

# MEDICAL TREATMENT REPORT

## Accident Report

Employee Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_

Accident Description: \_\_\_\_\_  
\_\_\_\_\_

I authorize the Physician and Hospital to disclose the information contained on this form concerning my condition to my employer and release the Physician and Hospital from any liability arising from such disclosure.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Treatment Report

Treatment Date: \_\_\_\_\_ Time In: \_\_\_\_\_ Time Out: \_\_\_\_\_

Check One:       Initial Visit       Re-Check       Admitted

Treating Physician: \_\_\_\_\_ Referred To: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Treatment Administered: \_\_\_\_\_  
\_\_\_\_\_

Medications Prescribed: \_\_\_\_\_

## Return To Work Orders

Return to Work Without Restrictions       Return to Work On a Trial Basis       Unable to Work Until: \_\_\_\_\_

Return to Work With the Following Restrictions:

Sed. Wk 10 lbs.       Lt 20 lbs.       Lt Med 30 lbs.       Med 50 lbs.       Lt Heavy 75 lbs.       Heavy 100 lbs.

No       No Excessive (3-5 Hrs/day)       Limited (5-8 Hrs/day)

Use of Rt. Upper Extremity

Repetitive Lifting

Pushing

Use of Lt. Upper Extremity

Exposure to Water

Pulling

Bearing Weight on Rt. Foot

Use of Rt. Hand

Squatting

Bearing Weight on Lt. Foot

Use of Lt. Hand

Climbing

Prolonged Standing

Lifting Over \_\_\_\_\_ Lbs.

Driving

Repetitive Bending

Monocular Vision

Other: \_\_\_\_\_

Work Restrictions Effective Until: \_\_\_\_\_ Call made to: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Charges \$ \_\_\_\_\_