MEDICAL REPORT

	Interim	Final	File Number
Name		**Address**	
Occupation	**Age**	**Marital Status**	**Phone Number**
First examination at		**on**	**19**

EVIDENCE OF prior injuries	prior disease	temporary impairment of faculties by alcohol or drugs at the time of first examination

First aid or other prior treatment received from:

Other inquiries for information concerning patient received from:

PATIENT'S ACCOUNT OF INJURY (Place and manner of occurrence)	Date	Time

DESCRIPTION OF INJURY(IES)

TREATMENT
Given at on (specify dates)

Surgical treatment, if any		
Other treatment prescribed		No. of sutures required
X-ray and findings		
Sent ☐ home or ☐ hospital	Name of Hospital	Date discharged

PROGNOSIS			PERMANENCY OF INJURY (Degree of permanent impairment)	
			Estimate Disability from date of accident	
			Total disability weeks	Partial disability weeks
Amount of account to date $	Amount of final account $	Signature M.D.	Date	