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 Testing 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 OSHA COORDINATOR . 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 SEDGWICK FOR FOLLOW-UP CARE INSTRUCTIONS. Revised 1/21/20