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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| http://inside.cbs.state.or.us/docs/branding/logos/wcd/en/JPEG/WCD-logo-black.jpg | | | | | | | **Invasive Medical Procedure Authorization**  **Autorización para Procedimiento**  **Médico Invasivo** | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Worker’s name: | | | | |  | | | | | | | | | | |
| Date of injury: | | | |  | | | | | | | | | | | |
| Insurer’s name: | | | |  | | | | | | | | | | | |
| Insurer’s claim number: | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Independent medical examination (IME) physician: complete this section | | | | | | | | | | | | | | |  |
|  |
| An invasive procedure is one that breaks the skin or penetrates, pierces, or enters the body using a surgical or exploratory procedure (e.g., by a needle, tube, scope, or scalpel). [Un procedimiento invasivo es aquel que penetra la piel o el cuerpo usando un procedimiento quirúrgico o de exploración (por ejemplo una aguja, tubo, o escalpelo).]  Proposed invasive procedure (Procedimiento invasivo propuesto): | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| IME physician’s name: | | | | | |  | | | | | Examination date: | | |  | |
| Address: | | |  | | | | | | | |  | | | | |
|  | | |  | | | | | | | |
| Phone: | |  | | | | | | | | |
|  | | | | | | | |  |  | |
| *IME physician’s signature* | | | | | | | | *Date* | |
| **Worker: complete this section (Trabajador: complete esta sección)** | | | | | | | | | | | | | |  | |
|  | |
|  | **YES.** I consent to the proposed invasive procedure described above.  (**SÍ,** estoy de acuerdo con el procedimiento invasivo propuesto descrito previamente.) | | | | | | | | | | | | | | |
|  | **NO.** I decline the proposed invasive procedure described above. I understand that my workers’ compensation benefits ***cannot*** be suspended if I say ***no***.  (**NO,** no estoy de acuerdo con el procedimiento invasivo propuesto descrito previamente. Tengo entendido que mis beneficios de compensación para trabajadores ***no podrán*** ser suspendidos si digo que ***no***.) | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | |  | | | |
| *Worker’s signature (firma del trabajador)* | | | | | | | | | | *Date (fecha)* | | | |
| Physician: Make copies of this form for the worker and your records; send the **original to the insurer.** | | | | | | | | | | | | | | | |
| 440-3227 (6/25/DCBS/WCD/WEB | | | | | | | | | | | | | **3227** | | |