

**MISSOURI UNIVERSITY OF SCIENCE AND TECHNOLOGY
WORKERS' COMPENSATION REFERRAL FOR MEDICAL CARE**

Patient Name: _____ Date/Time of Injury: _____
 Department/Contact Person: _____ Phone: _____
 Type of Injury/Illness: _____

 Authorized Signature

Physician: _____ Location: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

Date patient seen: _____
 Diagnosis: _____
 Medical Treatment: _____

RETURN TO WORK RECOMMENDATIONS

1. Employee may return to work immediately with no limitations.
2. May return to work with no limitations on _____ (date).
3. He/She may return to work on _____ (date) with the following limitations:

DEGREE	LIMITATIONS																																														
<input type="checkbox"/> Sedentary Work. Lifting 10 lbs. max. <input type="checkbox"/> Light Work. Lifting 20 lbs. max. <input type="checkbox"/> Medium Work. Lifting 50 lbs. max. <input type="checkbox"/> Heavy Work. Lifting 100 lbs. max. <input type="checkbox"/> Very Heavy Work. Lifting objects in excess of 100 lbs. OTHER INSTRUCTIONS AND/OR LIMITATIONS: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	<ol style="list-style-type: none"> 1. In an 8 hour work day patient may: <ol style="list-style-type: none"> a. Stand/Walk <table border="0"> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> 4-6 Hours</td> </tr> <tr> <td><input type="checkbox"/> 1-4 Hours</td> <td><input type="checkbox"/> 6-8 Hours</td> </tr> </table> b. Sit <table border="0"> <tr> <td><input type="checkbox"/> 1-3 Hrs.</td> <td><input type="checkbox"/> 3-5 Hrs.</td> <td><input type="checkbox"/> 5-8 Hrs.</td> </tr> </table> c. Drive <table border="0"> <tr> <td><input type="checkbox"/> 1-3 Hrs.</td> <td><input type="checkbox"/> 3-5 Hrs.</td> <td><input type="checkbox"/> 5-8 Hrs.</td> </tr> </table> 2. Patient may use hand for repetitive: <table border="0"> <tr> <td><input type="checkbox"/> Single Grasping</td> <td><input type="checkbox"/> Pushing and Pulling</td> </tr> <tr> <td><input type="checkbox"/> Fine Manipulation</td> <td><input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Power Tools</td> </tr> </table> 3. Patient may use feet for repetitive movement as operating foot controls: <table border="0"> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table> 4. Patient is able to: <table border="0"> <tr> <td></td> <td align="center">10/20</td> <td align="center">1/10</td> <td align="center">Not</td> </tr> <tr> <td></td> <td align="center">Per Hr.</td> <td align="center">Per Hr.</td> <td align="center">At All</td> </tr> <tr> <td>a. Bend</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>b. Squat</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>c. Climb</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>d. Twist Body</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>e. Power Tools</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </table> 	<input type="checkbox"/> None	<input type="checkbox"/> 4-6 Hours	<input type="checkbox"/> 1-4 Hours	<input type="checkbox"/> 6-8 Hours	<input type="checkbox"/> 1-3 Hrs.	<input type="checkbox"/> 3-5 Hrs.	<input type="checkbox"/> 5-8 Hrs.	<input type="checkbox"/> 1-3 Hrs.	<input type="checkbox"/> 3-5 Hrs.	<input type="checkbox"/> 5-8 Hrs.	<input type="checkbox"/> Single Grasping	<input type="checkbox"/> Pushing and Pulling	<input type="checkbox"/> Fine Manipulation	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both	<input type="checkbox"/> Power Tools		<input type="checkbox"/> Yes	<input type="checkbox"/> No		10/20	1/10	Not		Per Hr.	Per Hr.	At All	a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Twist Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Power Tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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4. These restrictions are in effect until _____ (date) or until patient is reevaluated on _____ (date).
5. Employee is totally incapacitated at this time and will be reevaluated on _____ (date).

Referrals For Specialist, PT, or diagnostic testing other than x-rays: call Brentwood Services at (636) 812-9913

 Physician Signature

Original - Return to Missouri S&T; Copy - Physician; Physician, please FAX to Brentwood Services at (615)724-9446

**All bills for these services to be submitted to: Brentwood Services Administrators, Inc.
 PO Box 4605
 Chesterfield, MO 63006-4065**