WYOMING WORKERS' COMPENSATION DIVISION
HEALTH CARE PROVIDER SPINE INJURY EVALUATION/RE-EVALUATION REPORT
Fax to 307-322-4763 or call 307-322-0291 for more information

PLEASE PRINT

First Name:	Middle Initial	Last Name	Claim Number

Date of Birth	Date of Injury	Last Day Worked

SUBJECTIVE

Explain the mechanism of injury:

_____

_____

_____

Is this a Traumatic Injury? ☐ Yes ☐ No

Any prior injury to this part of body?				☐ Yes	☐ No
Location	☐ Lumbar	☐ Cervical	☐ Thoracic	Spinal Level:	
Quality of Symptoms:	☐ Intermittent	☐ Constant		VAS (0:10 scale):	
When are symptoms worse	☐ Morning	☐ Afternoon	☐ Evening	☐ Night	
Headache present:				☐ Yes	☐ No
Lower Extremity	☐ Weakness	☐ Paresthesia	☐ Pain		
Upper Extremity	☐ Weakness	☐ Paresthesia	☐ Pain		
Saddle Numbness:				☐ Yes	☐ No
Loss of Coordination:				☐ Yes	☐ No
Bladder Dysfunction				☐ Yes	☐ No

OBJECTIVE

Cancer	☐ Yes	☐ No	Type/Location:		
Osteoporosis				☐ Yes	☐ No
Alcohol Use (amount)	Daily	Weekly	Monthly	Occasionally	How long:
Tobacco Use:	Packs per day:		How long:		
Illicit Drug Use:	☐ Yes	☐ No	List:		
Substance Abuse:	☐ Yes	☐ No	Rehab, When:		

ASSESSMENT

T	P	R	B/P	W	H	BMI

Current Medications:

_____

Inspection: _____

Palpation:

_____

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https://piers.wyo.gov

Are there any strength deficits? ☐ Yes ☐ No

Are there any reflex deficits? ☐ Yes ☐ No

Are there any range of motion deficits? ☐ Yes ☐ No

Are there any neurological symptoms? ☐ Yes ☐ No

Are there any musculoskeletal symptoms? ☐ Yes ☐ No

What is the initial OSWESTRY score? _____

PLAN

Medications/Lab/Imaging:

_____

_____

Specific Modification/Restrictions:

_____

_____

_____

Current Restrictions	☐ No Work	☐ Light-Modified Duty	☐ Full Duty
Dates:	Beginning:	Ending/Next Evaluation:	

Follow-up:

_____

_____

Name of Health Care Provider:	Phone Number
Address:	

_____

Health Care Provider Signature Date

_____

Tax ID number Clinic Name

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