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REQUEST FOR TREATMENT FORM

Revised: 6/06

TO BE COMPLETED BY EMPLOYER:

Date:	Employer:	Phone:	Contact Person:
Employee Name:		Home Phone No.:	
Employee Address:		Social Security No.:	
Occupation / Position:		Date & Place of Injury:	
Description of Injury:			
Body Part Injured:		Supervisor Signature:	

I authorize you to communicate with my employer and the Trust and to furnish them with any and all medical information, pertaining to this recent illness/injury without limitation, case history, physician's report and notes, nurse's notes, x-rays and x-ray reports, and laboratory reports.

Employee Signature: _____ **Date:** _____

TO BE COMPLETED BY PHYSICIAN:

Date & Time of Visit:		Diagnosis:		Exposure: Y N			
History of Injury/Illness:							
Treatment/Recommendations:							
Pre-existing Condition (Yes / No)		If yes, specify:					
DISPOSITION (check one)	Return to regular duty – No restriction on:						
	May not return to work – Follow-up appointment on:						
	Return to duty with restrictions on: (complete following information)						
Activity	Frequency			Activity	Frequency		
	None	# hours per day	# hours at a time		None	# hours per day	# hours at a time
Sit				Climbing			
Stand				Bending			
Lift / Carry				Twisting			
Walk				Hand Repetition–R / L			
Squat				Push / Pull			

Lifting Restrictions 0 – 10 lbs. 10 – 20 lbs. 20 – 30 lbs. 30 – 50 lbs. 50 – 75 lbs. 75+ lbs.

Est. Period of Disability	FU Appointment (Yes / No)	Date:
Referral to:	Employer Notified (Yes / No)	Contact:
Name of Treatment Facility:	Location:	

Physician's Name: _____ **Signature:** _____ **Date:** _____