AppleCare URGENT CARE

# 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, patient's social security number MUST be used. Please ensure all information is complete and legible.**

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)

**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 # _____

Claims Address _____ City _____State _____Zip _____

Adjuster's secure fax or email to send encounter notes & work status to _____

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

**AUTH TO DISPENSE IN-HOUSE MEDS?** ☐ Yes ☐ No

**Drug Screen** ☐ 5 Panel Send Out ☐ 5 Panel Instant ☐ 10 Panel Instant ☐ 10 Panel Send Out ☐ Escreen ☐ BAT

**Should employer or WC carrier be billed for drug screen? _____**

**Note: Any drug screens not paid by WC must be paid by employer**

**DER for BAT_____**

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

Employee Name _____Injury Site:_____Injury Date: _____

CONTINUE **FULL DUTY** AS OF TODAY? ☐ YES ☐ NO

DME PRESCRIBED PLACE STICKERS HERE

**RETURN TO WORK WITH THE FOLLOWING RESTRICTIONS:**

☐ NO LIFTING/PUSHING/PULLER OVER_____ POUNDS

☐ NO PROLONGED STANDING/WALKING LONGER THAN _____ minutes/per hour

☐ NO STOOPING ☐ NO CLIMBING ☐ NO SQUATTING ☐ NO OVERHEAD WORK

☐ NO KNEELING ☐ NO BENDING ☐ NO TWISTING ☐ SIT DOWN WORK

☐ NO USE OF: RIGHT _____/_____

LEFT _____ /_____

DIAGNOSIS: _____

_____

NOTES:_____

_____

REQUESTING AUTHORIZATION FOR: ☐ MRI ☐ CT SCAN

REFERRAL TO: ☐ ORTHO ☐ PT ☐ _____

FOLLOW UP APPT: _____

RETURN TO FULL DUTY TODAY? ☐ YES ☐ NO

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***