Form - 201

Injury On Duty (IOD) Report

Date:_____
Time Out:_____
Facility:_____ **MR #:**_____ **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:_____ **(BSA to make referral)**

REFERRAL TO PHYSICAL THERAPY:_____ **(BSA to make referral)**

REFERRAL TO DIAGNOSTIC TESTING:_____ **(BSA to make referral)**

I understand this report and acknowledge receipt of a copy:

Patient:_____ **Date:**_____ **Physician:**_____

FAX COMPLETED COPY TO BRENTWOOD AT 615-263-1301 **OR** EMAIL TO MetroNewLoss@ACRISURE.COM AND THEN RETAIN IN EMPLOYEE'S FILE. **GIVE COPY TO INJURED WORKER.**