REDWOODS
A CRUM & FORSTER COMPANY

# Employee Referral for Medical Treatment

*(To be presented to the Health Care Provider or Emergency Room)*

## Employer Name: _____

**Our employee, _____, had an illness or injury during work.** This brief document provides 1) basic information regarding the injured worker and the injury; 2) distribution information for bills and medical notes; 3) contact information for our contact person; 4) contact information for the claims adjuster; and 5) a form for reporting your diagnosis back to us. Specialty Risk Services (SRS) provides our workers' compensation claims handling.

Date of Injury: _____/_____/_____

What the employee was doing immediately before the incident: _____

_____

_____

What happened: _____

_____

Injured body part(s): _____

Specific item (if any) causing the injury: _____

Employer signature: _____ Employee signature: _____

Contact name: _____ Phone: _____ Date signed: ____/____/____

Employer address: _____

## Health Care Provider

1. The employee must be examined by the physician signing this form.
2. Please examine and give necessary treatment to this employee who reported an occupational injury/illness, then complete the necessary information below.
3. If you release this employee for restricted work, please specify activities to be avoided (i.e., bending, lifting, climbing, prolonged standing, operation of motor vehicles, etc.) and give associated parameters.

**Provider's name and address:** _____

_____

_____

After the employee has been examined by the health care provider, please send medical bills and medical notes to:

**Crum and Forster**
**P.O. Box 14801**
**Lexington, KY 40512**

## Diagnosis *(please indicate appropriate)*

**This employee may return to:**

- ❑ **Regular duty on _____/_____/_____.**
- ❑ **Restricted duty on _____/_____/_____, with the following restrictions:** _____

_____

- ❑ **No further treatment is required.**
- ❑ **Follow-up appointment required. Next visit _____/_____/_____.**
- ❑ **Referral to another physician:** _____

**Physician's signature:** _____