

TOWN OF LOS GATOS MEDICAL REFERRAL FORM

TO BE COMPLETED BY SUPERVISOR / MANAGER

Employee:
Department:
Date Injured:

Title:
Supervisor:
Date Sent to Doctor:

TO BE COMPLETED BY ATTENDING PHYSICIAN
and returned with employee

Please consider the availability of modified work when considering estimated periods of disability.

Date of Examination: _____ Time In: _____ Time Out: _____

WORK STATUS:

Regular work effective: _____

Temporary modified work, effective: _____ until: _____

(Outline Work Limitations Below)

Temporarily Totally Disabled, unable to perform any work until: _____

Please specify what precludes a return to work in a modified or limited hours capacity:

Anticipated Date of Return to Full Duty: _____

WORK LIMITATIONS: Check all functional limitations and outline frequency limitation.

- | | |
|---|--|
| <input type="checkbox"/> No prolonged walking/standing | <input type="checkbox"/> Limited walking/standing _____ hrs/min interval |
| <input type="checkbox"/> No repetitive bending/stooping | <input type="checkbox"/> No kneeling or squatting |
| <input type="checkbox"/> No climbing of stairs or ladders | <input type="checkbox"/> Limited sitting _____ hrs/min interval |
| <input type="checkbox"/> No pushing or pulling | <input type="checkbox"/> No lifting over _____ lbs |
| <input type="checkbox"/> No reaching above shoulder | <input type="checkbox"/> No operation/work around moving machinery. |
| <input type="checkbox"/> No Driving. | <input type="checkbox"/> Avoid exposure to extreme heat or cold |
| <input type="checkbox"/> Keep bandages clean and dry | |
| <input type="checkbox"/> Limited/No use of: _____ | |
| <input type="checkbox"/> Other: _____ | |

DISPOSITION:

- Future care recommended, no permanent disability anticipated
- Future care recommended, permanent disability unknown or anticipated
- Discharged, no permanent disability anticipated
- Discharged, permanent disability anticipated; anticipated permanent and stationary date: _____
- Physical Therapy Yes No _____ / _____ (times/week), or M T W TH F (circle one)

- Referred to Doctor: _____ Date: _____

For: _____ Authorized by: _____

Physician's name: _____ Signature: _____

Phone: _____

**Send Doctor's First Report To: Innovative Claim Solutions, Inc., P. O. Box 5128
San Ramon, CA 94583 (925) 327-8050 FAX (925) 327-8078
Fax Copy to: Town of Los Gatos (408) 399-5741**