

# 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

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**To be completed by Employer:**

MEDICAL TREATMENT EVALUATION IS AUTHORIZED WITH:

\_\_\_\_\_ *(Insert Name of Medical Provider/ Facility)*  
FOR : \_\_\_\_\_ *(Insert Name of Injured Employee)*

FOR DATE OF INJURY: \_\_\_\_\_

BRIEF DESCRIPTION OF ACCIDENT: \_\_\_\_\_

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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:

\_\_\_\_\_ *(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 5042  
Thousand Oaks, CA 91359-5042**

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: \_\_\_\_\_