

## Occupational Health Treatment Form

Employee's Name: _____	Work Telephone / Beeper: _____
Home Address: _____ _____	Department: _____
Home Telephone: _____	Campus: _____
Supervisor's Name: _____	Email (Home/Work): _____
Date of Accident: _____ Time: _____ Location: _____	Supervisor's Telephone: _____
Date Reported: _____	
Employee's description of what happened: _____ _____ _____ _____	
Please provide care for the above named employee: _____	
(Supervisor's signature)	Date

### Physician's Statement

Additional history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diagnosis	Alt	Full	Out	Plan	Consultation
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Return Visit: \_\_\_\_\_ Discharge: \_\_\_\_\_

Date: _____	_____
Time In: _____	MD/NP Signature
Time Out: _____	_____
	MD/NP Printed Name

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## INSTRUCTIONS

1. Upon injury or illness related to job/or work place, employee reports it immediately to his / her supervisor or foreperson, requesting medical care.
2. Supervisor or foreperson completes the top part of the form to the fullest extent possible and gives it to the injured employee as authorization for treatment at the Occupational Health Department (OHD), in the Hurtado Health Center or in Camden and Newark at their respective health centers. Care will not be provided without submitting the completed form, except in case of an emergency.
3. Employee should present the treatment form to the Receptionist or Nurse at the OHD or health center where treatment or referral will be provided. One copy of the form is retained by OHD or the respective health center. The second copy is forwarded Risk Management. The third copy is to be given to the supervisor by the injured employee.
4. The intent of the form is to provide Risk Management and the Department with prompt information regarding:
  - a. Return to work date and / or anticipated return to work date
  - b. Any physical restrictions such as no lifting 20lbs., no standing for more than 3 hours, etc.
  - c. At the supervisor's discretion the employee can still work within his / her job description if the medical restrictions are met.
5. If you have any questions concerning the above instructions please contact the OHD at (732) 932-8254 Ext. 221.

## Consent For Treatment & Release of Information For Insurers

Patient Name: \_\_\_\_\_

I hereby give permission and request for such diagnostic and therapeutic treatment, or referral for illness and injury, as may be considered necessary, desirable, or advisable for me by the medical provider of this service. All medical information contained either in this chart or stored/transmitted electronically is confidential, and access to it is strictly controlled. However, in order to insure quality medical care, all medical providers within the Rutgers system may access this chart or other information. In the event of a referral, I give consent and acknowledge that this information may be transmitted to a healthcare provider outside of Rutgers. I am aware that this information may also be conveyed to an organization responsible for the payment of my medical care (such as an HMO, PPO, POS, other insurance companies or the Claims Manager, Rutgers, The State University, for compensable injuries or illnesses). I further understand that in rare instances involving imminent danger to other and myself, in the event of a risk to the public health, or in the event of a legally delivered subpoena, this information may be provided to others on a need-to-know basis. I confirm and certify that I have read this form, or it was read to me, and that I have been given adequate information upon which to make an informed consent before I signed below.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_