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 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 1/21/2019