



CRESTWOOD MEDICAL CENTER

One Hospital Dr. Huntsville, AL 35801
256-429-4000

Occupational Health Dept: 256-429-4058 /256-348-9078

Treatment Authorization Form & Return To Work Report

SECTION I---To Be Completed by Employer:

Employee Name:	Date of Birth:	Home Phone:	Work Phone:
Employer/ Company Name:		Time of Injury:	Date:
Type of Accident/ Injury:		Body Part Injured:	
Services Requested: <input type="checkbox"/> Injury Treatment/ Evaluation <input type="checkbox"/> Drug Screen <input type="checkbox"/> Alcohol Screen <input type="checkbox"/> Other _____		Light Duty Available: <input type="checkbox"/> Yes <input type="checkbox"/> No Authorized for Treatment By: _____	

SECTION II---To Be Completed by Medical Provider: (Send Copy with Patient upon Discharge)

Diagnosis: _____

Drug/Alcohol Screen Complete: Yes No

Labs/X-rays/Medications: _____

Patient Disposition:

- Return to Work Full Duty; no restrictions
- Return to Work with restrictions (Complete "Physical Restrictions" Section Below)
- Off work until _____ then Return to Work on _____

Physical Restrictions: Limit Lifting/ Carrying to: <input type="checkbox"/> 0-5lbs <input type="checkbox"/> 6-10lbs <input type="checkbox"/> 11-25lbs <input type="checkbox"/> 26-50lbs <input type="checkbox"/> No lifting/carrying <input type="checkbox"/> Other: _____	Limit Pushing/Pulling to: <input type="checkbox"/> 0-5lbs <input type="checkbox"/> 6-10lbs <input type="checkbox"/> 11-25lbs <input type="checkbox"/> 26-50lbs <input type="checkbox"/> No pushing/pulling <input type="checkbox"/> Other: _____	Other Physical Limitations: <input type="checkbox"/> No exposure to vibrating tools <input type="checkbox"/> No operation of moving machinery <input type="checkbox"/> No climbing <input type="checkbox"/> No reaching above shoulders <input type="checkbox"/> No use of right/ left hand <input type="checkbox"/> Other: _____
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Time Limitations:
 Work requiring repeated stooping, crawling, kneeling or bending limited to _____ minutes per hour
 Continuous walking limited to _____ minutes per hour
 Repetitive hand/ wrist/ shoulder motion limited to _____ minutes per hour
 Work day limited to _____ hours per day
 Duration of physical limitations (Date) from _____ to _____

Follow-up/Referral Needed: Yes No

_____ Workwell Occupational Health Center (256-830-8930)
 _____ Physician Name: _____ Phone: _____
 _____ Therapy Other: _____

Prescription Given:	Yes	No
Physician Name/Signature	Nurse Name/Signature	