Form - 201

Injury On Duty (IOD) Report

Date:_____
Time Out:_____
Facility:_____ **Medical Record #:**_____ **Front Desk Initials:**_____

EMPLOYEE NAME:_____ **HOME #:**_____ **WORK #:**_____

DATE OF BIRTH:_____ **SS #:**_____ **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: (prescribed)_____

****Dispensing from MD office not allowed****

RETURN TO WORK OUTLINE

N/A – PENSIONER

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:**_____

FAX COMPLETED COPY TO ASC AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE. GIVE COPY TO INJURED WORKER.