



Texas Department of Insurance
Division of Workers' Compensation
 7551 Metro Center Drive, Suite 100 • MS-603
 Austin, TX 78744-1645
 (512) 804-4010 phone (512) 804-4011 fax

Presiding Officer's Directive to Order Designated Doctor Exam

I. Injured Employee Information

Employee Name	DWC #	Employee SSN	Date of Birth	Date of Injury
Telephone Number	Does the claim involve medical benefits provided through a Certified Workers' Compensation Health Care Network or a political subdivision pursuant to 504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool? Y N			
	If Yes, Name of Network or Health Care Plan:			

II. Other Contact Information

	E-Mail Address	Phone Number	Fax Number
Employee Representative Name			
Adjuster Name			
Treating Doctor Name / License Number / License Type / /			

III. Reason(s) for Exam - (See Page 2 Regarding Presiding Officer's Specific Instructions for Examination)

REASON	ADDITIONAL INFORMATION
A. Maximum Medical Improvement (MMI)	Statutory MMI Date (if any) (mm/dd/yyyy)
B. Impairment Rating (IR)	MMI Date (Only if Box A of this section is Not Checked) (mm/dd/yyyy)
C. Extent of Injury	Specific information should be included in Section V of this directive (Page 2)
D. Disability – Direct Result	Period to be assessed: From: _____ to _____ (mm/dd/yyyy) <i>*The ending date cannot be a future date. You may enter "present" for the ending date.</i>
E. Return to Work	Period to be assessed: From: _____ to _____ (mm/dd/yyyy)
F. Return to Work (Supplemental Income Benefits)	Period to be assessed: From: _____ to _____ (mm/dd/yyyy) Is the above qualifying period(s) applicable to the 9th quarter (or a subsequent quarter) of supplemental income benefits? Yes No
G. Other Similar Issues	Specific information should be included in Section V of this directive (Page 2)

IV. Body Areas/Diagnoses to be Assessed by the Designated Doctor

Should a New Designated Doctor be assigned? **Y N**

	Spine and Torso
	Upper Extremities
	Lower Extremities (excluding feet)
	Feet
	Teeth and Jaw
	Eyes
	Other Body Areas/Systems
	Traumatic Brain Injury
	Spinal Cord Injuries
	Severe Burns (including chemical burns)
	Multiple Bone Fractures (excluding spinal fractures)
	Infectious Diseases (complicated)
	Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)
	Chemical Exposure (excluding chemical exposure limited to skin exposure)
	Heart or Cardiovascular Condition

Employee Name	DWC #	Employee SSN	Date of Birth	Date of Injury
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V. PRESIDING OFFICER'S SPECIFIC INSTRUCTIONS FOR EXAMINATION

EXAMPLE -DWC USE ONLY

Presiding Officer (Printed Name):	Signature:	Date:
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