

# PROVIDER HOT SHEET

Appt date/time: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Company \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

Where/How did injury occur?: \_\_\_\_\_

Type of Injury: \_\_\_\_\_

Any previous Injuries:

Yes

No

Comments: \_\_\_\_\_

Any witnesses to injury:  Yes  No

Any initial treatment:  Yes  PMMC Emergency Room (**Medical release consent**)

Other: \_\_\_\_\_

No

Length of employment with company:

Less than 3 months

6 months to 1 year

1 year to 5 years

over 5 years

Employee shift /work schedule:

1<sup>st</sup>

2<sup>nd</sup>

3<sup>rd</sup>

Full time  Part time

**MODIFIED DUTY PROGRAM AVAILABLE:  YES  NO**

Comments: \_\_\_\_\_

**GUARANTOR /INSURANCE INFO VERIFIED WITH  
EMPLOYER CONTACT:  YES  NO**

**COMPANY REP INITIATING CALL:**

\_\_\_\_\_

**Instructed patient to have company contact call OH to  
verify information and authorize treatment.**

**\*\*\*\*\*Any changes to above info, please refer to  
Operations Manager or Client Services Coordinator**

\_\_\_\_\_  
Signature of person completing form

\_\_\_\_\_  
Date