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: _____

Office: 4305 Torrance Blvd., Suite #106, Torrance, CA 90503
Phone: 310-542-9758 Fax: 310-542-9292

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send tow 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 ☐ Male ☐ 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? ☐ Yes ☐ No	Return Date/Code

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.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination

B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐ Yes ☐ No
ICD-9 Code ___ ___ ___ - ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☐ Yes ☐ No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ 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

26. WORK STATUS -- Is patient able to perform usual work? ☐ Yes ☐ No
If "no", date when patient can return to: Regular work ___/___/___
Modified work ___/___/___ Specify restrictions _____

Doctor's Signature _____ CA License Number _____

Doctor Name and Degree (please type) _____ IRS Number _____

Address _____ Telephone Number (____)_____

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Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.