

Urgent Care Center of South Bay

Occupational Injury Status Report

Employee: _____ Date: _____

Employer: _____ Time In: _____

Date of Injury: _____ Job Title: _____ Time Out: _____

Diagnosis:

Treatment

Examined	Determined Range of Motion	Disp. Eye drop
Wound Check	Examined under Slit Lamp	Crutches/Cane
Repair Laceration	Remove Foreign body	Cleaned & Dresses
Tetanus Immunization	Ice Applied	Splint Applied
Elastic Bandage Applied	Physical Therapy	X-Rayed
Disp. Medication	First Aid	Suture Removal
Injection	Other	Urine Drug Screening

Work Status

He/she is cleared to return to Full Duty as of :
He/she is cleared to return to Modified Duty as of :
He/ she is not to return to work until re-evaluated:

Work Modifications

No Excessive Walking-Prolonged Standing-Ladder Climbing	No commercial driving
No Repetitive bending-lifting-stooping-twisting	Avoid chem./Fum exposure
No Lifting pushing or pulling at or above shoulder level with _____ arm(s)	No Squatting:
Must keep bandage dry and avoid direct pressure on wound:	May sit for _____ min. per hr.
Must/May wear splint, cast, sling other	Other
No/Limited use _____ hand/arm and no forceful gripping, grasping or twisting	
Not operate dangerous equipment/machinery	
No lifting over _____ lbs/ No Pushing/Pulling over _____ lbs	
Use Proper protective equipment/machinery	
Must keep _____ Elevated	
Sedentary work, minimal Walking	

Disposition

Return for re-evaluation on:
Patient Discharge from care, no permanent disability anticipated:
Referred to Specialist:
Referred to private physician at their own expense, condition is Non- Industrial:
Other:

Physician Signature: _____

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS			PLEASE DO NOT USE THIS COLUMN	
2. EMPLOYER NAME			Case No.	
3. Address	No. and Street	City	Zip	Industry
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)				County
5. PATIENT NAME (first name, middle initial, last name)		6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth	Mo. Day Yr. Age
8. Address:	No. and Street	City	Zip	9. Telephone number () Hazard
10. Occupation (Specific job title)			11. Social Security Number	Disease
12. Injured at:	No. and Street	City	County	Hospitalization
13. Date and hour of injury or onset of illness	Mo. Day Yr.	Hour a.m. p.m.	14. Date last worked	Mo. Day Yr. Occupation
15. Date and hour of first examination or treatment	Mo. Day Yr.	Hour a.m. p.m.	16. Have you (or your office) previously treated patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Return Date/Code
<p>Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.</p> <p>17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED. (Give specific object, machinery or chemical. Use reverse side if more space is required.)</p>				
18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)				
<p>19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)</p> <p>A. Physical examination</p> <p>B. X-ray and laboratory results (State if non or pending.)</p>				
20. DIAGNOSIS (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? <input type="checkbox"/> Yes <input type="checkbox"/> No ICD-9 Code _____				
21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no", please explain.				
22. Is there any other current condition that will impede or delay patient's recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please explain.				
23. TREATMENT RENDERED (Use reverse side if more space is required.)				
24. If further treatment required, specify treatment plan/estimated duration.				
25. If hospitalized as inpatient, give hospital name and location		Date admitted	Mo. Day Yr.	Estimated stay
<p>26. WORK STATUS — Is patient able to perform usual work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "no", date when patient can return to: Regular work ____/____/____ Modified work ____/____/____ Specify restrictions _____</p>				
Doctor's Signature _____		CA License Number _____		
Doctor Name and Degree (please type) _____		IRS Number _____		
Address _____		Telephone Number (____) _____		