A *Section "A" to be Completed by employer.*

DATE OF INJURY _____ NAME OF COMPANY _____

NAME OF EMPLOYEE _____ COMPANY– 24 HR CONTACT PHONE _____

DATE OF BIRTH _____ NAME OF INSURANCE COMPANY _____

X _____ Company Authorized Signature _____ Date

Treatment Requested:

❑ Injury Treatment

❑ Drug Screen Required

Refer Patient to:

_____ Physician/Clinic

B *Section "B" for LCMC use only.*

TREATMENT

❑ MD Exam ❑ Wound cleaned ❑ Suture Removal ❑ X– Ray of _____

❑ Sutures ❑ Dressing cleaned ❑ Antibiotic Injection ❑ X– Ray result _____

❑ Tetanus ❑ Splint ❑ Hepatitis Vaccine ❑ Crutches

❑ Other Treatment _____

DRUG SCREEN COLLECTED: ❑ No ❑ Specimen sent to: _____ Lab Name

MEDICATION: (*Indicate name of drug*)

❑ Antibiotic _____ ❑ Anti– inflammatory _____ ❑ Narcotic _____

❑ Analgesic _____ ❑ Muscle Relaxant _____ ❑ Other _____

Disposition

❑ Return for Recheck (Date: _____) ❑ Physician/Clinic (Date: _____)

❑ Suture Removal (Date: _____)

Work Status

❑ Return to Full Duty on: _____ ❑ No Work Until - Evaluation by Physician/Clinic: _____

RESTRICTIONS

Modified Work Involving:

Hand R L _____ ❑ Wear Splint

Arm R L _____ ❑ No Heavy Lifting (less than 10-24lbs Only)

Leg R L _____ ❑ Light Duty

❑ Desk work ONLY ❑ Restricted Duty Until - Evaluation by (see above): _____

Other Restrictions:

_____

DIAGNOSIS: _____

Company Rep Called: _____ Called by: _____ Time: _____

Comments: _____

X _____ Physician's Signature _____ Date _____ Time

LAS COLINAS Medical Center

6800 N. MacArthur Blvd. • Irving, TX 75039
(972) 969-2000

PATIENT IDENTIFICATION

AFTER–HOURS CARE
MEDICAL TREATMENT AUTHORIZATION

POS

LCM00120 (Rev. 9/09)