



Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

<http://www.tn.gov/workforce/article/medical-impairment-rating-mir-registry>

**MEDICAL IMPAIRMENT RATING (MIR) REPORT
AMA GUIDES™, 5TH EDITION**

A. PATIENT INFORMATION (please use the "TAB" key to advance from each field)

Claimant Name

Address

City State ZIP -

Phone # - -

State File # - MIR case #

Social security # - - Date of Birth / /

Date of Injury / / Date of MIR Evaluation / /

B. MIR PHYSICIAN INFORMATION

MIR Physician Name

Address 1

Address 2

City State ZIP -

Phone # - - Fax # - -

Location evaluation was performed (if different than above)

C. EXAMINEE HISTORY

INTRODUCTION AND OVERVIEW (EXAMINEE'S brief description of the injury/illness, EXAMINEE'S description of prior treatment received and the treatment outcome, the time periods EXAMINEE was unable to work, CURRENT SYMPTOMS as described by the EXAMINEE, current medications, AND CURRENT ADL Limitations) Note: Record Review is to be documented in Sections E, F, & G.

D. PHYSICAL EXAMINATION: Height _____ Weight _____

E. CLAIMANT'S CHRONOLOGICAL MEDICAL HISTORY

Name of All Treatment Providers	Date Treatment Received Month & Year	Nature of the injury or illness? Part of the body affected?
	/ / / / /	
	/ / / / /	
	/ / / / /	

E. CLAIMANT'S CHRONOLOGICAL MEDICAL HISTORY--Continued

Name of All Treatment Providers	Date Treatment Received Month & Year	Nature of the injury or illness? Part of the body affected?
	/ / / / /	
	/ / / / /	
	/ / / / /	

F. MEDICAL RECORD REVIEW (Use additional pages as required)

In the space below, check the applicable blocks next to any test results which you reviewed and relied upon to base your medical assessments or conclusions. Be sure to show the date of each test and summarize results. Attach copy(ies) of report(s) if applicable.

	DATE(S) PERFORMED	SUMMARY OF RESULTS
<small>Within the Summary of Results section, please note whether it was the actual images reviewed or if the paper report was reviewed.</small>		

<input type="checkbox"/> X-RAY(s) <small>Specify for each whether the images or just the radiology report was present and reviewed</small>	/	
	/	
	/	
	/	
	/	

	DATE(S) PERFORMED	SUMMARY OF RESULTS
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<input type="checkbox"/> EMG/NCS <small># Reviewed</small>	/	
	/	
	/	
	/	
	/	

	DATE(S) PERFORMED	SUMMARY OF RESULTS
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<input type="checkbox"/> CT SCAN <small>Specify for each whether the images or just the radiology report was present and reviewed</small>	/	
	/	
	/	
	/	
	/	

DATE(S) PERFORMED**SUMMARY OF RESULTS**

[] MYELOGRAMSpecify for each whether the images or just
the radiology report was present and reviewed/
/
/
/
/

DATE(S) PERFORMED**SUMMARY OF RESULTS**

[] MRISpecify for each whether the images or just
The radiology report was present and reviewed/
/
/
/

DATE(S) PERFORMED**SUMMARY OF RESULTS**

[] OTHERS (Describe)

Reviewed

/
/
/
/
/

G. SURGICAL PROCEDURES

Please list all operative procedures performed in chronological order with the operation title, surgical findings, and operation performed.

H. IMPAIRMENT

1. Does the claimant have a permanent impairment? **(Mark with an "X")** YES NO
2. Has the claimant reached maximum medical improvement (MMI)? **(Mark with an "X")** YES NO
If YES, date MMI was reached / / If NO, SKIP TO SECTION I on PAGE 9.
3. Do the *AMA Guides* adequately assess the medical impairment rating of the claimant? **(Mark with an "X")**
Yes NO

If YES, Please SKIP TO QUESTIONS 4 AND 5 AND PROCEED.

If NO, Please express an impairment that you think is appropriate %
Calculated total whole person impairment: % (if appropriate).

Explain the method utilized to determine it, and how you arrived at the percentage.

4. Impairment Rating Criteria: at MMI—the residual function, the limitations of activities of daily living, the prognosis, etc.

5. Using the *AMA's Physicians Guide to the Evaluation of Permanent Impairment* (applicable edition) or another appropriate method, please translate the claimant's condition to a percentage of impairment.

Impairment Rating and Rationale Organ system and whole person impairment						
Body part or system	Chapter Number	Table Number	Figure Number	Text Cited Page Number	% Impairment of the Scheduled Member	% Impairment of the Whole Person If appropriate
a.					%	%
b.					%	%
c.					%	%
d.					%	%
e.					%	%
f.					%	%
g.					%	%
h.					%	%

From the preceding chart, calculate the total whole person impairment: % (if appropriate)

Discuss:

1. any possible inconsistencies in the examination
2. the rationale of the impairment rating and
3. the ratings assigned by other physicians, and why this rating is correct and at least one of the other ratings is not correct

I. PHYSICIAN CERTIFICATION AND QUALIFICATIONS

“It is my opinion, both within and to a reasonable degree of medical certainty that, based upon all information available to me at the time of the MIR impairment evaluation and by utilizing the relevant AMA Guides or other appropriate method as noted above, that the claimant has the permanent impairment so described in this report. I certify that the opinion furnished is my own, that this document accurately reflects my opinion, and that I am aware that my signature attests to its truthfulness. I further certify that my statement of qualifications to serve on the MIR Registry is both current and completely accurate.”

Signature: _____ **Dated:** _____

Printed full name of physician _____

Complete and return with all required attachments via overnight delivery to:

**Bureau of Workers' Compensation
ATTN: Medical Impairment Rating Registry
220 French Landing Drive
Nashville, TN 37243-1002**