Medical Referral and Work Release Form

Patient's Name_____

Patient's Complaint _____

Patient's Job Duties _____ Date of Injury/Illness _____

Referred By: _____

Substance Abuse Screening Policy Testing Consent Agreement & Medical Authorization

Company substance abuse policy requires post-accident substance testing when an injury/illness becomes OSHA recordable or medical treatment other than first-aid is required.

By my signature below, I hereby certify and agree as a condition of my employment and continued employment that:

- I have personally read (or had read to me), understand and will comply with all provisions set forth in the Substance Abuse Screening Policy as presented to me, including this consent to be tested.
- I understand that failure to comply with and/or honor of the terms of this policy is sufficient cause for termination of my employment.
- A photocopy of this consent form will serve in it's stead as an original authorization document regardless of the date signed.

By my signature below, I hereby consent to, and by this Authorization, or any photocopy hereof, authorize the release to my employer or any other agent or employee of the company by any hospital, medical clinic, surgeon, physician, pharmacist or any other provider of medical services, treatment or supplies all medical reports, histories, findings, prognosis, bills, information and other documents relating to any medical treatment, hospitalization, prescription drugs or other medical service or supplies, including psychiatric treatment or treatment for alcoholism or drug abuse provided to or utilized by myself.

Employee Signature _____ Date _____

Reader/Interpreter Signature _____ Date _____

_____

Medical Provider: please provide the following information

Please Call {INSERT JOB TITLE} at XXX-XXXX, Extension XXXX

if you need further information or need to relay information concerning this patient.

Date _____ Time In _____ Time Out _____

Diagnosis _____

Treatment Plan _____

Return Appointment? ❑ Yes ❑ No Date _____ Time _____ am/pm

Referred to: Dr. _____ Date _____ Time _____am/pm

Work Release

Modified work, other than the patient's regular job may be available. To assist in restoring the patient's regular work and pay, please complete the information below

❑ No Duty from _____ to _____

❑ Modified Duty from _____ to _____

❑ Return to Full Duty on _____

Modified Duty Limitations Physical Limitations

❑ No prolonged standing _____

❑ No prolonged walking _____

❑ No prolonged sitting _____

❑ No knee bending, squatting, kneeling _____

❑ Limited or no use of _____

❑ Weight lifting restrictions _____

❑ Keep affected area elevated _____

❑ Keep dressing dry and clean _____

❑ Use crutches/sling/splint _____

❑ Other _____ _____

List of prescribed medication and frequency of directed use

_____ **Prescribed therapy and frequency**

_____

Physician Comments:

_____

Physician's Signature _____

By my signature, I have read, or had read to me, and fully understand the work restrictions as listed by the Physician.

Patient's Signature _____ **Date** _____

Reader/Interpreter Signature _____ Date _____