

# 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

- |  |   |
|--|---|
| <input type="checkbox"/> No standing over _____ hrs.             | <input type="checkbox"/> No lifting over _____ lbs    |
| <input type="checkbox"/> No overhead reaching                    | <input type="checkbox"/> No stooping/bending/twisting |
| <input type="checkbox"/> No use using _____ hand/upper extremity | <input type="checkbox"/> No walking over _____ hours  |
| <input type="checkbox"/> No climbing                             | <input type="checkbox"/> No weight bearing _____ foot |
| <input type="checkbox"/> No pushing/pulling over _____ lbs.      | <input type="checkbox"/> No operation of machines     |
| <input type="checkbox"/> Keep wound clean, dry                   | <input type="checkbox"/> 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: \_\_\_\_\_