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

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 ☐ Yes ☐ No ☐ Questionable	
Reason for Referral: ☐ 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 ☐ Yes ☐ No ☐ Questionable	Degree of Injury ☐ First Aid ☐ Medical Treatment ☐ Other (Explain)		
Recommended Disposition of Employee: ☐ Return to Perm. Job _____ ☐ Restrict Activity Until _____ ☐ Employee to Seek Care from Private Physician ☐ Referred to Private Physician/Hospital ☐ Temporary Transfer to Another Job ☐ Other (Explain)			
Remarks:			
Provider Signature: _____ Phone: _____	☐ Evaluation Completed ☐ Follow-up On or Before (date) _____		