Kahnawake Workers Compensation Administration

MSI-8
Medical Update

Patient's Name: _____D.O.B._____
m d y

Date patient was seen: _____/_____ /_____
m d y

1. Patient's current medical condition:

_____

_____

2. Do you believe this patient is capable of ***returning to work*** in his/her own occupation at this time?

   Yes____ No_____ If so, when? _____/_____/_____
   m d y

3. Does the patient have any physical restrictions that need to be considered? Yes _____ No _____
   If so, please identify these restrictions?

_____

_____

_____

4. What is the current treatment plan for this patient?

_____

_____

_____

5. Does the patient have a follow up appointment? Date:_____

Additional Comments/Issues:

_____

_____

_____

_____
Physician's Signature

_____/_____/_____
m d y

_____
Worker's Signature

_____/ _____/_____
m d y

Please forward this form to Mohawk Self Insurance via fax at 450-632-0976
Should you have any questions or concerns, please contact MSI at 450-638-0500 ext 2329
Mailing Address: Mohawk Self Insurance
Attn.: Claims Department
P.O. Box 720
Kahnawake, Quebec
J0L 1B0