P.O. Box 20908
Louisville, KY
40250-0908

**QUESTIONS? 495-5040 or 1-800-KYCOMP-4**

**Please fax this & other relevant info to OMCA 502-495-5048 or 800-592-2945**

TREATMENT FACILITY ____________________ Date __________ ☐ Initial ☐ Follow Up ☐ Priority

TREATING PHYSICIAN ____________________ County __________ Time In _____am/pm Time Out _____am/pm

PATIENT NAME ______________________________ SS# _____-_____-_____ DATE OF INJURY ___________

**ASSESSMENT** ____________________________________________

____________________________________________

____________________________________________

Findings consistent with reported work injury? ☐ yes ☐ no

**TREATMENT** ____________________________________________

____________________________________________

____________________________________________

____________________________________________

**TREATMENT PLAN** ____________________________________________

____________________________________________

**EXPECTED DURATION** ____________________________________________

____________________________________________

***WORK STATUS – ACTIVITY RESTRICTIONS – INSTRUCTIONS***

Return to regular duty on ____-____-____

Return to work ____-____-____ with following restrictions:

Lift / carry ____lbs.

Push / pull ____ lbs.

Remain off work until next office visit ____-____-___

Explanation ______________________________

Expected return to work/release date ____-____-___

Additional restrictions / notes: ______________________________

______________________________

______________________________

______________________________

**PHYSICIAN SIGNATURE** ______________________________ Date ______________

**Follow Up Appointment**

Date ____-____-____ Time __________am / pm

Location ______________________________

**Referral Appointment**

Date ____-____-___ Time __________am / pm

Doctor ______________________________

Address ______________________________

***If NOT within OMCA network, MUST call 1-800-KYCOMP-4 for approval.***

I hereby authorize any treating physician and/or treatment facility to disclose any information regarding this incident to my employer and workers compensation claims representative, and hereby release the physicians and treatment facility from any liability arising from such disclosure. I fully understand the instructions above and acknowledge receipt of a copy. I UNDERSTAND IT IS MY RESPONSIBILITY TO TAKE A COPY OF THIS FORM TO MY EMPLOYER AND TO ANY REFERRAL APPOINTMENT.

Patient Signature ______________________________ Phone # ______________ Date ______-______-______