NOTICE OF EXACERBATION

Patient Name _____ **Date of Injury** _____

WCB# _____ **Carrier Case#** _____ **SS#** _____

This injured worker is seeking treatment in my office for an exacerbation of a work-related injury as defined by the NYS WCB: "a temporary worsening of a prior condition by an exposure/injury." The NYS WCB has directed that "a variance (MG-2) is not required for the initial treatment of an exacerbation, when the care provided is consistent with the MTG" and that "a completed C-4.2, Doctor's Progress Report, or EC-4NARR, Doctor's Narrative Report, which contains all the required documentation would be sufficient to fulfill the MTG requirements." (Medical Director's Office Bulletin MDO-2012 #1)

The goals of treatment are to return the patient to his/her previously documented baseline status. Re-evaluation of the patient and reconsideration of the treatment plan will occur in 2 to 3 weeks following the initial evaluation, as recommended by the Medical Treatment Guidelines. This form is derived from and consistent with the requirements outlined in the MDO-2-12 #1.

Date of this examination: _____ ☐ Initial evaluation ☐ Re-evaluation / Interim report

Based upon the history and findings, it is my opinion that this is a: ☐ causally related exacerbation ☐ new injury

Date of exacerbation: _____

1. Mechanism of exacerbation: ☐ This is an interim report. Please refer to the initial evaluation of this exacerbation.

_____

_____

2. Objective regression from baseline function (Include symptoms, corresponding physical exam findings, measured deterioration, and an explanation of how these elements result in deterioration in the functional ability to meet daily and work related activities.)

☐ Range of Motion ☐ Positional Tolerance ☐ Strength/Endurance ☐ Work duties/ADLs ☐ _____

_____

_____

_____

3. Treatment plan (Include type and frequency of treatment to return the patient to baseline): _____

_____

_____

4. Response to treatment (Goals, objective functional improvement in measures reported above): _____

_____

_____

5. Additional comments / complicating factors: _____

_____

Provider's Signature: _____ Date _____