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
☐ Sedentary Work. Lifting 10 lbs. max. ☐ Light Work. Lifting 20 lbs. max. ☐ Medium Work. Lifting 50 lbs. max. ☐ Heavy Work. Lifting 100 lbs. max. ☐ Very Heavy Work. Lifting objects in excess of 100 lbs. OTHER INSTRUCTIONS AND/OR LIMITATIONS:	1. In an 8 hour work day patient may: a. Stand/Walk ☐ None ☐ 4-6 Hours ☐ 1-4 Hours ☐ 6-8 Hours b. Sit ☐ 1-3 Hrs. ☐ 3-5 Hrs. ☐ 5-8 Hrs. c. Drive ☐ 1-3 Hrs. ☐ 3-5 Hrs. ☐ 5-8 Hrs. 2. Patient may use hand for repetitive: ☐ Single Grasping ☐ Pushing and Pulling ☐ Fine Manipulation ☐ R ☐ L ☐ Both ☐ Power Tools 3. Patient may use feet for repetitive movement as operating foot controls: ☐ Yes ☐ No 4. Patient is able to: 10/20 Per Hr. / 1/10 Per Hr. / Not At All a. Bend ☐ ☐ ☐ b. Squat ☐ ☐ ☐ c. Climb ☐ ☐ ☐ d. Twist Body ☐ ☐ ☐ e. Power Tools ☐ ☐ ☐

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 Corporate Claims at 1-800-449-2264

_____
Physician Signature

Original - Return to Missouri S&T; Copy - Physician; Physician, please FAX to Corporate Claims at 636-519-7572

All bills for these services to be submitted to: **Corporate Claims Management, Inc.**
770 Spirit 40 Park
Chesterfield, MO 63005