

**Medical Referral Form
FOR OFFICIAL USE ONLY (WHEN FILLED IN)**

Supervisor's Report		To Medical (Location)	Date of Report	
Employee's Name		Time & Date of Injury	Time Left Job	Time Returned
Social Security Number		Grade, Rate, Job Title	Occupational <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Questionable	
Reason for Referral: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Return to Work <input type="checkbox"/> Employee's Request <input type="checkbox"/> Other (Specify)				
Remarks:				
Supervisor's Signature:		Shop/Office:	Telephone #	Email:
Medical Report		Time Reported:	Time Released:	
Occupational <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Questionable		Degree of Injury <input type="checkbox"/> First Aid <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Other (Explain)		
Recommended Disposition of Employee: <input type="checkbox"/> Return to Perm. Job _____ <input type="checkbox"/> Referred to Private Physician/Hospital <input type="checkbox"/> Restrict Activity Until _____ <input type="checkbox"/> Temporary Transfer to Another Job <input type="checkbox"/> Employee to Seek Care from Private Physician <input type="checkbox"/> Other (Explain)				
Remarks:				
Provider Signature: _____		<input type="checkbox"/> Evaluation Completed		
Phone: _____		<input type="checkbox"/> Follow-up On or Before (date) _____		