



Authorization For Work Comp Medical Treatment



THIS SECTION TO BE COMPLETED BY EMPLOYER

Employer Name: _____ Date: _____
 Location patient will be treated: _____
 Clinic/Hospital: _____
 Address: _____
 Employee Name: _____ Date of Accident: _____
 Employee Job Title: _____ Time of Accident: _____
 Employee SS#: _____ Visit Authorized by: _____
 Employee Date of Birth: _____ Phone Number: _____
 Physician Should Complete: Urine Drug Screen Lab Preference: _____
 Evidential Breath Test (EBT) Blood Alcohol Only
 Describe how injury or illness occurred and part of body involved: _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Date of Treatment: _____ Time In: _____ Time Out: _____ New Injury Recheck
 Diagnostics: X-Rays Taken: _____ Lab
 Urine Drug Screen EBT Blood Alcohol Other: _____

Impression: _____
 Treatment: _____
 Rx: _____

May return to work with no limitations: Today Next Work Shift
 Unable to return to work
 Return to work with the following limitations checked below

In an 8-hour day, an employee can:

	No Restrictions	Never	Occasionally (up to 25%)	Frequently (25-50%)	Most of the time (up to 75%)
Stand/Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overhead reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repetitive hand tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work above ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Comments:

No pushing/pulling/lifting over _____lbs. Do not drive/operate machinery
 Wear splint/sling _____days Keep wound/dressing clean and dry

Physical Therapy Order: _____ Recheck or Suture Removal Date: _____
 Referred to: _____ Date: _____
 Attending Physician: _____ Patient Signature: _____

EMPLOYEE MUST RETURN THIS FORM TO YOUR SUPERVISOR IMMEDIATELY AFTER VISIT
Clinic must fax to IMA, Victoria Vanderhoof after each visit: (316) 303-3711