INITIAL MEDICAL REFERRAL FORM

INSTRUCTIONS : THIS FORM IS TO BE TAKEN TO THE DOCTOR. THE PHYSICIAN WILL FILL OUT THE SECOND PAGE. THE EMPLOYEE MUST RETURN THIS FORM TO THEIR SUPERVISOR

To be completed by Employer:

MEDICAL TREATMENT EVALUATION IS AUTHORIZED WITH:
_____ (***Insert Name of Medical Provider/ Facilty)***
FOR : _____ ***(Insert Name of Injured Employee)***
FOR DATE OF INJURY:_____
BRIEF DESCRIPTION OF ACCIDENT:
_____

NAME OF EMPLOYER REPRESENTATIVE MAKING REFERRAL:_____
TITLE: _____
SIGNATURE : _____ DATE: _____

OUR EMPLOYEES ARE OUR MOST VALUABLE ASSET. PLEASE TREAT THIS EMPLOYEE WITH SPECIAL CARE. OUR GOAL IS TO PROVIDE MODIFIED WORK WHENEVER POSSIBLE.

MEDICAL PROVIDER: Please complete the next section and advise what work restrictions, if any, the above employee has at the present time.

_____ ***(Name of Employee)***

1. [ ] MAY RETURN TO REGULAR WORK DUTIES NOW WITHOUT RESTRICTION.
2. [ ] MAY WORK 4( ) 6( ) 8( ) HOURS PER SHIFT. [ ] Other:_____
3. [ ] MAY RETURN TO WORK WITH THE FOLLOWING RESTRICTIONS:

THIS EMPLOYEE MAY NOT:

[ ] LIFT/PUSH/PULL/CARRY MORE THAN 10 20 30 50 POUNDS FREQUENTLY OR REPETITIVELY.
[ ] LIFT/PUSH/PULL/CARRY MORE THAN 10 20 30 50 POUNDS AT ANY TIME.
[ ] PROLONGED BENDING OR STOOPING
[ ] PROLONGED WALKING OR STANDING
[ ] PROLONGED OR REPETITIVE CLIMBING, KNEELING OR SQUATTING
[ ] CLIMB LADDERS OR WORK AT HEIGHTS
[ ] OPERATE VEHICLES OR MOVING EQUIPMENT
[ ] SIT MORE THAN _____ HRS/MIN.
[ ] PROTECT THE INJURED AREA FROM DIRT AND MOISTURE
LIMITED USE OF: RIGHT HAND LEG
LEFT ARM FOOT
OTHER RESTRICTIONS:
_____
THESE RESTRICTIONS SHOULD BE OBSERVED UNTIL :_____ ***(DATE)***

4. MAY NOT RETURN TO WORK UNTIL : _____

DIAGNOSIS: _____
FOLLOW-UP APPOINTMENT REQUIRED: _____

PHYSICIAN'S NAME ***(PLEASE PRINT)*** _____
PHYSICIAN'S SIGNATURE: _____
DATE: _____

NOTICE TO PHYSICIAN/MEDICAL PROVIDER AVAILABILITY OF MODIFIED WORK

EMPLOYER: _____ DATE : _____

WORKERS' COMP CARRIER: Pacific Compensation Insurance Company
P.O Box 33070
Phoenix, AZ 85067-3070

WE ARE COMMITTED TO BRINGING OUR EMPLOYEES BACK TO A MEDICALLY APPROPRIATE POSITION WHILE THEY RECUPERATE FROM THE EFFECT OF THEIR INJURY. WE WILL MAKE EVERY EFFORT TO MODIFY THE FOLLOWING JOB FACTORS TO ACCOMODATE WHATEVER PHYSICAL LIMITATIONS THE EMPLOYEES WILL HAVE:

[ ] JOB DUTIES
[ ] HOURS
[ ] WORK STATION
[ ] EQUIPMENT
[ ] REASSIGNMENT TO ANOTHER POSITION
[ ] ANY OF THE ABOVE
[ ] PLEASE CONTACT ME TO DISCUSS
[ ] I AM ATTACHING DESCRIPTIONS OF ALL OF OUR AVAILABLE POSITIONS.

IF YOU FIND THAT THE EMPLOYEE CANNOT DO ONE OR MORE OF HIS/HER JOB DUTIES, PLEASE SPECIFY WHAT DUTIES CANNOT BE DONE AND GIVE AN ESTIMATE AS TO PROBABLE LENGTH OF THIS DISABILITY.

EMPLOYER REPRESENTATIVE : _____

PHONE NUMBER: _____