Form - 201

Date ______________

Time In: ___________

Time Out: __________

Injury On Duty (IOD) Report

Facility:_______________ **Medical Record #:**__________ **Front Desk Initials:**____________________

EMPLOYEE NAME:______________________________**HOME #:**________________**WORK #:**_____________________________

DATE OF BIRTH:_________________**Emp ID#:**__________________**DEPARTMENT:**____

DATE OF INJURY:____________________**TIME OF INJURY:**_____________________**INITIAL/RECHECK (PLEASE CIRCLE)**

TREATING PHYSICIAN:____________________**HOW WAS AUTHORIZATION OBTAINED?**___________________________________

DESCRIPTION OF INJURY:____

ASSESSMENT/DIAGNOSIS:____
____

Is condition claimed and compatible to be work related? ☐ Yes ☐ No
Are known pre-existing or other conditions contributing? ☐ Yes ☐ No
TREATMENT RENDERED:____
____
____

MEDICATIONS: (dispensed_____/prescribed______)____

RETURN TO WORK OUTLINE

____RETURN TO REGULAR DUTY

____DISCHARGED FROM CARE

____SENT HOME (UNABLE TO WORK)

____ADMITTED TO:__________

____LIMITED DUTY
IF LIMITED DUTY NOT AVAILABLE, MUST BE OFF WORK UNTIL NEXT VISIT

____No use of injured hand/arm
____No repetitive overhead work
____No lift/push/pull over __lbs.
____No repetitive/tight gripping
____No use of vibrating tools
____No repetitive/outstretched arm/hand use
____Sitting job with foot/leg elevated
____Stand/walk ___% of time
____ Alternate sit/stand, may walk short distances
____ No use of hazardous machinery
____ No squatting or kneeling
____ No running/jumping

____Sitting job only
____Alternate sit/stand ____mins/hr
____May stand/walk up to ____ hrs/day
____No repetitive stoop/bend/twist
____May stoop/bend/twist__ times/hour
____Weight limit ______lbs.
____ Sit ___% of the time
____Keep dressing clean/dry
____No driving company vehicles/bus
____No working heights/on ladders
____No safety sensitive duties

____Use brace/ walker/ orthotic/ cane/ crutches as needed (Please Circle)

FOLLOW UP APPT. REQUIRED? ☐ **YES** ☐ **NO** ☐ **AS NEEDED** **DATE:**____/____/____ **TIME:** ______________
REFERRAL TO SPECIALTY:____**(ASC to make referral)**
REFERRAL TO PHYSICAL THERAPY:____**(ASC to make referral)**
REFERRAL TO DIAGNOSTIC TESTING:____**(ASC to make referral)**

I understand this report and acknowledge receipt of a copy:

Patient:__________________________________**Date:**_____________________**Physician:**____________________

WHITE: FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE.
GIVE EMPLOYEE COPY TO RETURN TO SUPERVISOR.