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 (CHECK ALL THAT APPLY) START DATE: ___/__/____ END DATE:__/____/_____

___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 ____________________

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____

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. TO FAX COMPLETED COPY TO SEDGWICK AT 859-280-4803 AND OSHA COORDINATOR. PLEASE GIVE EMPLOYEE A 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 3/26/2024