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**FINAL MEDICAL REPORT (LEG AND KNEE)  
COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 AS AMENDED**

<b>Claim Number</b>	<b>Date of Accident</b>	<b>Staff Number</b>
<b>Name of Employer:</b>		
<b>Name of Employee:</b>		

**LEG AND KNEE**

1	Injured side:	Left		Right		Both	
2.	Evidence of scarring:						
3.	Surgery performed:	Yes		No			
4.	Amputation	Yes		No			
	Level	cm above joint line					
		Through knee joint					
		cm above joint line					
		cm below tibial tubercle					
5.	Deformity of knee:	Yes		No			
	Describe: Varus/Valgus						
6.	Leg Length: specify measurement	Yes		No			
7.	Arthroscopy						
	Findings						
	Menisci:						
8.	Nerve lesion:	Yes		No			
	Level						
	Describe/Attach EMG Report:						
9.	Power/Strength						
10.	Vascular lesion	Yes		No			
	<b>Arterial</b>						
	<b>Venous</b>						
11.	<b>Range of movement (ROM):</b>						



	<b>Knee</b>	<b>Measured Rom (Ankylosed joint in fixed degrees)</b>	<b>Comments</b>
	Flexion	(0-150)	
	Loss of extension	(0-40)	
	Ligament stress test: If unstable please state the grade		
	Lachman	Stable	
	Lateral Stress	Stable	
	Medial Stress	Stable	
	Chondromalacia	0+\-	
12.	Radiology Report: please insert the latest report:		
13.	Other Comments		

<b>DECLARATION</b>	
I hereby declare that the information furnished in this report is true and correct according to my knowledge.	
Initial Surname:	Practice No
E-mail:	Tel:
Signature:	Date:

Stamp and Doctor's signature

