**Medical Referral Form**
**FOR OFFICIAL USE ONLY (WHEN FILLED IN)**

OPNAV Report: OPNAV 5100-28

| **Supervisor's Report** | To Medical (Location) | Date of Report | |
|---|---|---|---|
| Employee's Name | Time & Date of Injury | Time Left Job | Time Returned |
| Social Security Number | Grade, Rate, Job Title | Occupational<br>☐ Yes ☐ No ☐ Questionable | |
| Reason for Referral:<br>☐ Injury ☐ Illness ☐ Return to Work ☐ Employee's Request ☐ Other (Specify) | | | |
| Remarks: | | | |
| Supervisor's Signature: | Shop/Office: | Telephone # | Email: |
| **Medical Report** | Time Reported: | Time Released: | |
| Occupational<br>☐ Yes ☐ No ☐ Questionable | | Degree of Injury<br>☐ First Aid ☐ Medical Treatment ☐ Other (Explain) | |
| Recommended Disposition of Employee:<br>☐ Return to Perm. Job _____<br>☐ Restrict Activity Until _____<br>☐ Employee to Seek Care from Private Physician | | ☐ Referred to Private Physician/Hospital<br>☐ Temporary Transfer to Another Job<br>☐ Other (Explain) | |
| Remarks: | | | |
| Provider Signature:<br>_____<br>Phone: _____ | | ☐ Evaluation Completed<br>☐ Follow-up On or Before (Date) _____ | |
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OPNAV Form: OPNAV 5100/9 (2-05)