



Instructions:

- The treating physician must complete this form in its entirety at least annually to avoid delays or denial of caregiver services and reimbursement.
- Office notes from the examination should document medications, current plan of care, and identification of new treatment services needed. New treatment requests should be submitted to the assigned managed care organization on a Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9) report.
- Return the completed form by an encrypted email to bwc.catnurse@bwc.ohio.gov or mail to BWC Catastrophic Claims Unit, 30 W. Spring St., Level 20, Columbus, OH 43215. You may also fax it to 614-719-5300.

Injured worker name		Claim number		Date of injury	
Date of last examination	Date of this examination	Primary claim allowance (ICD-10 code and description)			
Based on your evaluation, please indicate below the activities of daily living the injured worker needs assistance with due to the allowed claim condition(s). Include type of assistance (full, partial, no), times per day, and hours per day that assistance is required.					
Activity of daily living (ADL)	Type of ADL assistance needed	Times per day	Hours per day	Comments and other services needed	
Bathing	☐ Full ☐ Partial ☐ No				
Dressing	☐ Full ☐ Partial ☐ No				
Feeding	☐ Full ☐ Partial ☐ No				
Personal hygiene	☐ Full ☐ Partial ☐ No				
Taking medications	☐ Full ☐ Partial ☐ No				
Toileting / diaper / foley / ostomy care	☐ Full ☐ Partial ☐ No				
Transfer (bed to chair, etc.)	☐ Full ☐ Partial ☐ No				
Transportation to medical appointments	☐ Full ☐ Partial ☐ No				
What mobility device(s) does the injured worker use on a regular basis? ☐ Cane ☐ Walker ☐ Wheeled mobility device ☐ Scooter ☐ Manual wheelchair ☐ Electronic wheelchair ☐ Other					
Does the injured worker have any other medical or psychological condition(s), other than those allowed in the claim, contributing to the need for caregiver services? ☐ No ☐ Yes, indicate condition(s)					
Has the injured worker been admitted inpatient in a hospital or skilled nursing facility since your last examination? ☐ No ☐ Yes, indicate inpatient dates					
Prognosis: Indicate your prognosis for the injured worker's condition over the next year and provide rationale for your prognosis selection. ☐ Remain static ☐ Improve ☐ Deteriorate due to allowed claim condition(s) ☐ Deteriorate due to aging process, co-morbidities, or other conditions					
Certification: I have examined the injured worker and based on that evaluation, I am making the determination below regarding the continuation or discontinuation of caregiver services. ☐ I recommend caregiver services should be continued. ☐ I recommend caregiver services should be discontinued as of _____.					
I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.					
Physician signature		BWC provider number		Date	
Physician's name (print legibly)		Address, city, state, nine-digit ZIP code			
Telephone number					
Fax number					