City of Memphis Injury On Duty (IOD) Attending Physician Form & Physical Therapy Note

Medical Facility: _____ **Front Desk Initials:** _____ **Date:** __/___/___**Time In:** _____**Time Out:** _____

(To be completed by Employee)

EMPLOYEE NAME: _____**HOME #:**_____**WORK #:**_____

DATE OF BIRTH: _____**SSN:** _____**DIVISION:** _____**DEPT:**_____

DATE OF INJURY: _____/_____/_____ **TIME OF INJURY:** _____ **SUPERVISOR NAME:** _____

(To be completed by Treating Physician)

INJURY: _____

ASSESSMENT/DIAGNOSIS: _____

Is condition work related? □ Yes □ No Any known pre-existing or other conditions contributing? □ Yes □ No; if so explain_____

_____ **Treatment Rendered:** _____

MEDICATIONS Prescribed: □ Narcotic Medication: _____ **□ Other Medication:** _____ **Frequency:** _____

□Do not take while working □ Do not take while driving

WORK STATUS – SELECT ONE ONLY

☐ **NO RESTRICTIONS/ RETURN TO REGULAR DUTY**
(CHECK ALL THAT APPLY)

___DISCHARGE FROM CARE **DISCHARGE DATE: ___/___/___**
___MMI **MMI DATE: ___/___/___**

☐ **RESTRICTIONS/ RETURN TO LIMITED DUTY START DATE: ___/____/____ END DATE: ____/____/_____**
(CHECK ALL THAT APPLY)

___Limited/Transitional
___Permanent Restrictions

UPPER EXTREMITY
____No use of injured hand/arm
____No repetitive overhead work
____No lift/push/pull over ____ lbs.
____No repetitive/heavy gripping
____No use of vibrating tools
____No repetitive/outstretched arm use

BACK
____Sitting job only
____Alternate sit/stand
____May stand/walk up to ____ hrs. /day
____No repetitive stoop/bend/twist
____May stoop/bend/twist___times/hour
____Weight limit _____lbs.

____Other _____
_____
_____

LOWER EXTREMITY
____Sitting job with foot/leg elevated
____Alternate sit/stand, may walk
____ Short distances
____No squatting or kneeling

OTHER
____Keep dressing clean/dry
____Injury prohibits driving while at work
____No use of hazardous machinery
____Medications may cause drowsiness

____Other _____
_____
_____

☐ **UNABLE TO WORK START DATE: ___/____/____ END DATE: ____/____/_____**

FOLLOW UP APPT. REQUIRED? □ YES □ NO □ AS NEEDED DATE: _____/_____/_____ TIME: _____ Pre Authorization Required? □ YES □ NO

REFERRAL To: Specialty: _____**Therapy:** _____**Diagnostic Testing:** _____ **(TPA to make referral)**

Comments: _____

Physician Name_____ **Physician Signature:** _____**Date:**_____/_____/_____
(Print Name)

PHYSICAL THERAPY NOTE: Therapist Name: _____ **Therapist Signature:** _____

Date: ____/_____/_____ **Start Time:** _____ **End Time:** _____ **Did Employee Attend: Y/N** _____

No. of sessions approved: _____ **No. of Sessions Remaining:** _____ **Next Therapy appointment:** _____ **Time:** _____

FORM TO BE COMPLETED AND SIGNED BY TREATING PHYSICIAN/THERAPIST OR HIS/HER DESIGNEE.
FAX COMPLETED COPY TO SEDGWICK AT (901)566-3415 and Division OSHA Coordinator at _____**. PLEASE GIVE EMPLOYEE COPY OF THIS FORM TO RETURN TO SUPERVISOR. **UPON DISCHARGE FROM MEDICAL FACILITY and IF SPECIALTY CARE IS NEEDED, EMPLOYEE MUST MAKE IMMEDIATE CONTACT WITH SUPERVISOR/OSHA REP FOR RETURN TO WORK INSTRUCTIONS AND SEDWICK FOR FOLLOW-UP CARE INSTRUCTIONS**

**** Form Revised as of 10/2012****