune	☐	☐	
Blood clot/stroke	☐	☐	
Urinary/kidney problems	☐	☐	

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

If yes, explain

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

SECTION 3 – *Social/family/home environment*

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

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?
☐ 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 any hobbies or interests?
☐ Yes ☐ No

If yes, explain

What is your typical day or daily activities?

Do you own a vehicle? ☐ Yes ☐ No		If yes, state/type/restrictions
Do you have a current driver's license? ☐ Yes ☐ No	If yes, state/restrictions	If no, when are you eligible to obtain a license?
Do you use tobacco products? ☐ Yes ☐ No		If yes, how often, how long, what kind
Do you consume alcoholic beverages? ☐ Yes ☐ No		If yes, how often, how long, what kind
Do you use illicit or recreational drugs? ☐ Yes ☐ No		If yes, how often, how long, what kind

Do you have any financial concerns?
☐ Yes ☐ No

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

	Comments
Reaching	
Bending	
Kneeling	
Lifting	
Driving	
Walking	
Standing	
Sitting	

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

SECTION 5 – *Durable Medical Equipment*

Assistive devices

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

SECTION 6 – *Employment*

Job title

Employer of injury

Description of preinjury work

In contact with employer of injury?
☐ Yes ☐ No

Is transitional work available?
☐ Yes ☐ No

Current physical capabilities/restrictions

Do you have a home-based business or second employer?
☐ Yes ☐ No

Comments

SECTION 7 – *Case management plan/recommendations*

Plan/recommendations

Nurse case manager		Date
Telephone number	Email address	Fax number