AppleCare Work Comp/Work Status/Employee Acknowledgment

Workers Compensation Claims: To be filled out by Employer
Please complete for all workers compensation claims. If claim number is not available, patients social security number must be used.

Employee Name _____DOB _____

Employer Name _____Authorizing Signature_____

Employer Address _____Employer Phone_____

Fax Work Status To _____Fax Number _____

Has employer filed a First Report of Injury? ❑ Yes ❑ No (send/attach copy if available)

Work Comp Insurance Carrier (If carrier information is not available employer is responsible for payment of claim)

Carrier _____WC Claim # or SS# _____

Work Comp Carrier Phone #_____ Work Comp Contact _____

Address _____City _____State _____Zip _____

Date of Injury_____ Time of Injury _____ Injury Site (example: arm, leg, elbow) _____

Drug Screen: ❑ 5 Panel Send Out ❑ 5 Panel Instant ❑ 10 Panel Send Out ❑ 10 Panel Instant ❑ Escreen ❑ BAT

DER for BAT _____

Workers Compensation Work Status: To be filled out by AppleCare Team Member

Employee Name _____Injury Site:_____Injury Date: _____

RTW FULL DUTY ON ___/____/____ CONTINUE FULL DUTY AS OF TODAY _____YES _____NO

RETURN TO WORK WITH THE FOLLOWING RESTRICTIONS:

❑ NO LIFTING OVER_____ POUNDS WITH _____RT_____LT UPPER EXTREMITY

❑ NO PROLONGED STANDING/WALKING _____(acceptable limit per physician)

❑ NO PUSHING ❑ NO PULLING ❑ NO OVERHEAD WORK

❑ NO CLIMBING ❑ NO STOOPING ❑ NO KNEELING

❑ NO SQUATTING ❑NO BENDING ❑NO TWISTING

DME Prescribed
Place Sticker(s) Here

NO USE OF: RIGHT _____/LEFT _____/_____

DIAGNOSIS: _____

_____

NOTES:_____

_____

REQUESTING AUTHORIZATION FOR: MRI _____ CT _____ REFERRAL TO: _____

FOLLOW UP APPT: _____

HAVE PAIN MEDICATIONS BEEN PRESCRIBED TO PATIENT? _____YES _____ NO

PATIENT IS AWARE OF RESTRICTION ALONG WITH NO DRIVING, USE OF MACHINERY, OR DECISION MAKING WITHIN SIX (6) HOURS OF TAKING PAIN MEDICATIONS

TREATING PHYSICIAN SIGNATURE:_____DATE:_____

*** PLEASE SEE OFFICE NOTE FOR FULL DETAILS***