PHYSICIAN'S REPORT OF EMPLOYEE INJURY

TO BE SENT WITH INJURED EMPLOYEE AND GIVEN TO PHYSICIAN

All referrals for testing or to another doctor require authorization. All bills for authorized medical treatment must have corresponding medical notes attached and should be directed to:

OccuSure PO BOX 682829 / FRANKLIN, TN 37068 615-373-0500/ FAX 615-377-4735

TO BE COMPLETED *BY EMPLOYER* PRIOR TO TREATMENT BY PHYSICIAN:

Employer Name:

Address: **City:** **State:** **Zip:**

Phone:_____ **Fax:** _____ **Contact:** _____

Name of Injured Employee:_____ **Date of Injury:**_____

Description of Incident:_____

Body part(s) To Be Treated:_____

Authorized Employers Signature:_____ **Date:**_____

Employees Signature (for treatment on the above injury):_____ **Date:**_____

TO BE COMPLETED BY TREATING PHYSICIAN:

Date of First Treatment:_____

Initial Complaint: (*NOTE TO TREATING PHYSICIAN: Employee is to be treated for the injury listed above. Any other treatment that is not related must obtain prior authorization.)_____

Diagnosis:_____

Nature, extent, degree, body location of injury:_____

Treatment Prescribed and Prognosis:_____

Medications/Testing Prescribed:_____

X-Rays taken ☐ Yes ☐ No **If yes, results:** ☐ Positive ☐ Negative

Drug/Alcohol Screen is Required for Initial Visit
Completed
Yes No
Results should be sent to Employer

_____

Was there any evidence of a prior or pre-existing injury or illness ____yes ____no **If yes, what condition and to what extent may it contribute to incapacity or recovery?**_____

_____

To help employees return to work more quickly, a temporary modified/light duty program is available, this employee:

☐ May return to work today without restrictions ☐ May return to work today with restrictions as indicated below for _____days

☐ May not return to work until _____ Reason_____

If restrictions are required, please indicate below

- No standing over _____ hrs.
- No overhead reaching
- No use using _____hand/upper extremity
- No climbing
- No pushing/pulling over _____lbs.
- Keep wound clean, dry
- No lifting over _____ lbs
- No stooping/bending/twisting
- No walking over ____hours
- No weight bearing _____foot
- No operation of machines
- Other:_____

Released to restricted duty on _____,20_____ **Released to regular duty on**_____,20_____

Will employee require further medical treatment? ____No ____ Yes, PRN ____Yes **If yes, date of next appt:** _____

Expected date of MMI **Please explain**_____

Signature of Physician: **Date**: