

State of

California

Qualified or Agreed Medical Evaluator's Findings Summary Form

Employee	1. Employee Name (First, Middle, Last)	2. Social Sec No.(Optional)	3. Date of Injury (Mo/ Dy/Yr)
	4. Street Address	City	Zip
			5. Telephone

Claims Administrator/ Employer	6. Name:	7. Street Address	8. Telephone
		City	Zip

Exam Referral Schedule	9. Date of Appointment Call	10. Date of Initial Examination	11. Date of Referral for Medical Testing/Consultation
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12. Date AME/QME's Report Served on all Parties _____

13. The following medical issues will be used to determine the patient's eligibility for workers' compensation.

Disputed Medical Issues And Conclusion

Check the appropriate box and reference the corresponding page(s) or section of the med-legal report for details.

	Report page(s) or section	Yes	No	Pending or Info. Not Sent
a. Is there permanent disability?	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Is the medical condition stable and not likely to improve with active medical or surgical treatment (i.e., is the condition permanent and stationary)?	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Did work cause or contribute to the injury or illness?	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. If permanent disability exists, is apportionment warranted?	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Is there a need for current or future medical care?	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Can this employee now return to his/her usual job?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes:				
i. Without restrictions	<input type="checkbox"/> Yes <input type="checkbox"/> No,			If YES, Date: _____
ii. With restrictions	<input type="checkbox"/> Yes <input type="checkbox"/> No,			If YES, Date: _____
If restricted work is recommended, reference page(s)/section in report for details: _____				

Basis for Conclusions	Check box and refer to page(s) or section in report.	Report page(s) or section	Yes	No	Pending or Info. Not Sent
	14. Are there subjective complaints?	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	15. Are there any abnormal physical or psychological examination findings?	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	16. Are there any relevant diagnostic test results (x-ray/laboratory)?	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	17. What are the diagnoses? (List) _____				
	18. Were treating physician's reports reviewed?	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	19. Were other physicians consulted?	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

QME 20. Signature _____ Date: _____

21. Name _____ Specialty _____

22. Street Address _____ City _____ Zip _____

23. Telephone _____ Cal. # _____

Instructions

To the **QME or AME**: You are required by Labor Code section 4061 to summarize the medical findings from your comprehensive medical-legal evaluation on the form prescribed by the Industrial Medical Council (IMC). Please complete the form in its entirety.

Employee Information: Fill in employee's full name, address, telephone number and date of injury

Exam Referral Schedule: complete dates that patient called for an appointment, date of initial examination, date referred for consultation(s), if any, and date report served on all parties. Supplying these dates are a legal requirement.

Disputed Medical Issues and Conclusions: Complete this section by checking appropriate box and stating what page(s) or section of the medical legal report contain the narrative for details. If diagnostic or laboratory tests have been ordered and the results or a medical records request is pending, check that box. If you cannot render opinions because of pending information, please complete and serve the report to comply with the 30 day time requirement and state what issues could not be evaluated.

Basis for Conclusions- Check appropriate box and give page numbers or section where the narrative in the full report is found. For diagnoses, in addition to page numbers, please briefly summarize the diagnoses in lay terms where possible. Also, list name and specialty for other physicians who provided information used in the medical legal report.

Signature Remember under the Labor Code, all your reports must be signed under the penalty of perjury.

You are required to serve the medical legal report and this form on the employee, the claims administrator, (if none, employer) and the Disability Evaluation Unit (DEU) having jurisdiction over the employee's area of residence.

Authority cited: Sections 139, 139.2, and 4061 Labor Code.

Reference: Sections 139.2 and 4061 Labor Code.