Was the employee referred to a HCP for injury assessment and treatment? ____ Yes ____ No

Name of HCP employee was referred to: _____

Address: _____

_____

Phone: _____ Fax: _____

Confirm (check box) that the HCP evaluating the injury was supplied the following information:

☐ Description of employee's job

☐ Physical work activities

☐ Risk factor analysis

☐ Job hazard

Date employer/safety management received written opinion from HCP: _____

Confirm (check box) that the opinion from the HCP contained the following information:

☐ Assessment of physical condition as it related to job

☐ Recommendations for work restrictions (if applicable)

☐ Recommendations for time off to recover (if applicable)

☐ Follow-up needed (i.e. physical therapy)

☐ A statement that employee has been informed of results of evaluation and follow-up

☐ A statement that employee has been informed about activities that could impede recovery

If recommended by the HCP - did the employer/safety management offer (check):

☐ work restrictions

☐ temporary job alternative

☐ time off

If time off was recommended - give date employee is to return to work: _____

If follow-up medical visits and treatment were recommended - did the employee go to the appointments and follow recommended treatment? ____ Yes ____ No

If 'no' explain why: _____

_____

Did the employee, employer or safety management request a second opinion? ____ Yes ____ No

If yes - did it agree with initial opinion? ____ Yes ____ No

If 'no' was disagreement resolved? ____ Yes ____ No