Report of Accident

COHE Best Practice #1: Complete & Timely ROA (1040M)

Fax to 360.902.6690 or 800.941.2976 Toll Free

within 2 business days of exam date (box 15b)

Language preference (check one) ❑ English ❑ Español/S ❑ 简体中文/Chinese Simplified ❑ 한국어/Korean ❑

Worker Information

1. Name (First-Middle-Last)
2. ❑ Male ❑ Female
3. Social Security Number
4. Home phone ( )
5. Birth date month / day / year
6. Home address
7. Height (Ft-In.) _
8. Weight
City State ZIP Code
9. Mailing address (if different from home address)
City State ZIP Code
10. Family status: ❑ Married ❑ Widowed ❑ Separated ❑ Single ❑ Divorced ❑ Registered Domestic Partner

Dependent Information

Family and dependent eligibility: *You may be required to show proof of marriage, domestic partnership registration, or dependent eligibility.*

11. Dependent children Include unborn/ estimate birth date. Benefits will be based in part on number of legally dependent children. If you don't have legal custody, complete Box 13.

12. Name of Spouse or Registered Domestic Partner:

Name	Relationship	Legal Custody	Birth date
		❑ YES ❑ NO	/ /
		❑ YES ❑ NO	/ /
		❑ YES ❑ NO	/ /
		❑ YES ❑ NO	/ /
		❑ YES ❑ NO	/ /

13. Name & address of children's legal guardian
Name Address
City State ZIP Code

Injury Information

14. Date of injury or last occupational exposure / /
15. Time of injury: : ❑ AM ❑ PM
16. Shift (check one) ❑ Day ❑ Swing ❑ Night
17. Have you ever been treated for the same or similar condition? ❑ YES ❑ NO
18. Is this condition due to a specific incident? ❑ YES ❑ NO
19a. Body parts injured or exposed: **List all body parts impacted.**
19b. Describe in detail how your injury or exposure occurred. (Include tools, machinery, chemicals or fumes that may have been involved)
Encourage the worker to describe in detail *HOW* the injury or exposure happened.
20. Were you doing your regular job? ❑ YES ❑ NO
21. Where did the injury or exposure occur? ❑ Employer Premises ❑ Jobsite ❑ Other:
22. Where did the injury/exposure occur? Name of business:
Address City County State ZIP
23. Injury caused by a faulty machine, product or person other than my employer or co-worker? ❑ YES ❑ NO ❑ POSSIBLY
24. List any witnesses:
25. When will you return to work? / /
26. When did you last work? / /
27. Did you report the incident to your employer? ❑ YES ❑ NO If "yes" write name and title:
28. Date you reported it: / /
29. Did you have employer-paid health care benefits on the day injured? ❑ YES ❑ NO

Employment Information

30. Business name of your employer
Verify employer is not self-insured.
31. Type of business
32. How long have you worked there? ____ Years ____ Months ____ Weeks ____ Days
33. Employer's phone ( )
34. Your employer's address
https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/find-a-self-insured-employer
City State ZIP Code
35. List your job title and describe your job duties
Encourage the worker to describe their job duties in detail.
36. Rate of pay at this job (check one) $ ❑ Hour ❑ Week ❑ Day ❑ Month ❑ More than 1 rate of pay
37. Hours per day
38. Days per week
39. Additional earnings (daily average) $ (check all that apply) ❑ Piecework ❑ Regular overtime ❑ Commission ❑ Tips ❑ Shift diff. ❑ Bonuses in the last 12 months
40. How many paying jobs do you have?
41. I am a: ❑ Owner ❑ Partner ❑ Corp. Officer ❑ Corp. Shareholder ❑ Corp. Director ❑ Optional Coverage ❑ Does not apply to me

42. Signature **Note: READ LEGAL NOTICES ON THE WORKER'S COPY OF THIS FORM**
I declare these statements are true to the best of my knowledge and belief. In signing this form, I permit health care providers, hospitals, or clinics to release relevant medical reports, which they or others produce, to the Dept. of Labor & Industries.
X **Worker Signature** Today's date **& DATE** / /

43. Signature
I authorize the Department of Labor & Industries, or others acting on their behalf, to obtain confidential employment records from the Employment Security Department (ESD) to help determine workers' compensation benefits.
X **Worker Signature** Today's date **& DATE** / /

Health Care Provider Information

1. Diagnosis
2. ICD Codes
1. Diagnosis
2. ICD Codes

Confirm body parts in 19a (above) have been addressed.
Describe the diagnosis & enter ICD Codes.
ICD Codes for "INJURY OF (*enter body part*)" are allowable.
"INJURY" (by itself), "PAIN" (anywhere), or an event such as "MVA" *IS NOT allowed* and will require additional form completion.

3. Date you first saw patient for this condition. / /
Claim No.
COHE Alliance of Western Washington
4. Is the condition due to a specific incident? ❑ YES ❑ NO
5. Objective findings supporting your diagnosis (Include physical, lab and X-ray findings)
***Examples*: Decreased ROM, Swelling of Joint, Image Findings**
6a. Is more treatment needed? ❑ YES ❑ NO ❑ POSSIBLY
6b. Treatment and diagnostic testing recommendations:
***Examples:* PT, RICE, NSAIDS, X-Ray**
7. Was the diagnosed condition caused by this injury or exposure? **Check one.** ❑ YES ❑ PROBABLY (51% or more) ❑ NO ❑ POSSIBLY (Less than 50%)
8. Will the condition cause the patient to miss work? ❑ YES ❑ NO If yes, estimate the number of days: _____
9. Is there any pre-existing impairment of the injured area? ❑ YES ❑ NO If YES, describe briefly or attach report.
10. Has patient ever been treated for the same or similar condition? If YES, provider name, city & year: ❑ YES ❑ NO Name City Year
11. Are there any conditions that will prevent or slow recovery? If YES, describe briefly or attach report. ❑ YES ❑ NO
12. Did you refer the patient to an L&I medical network provider for follow-up? Referred to: ❑ YES ❑ NO
13. Name of attending health care provider (Please print)
Clearly Print Provider Name
Patient's ID number, if available:
14. **IMPORTANT: L&I Provider Number or NPI of provider listed in Box 13.**
Use *Provider L&I#* associated with site.
15a. Name of hospital or clinic where patient was treated:
Name **Include Service Location information -**
Address **stamp or label preferred** City State ZIP Phone ( )
15b. This exam date ***Fax ROA to L&I within 2 days of this date!***
16. Signature (NOTE: Licensed health care provider must sign report.)
X **Provider *MUST* Sign** Today's date **& DATE** / /

Use the APF to communicate that Activity helps Recovery.

To learn how to complete an APF, go to: www.lni.wa.gov/activityRX

COHE Alliance of Western Washington
sponsored by Virginia Mason Franciscan Health

COHE Best Practice #2:

Complete & Timely Activity Prescription Form (APF 1073M)

Fax APF with chart notes to 360.902.4567

General info

Worker's Name:	Patient ID:	Visit Date:	Claim Number: Enter Claim # from ROA
Healthcare Provider's Name (please print):		Date of Injury:	Diagnosis:

* Required: Work status

☐ Worker is **released** to the job of injury (JOI) without restrictions (related to the work injury) as of (date): ____/____/____
(If selected, skip to "Plans" section below)

☐ Worker **may perform modified duty**, if available, from (date): _____/_____/_____ to* _____/_____/_____ (*estimated date) **
☐ If released to modified duty, may work more than normal schedule

☐ Worker **may work limited hours**: _____ hours/day from (date): _____/_____/_____ to* _____/_____/_____ (*estimated date) **

☐ Worker **is working** modified duty or limited hours _____

Start & End Dates Required

☐ Worker **not released to any work** from (date): ____/____/____ **to*** ___/___/___ (*estimated date)**

☐ **Poor prognosis for return to work** at the job of injury at any date

*** Required: Measurable Objective Finding(s)**
(also referred to as Objective Medical Findings)
(e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)

Note objective medical findings that support the diagnosis and work capacities.

* Required: Estimate what the worker can do at work and at home unless released to JOI

How long do the worker's current capacities apply (estimate)?

☐ **1-10 days** ☐ **11-20 days** ☐ **21-30 days** ☐ **30+ days** ☐ **permanent**

Capacities apply all day, every day of the week, at home as well as at work. **24/7**

Worker can: (Related to work injury) A blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% (Not restricted)
Sit					
Stand / Walk					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist (flexion/extension) L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					
Vibratory tasks; high impact L, R, B					
Vibratory tasks; low impact L, R, B					

Complete All Capacities related to diagnosis if restrictions exist.

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift L, R, B	lbs	lbs	lbs	lbs	lbs
Carry L, R, B	lbs	lbs	lbs	lbs	lbs
Push / Pull L, R, B	lbs	lbs	lbs	lbs	lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐ Yes ☐ No
Modified duty available? ☐ Yes ☐ No
Date of contact: _____/_____/_____
Name of contact: _____

COHE Best Practice #3: 2-Way Communication
Use modifier (-32) with phone or email codes.

Note to Claim Manager:
Please note if you requested COHE Health Service Coordination (HSC) support.

☐ May need assistance returning to work
New diagnosis: _____

Opioids prescribed for: ☐ Acute pain or ☐ Chronic pain

* Required: Plans

Worker progress: ☐ As expected / better than expected ☐ Slower than expected (*address in chart notes*)

Current rehab: ☐ PT ☐ OT ☐ Home exercise ☐ Other (e.g., Activity Coaching) _____

Surgery: ☐ Not Indicated ☐ Possible ☐ Planned Date: ____/____/____ ☐ Completed Date: ____/____/____

☐ Next scheduled visit in: ___days ___weeks or Date: ___/___/__
☐ Treatment concluded, Max. Medical Improvement (MMI)
☐ Any permanent partial impairment? ☐ Yes ☐ No ☐ Possibly
If you are qualified, please rate impairment for your patient
☐ Will rate ☐ Will refer ☐ Request IME
☐ Care transferred to: _____
☐ Consultation needed with: _____
☐ Study pending: _____

* Reg: Sign

☐ Copy of APF given to worker ☐ Discussed three key messages on back of form with patient

Signature: **Provider *MUST* Sign** _____ **& DATE** ____/____/____ **& BEST Contact number** (___)___-____

☐ Doctor ☐ ARNP ☐ PA-C — Date — Phone