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HENRY FORD WYANDOTTE HOSPITAL

## EMPLOYEE HEALTH SERVICE REQUEST

DATE OF INCIDENT: | TIME OF INCIDENT: | LOCATION OF INCIDENT:

NAME: | SOCIAL SECURITY NUMBER: | BIRTHDATE: | SEX:

JOB TITLE: | DEPARTMENT: | BENEFIT STATUS: | SHIFT: | EXTENSION:

HOME ADDRESS: | CITY: | ZIP: | HOME TELEPHONE NUMBER:

WHAT HAPPENED?

WHEN DID YOU FIRST NOTICE SYMPTOMS?

HAVE YOU EVER HAD THESE SYMPTOMS BEFORE? ☐ NO ☐ YES WHEN?

EQUIPMENT / PRODUCT RELATED (i.e. chemical, furniture)? ☐ NO ☐ YES WHAT?

CURRENT MEDICATIONS:

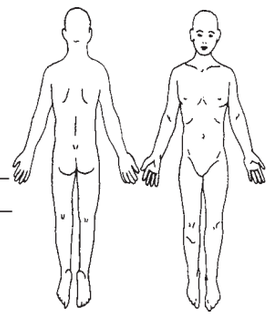
ALLERGIES:

FIRST PERSON INCIDENT REPORTED TO: ANY WITNESSES TO INCIDENT? (Name)

HOW COULD INCIDENT HAVE BEEN PREVENTED?

✓TYPE OF PROBLEM:
CIRCLE OR SHADE AFFECTED AREA

☐ Aching / pain
☐ Burning
☐ Numbness
☐ Stiffness
☐ Other: _____



WAS ACTIVITY:
☐ Repetitive
☐ Heavy
☐ Other: _____

EMPLOYEE SIGNATURE: | DATE/TIME: | SIGNATURE OF REFERRING SUPERVISOR: | DATE/TIME:

### MANAGER / SUPERVISOR

HOW DID INCIDENT HAPPEN?

HOW COULD INCIDENT HAVE BEEN PREVENTED?

EQUIPMENT / AREA INSPECTED? ☐ NO ☐ YES
WORK ORDER SENT? ☐ NO ☐ YES ☐ N/A
WORK ORDER NUMBER _____

WERE PROPER POLICIES / PROCEDURES FOLLOWED? ☐ NO ☐ YES POLICY #

COMMENTS:

INCIDENT / RESOLUTION DISCUSSED WITH EMPLOYEE? DATE: BY:

EMPLOYEE SIGNATURE: | MANAGER / SUPERVISOR SIGNATURE: | DATE/TIME:

### EMPLOYEE HEALTH SERVICES

DIAGNOSIS / TREATMENT / REMARKS:

PHYSICIAN ORDERS:

DISCHARGE INSTRUCTIONS:

RETURN TO WORK: ☐ NO ☐ YES

PHYSICAL RESTRICTION: ☐ NO ☐ YES (see above)

FOLLOW-UP APPOINTMENT: ☐ NO ☐ YES Date: _____ Time: _____

TARGET RETURN TO WORK DATE:

PHYSICIAN SIGNATURE: DATE / TIME:

RESTRICTIONS DISCUSSED WITH SUPERVISOR: ☐ NO ☐ YES DATE / TIME: BY:

DISCHARGE INSTRUCTIONS DISCUSSED WITH PATIENT:

EMPLOYEE HEALTH _____

PATIENT SIGNATURE _____

### MANAGER

MANAGER'S ANALYSIS / COMMENTS / RECOMMENDATIONS:

**•DO NOT PHOTOCOPY THIS FORM•**



☐ Copy to Insurance Administrator Date: _____ By: _____ OSHA CODE: _____

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**1-Employee Health Services** **2-Worker's Compensation** **3-Manager** **4-Employee**

FACE PARTS 1 & 2

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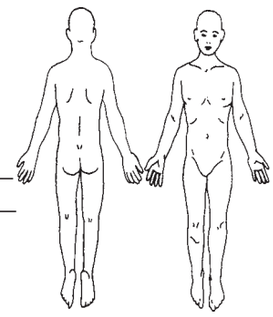

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☐ Stiffness
☐ Other: _____

WAS ACTIVITY:
☐ Repetitive
☐ Heavy
☐ Other: _____

EMPLOYEE SIGNATURE: | DATE/TIME: | SIGNATURE OF REFERRING SUPERVISOR: | DATE/TIME:

### MANAGER / SUPERVISOR

HOW DID INCIDENT HAPPEN?

HOW COULD INCIDENT HAVE BEEN PREVENTED?

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INCIDENT / RESOLUTION DISCUSSED WITH EMPLOYEE? DATE: BY:

EMPLOYEE SIGNATURE: | MANAGER / SUPERVISOR SIGNATURE: | DATE/TIME:

### EMPLOYEE HEALTH SERVICES



PHYSICIAN ORDERS:

DISCHARGE INSTRUCTIONS:

RETURN TO WORK: ☐ NO ☐ YES

PHYSICAL RESTRICTION: ☐ NO ☐ YES (see above)

FOLLOW-UP APPOINTMENT: ☐ NO ☐ YES Date: _____ Time: _____

TARGET RETURN TO WORK DATE:

PHYSICIAN SIGNATURE: DATE / TIME:

RESTRICTIONS DISCUSSED WITH SUPERVISOR: ☐ NO ☐ YES DATE / TIME: BY:

DISCHARGE INSTRUCTIONS DISCUSSED WITH PATIENT:
EMPLOYEE HEALTH _____
PATIENT SIGNATURE _____

### MANAGER

MANAGER'S ANALYSIS / COMMENTS / RECOMMENDATIONS:

**•DO NOT PHOTOCOPY THIS FORM•**

☐ Copy to Insurance Administrator Date: _____ By: _____ OSHA CODE: _____

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FACE PARTS 3 & 4