IUPUI
CAMPUS HEALTH
Phone Number: 317.274.8214 Fax: 317.274.7657

IU Worker's Compensation Visit

Patient's Name: _____ Date of Birth: _____ Phone #: _____

Date of Injury: _____ Date of Initial Visit: _____

Work Status:

☐ Return to regular work on date: _____

☐ Remain off work until (date): _____

☐ Return to work with restrictions (date): _____ ☐ Full Time ☐ Part-time, Hours per Day: _____

Restrictions:

☐ Limit lifting, carrying, pushing to _____ pounds.
☐ No overhead working ☐ R arm ☐ L arm ☐ both arms.
☐ Right-handed work only.
☐ Left-handed work only.
☐ Avoid frequent or repetitive bending, stooping, or twisting.
☐ Avoid weight bearing on the injured extremity.
☐ Use ☐ crutches ☐ cane ☐ scooter.
☐ No ladders or scaffolds.
☐ Sitting work only.
☐ Keep the injury clean and dry. Watch for signs of infection (warmth of area, redness, swelling, drainage, fever).
☐ Rest breaks every _____ minutes for _____ minutes.
☐ Heat/ice to area _____ times daily for _____ minutes.
☐ Medication may cause drowsiness. May not operate vehicles while taking medication.
☐ Other restrictions.

_____

_____

Follow-up appointment at IUPUI Campus Health: Date: _____ Time: _____

1. Restrictions apply to work and home
2. If you need to reschedule, pleases call (317) 274-8214 prior to your appointment time.
3. The employee must take this page to his/her supervisor immediately following your appointment.
4. Please come to follow up appointments ready to return to work and in proper work dress
5. If you do not keep your appointments, or comply with your restrictions, you may lose all or part of your workers compensation benefits.

_____	_____	_____
Provider Signature	Printed Name	Date
_____	_____	_____
Patient Signature	Printed Name	Date

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Patient's Name: _____ Date of Birth: _____ Phone #: _____

Date of Injury: _____ Date of Initial Visit: _____ Diagnosis/ICD10: _____

Referral needed by the IU Worker's Compensation Group: ☐ No ☐ Yes

Physical or Occupational Therapy: Referrals appointment made by IU Worker's Compensation Group.

☐ Physical Therapy ☐ Occupational Therapy **(IU WC Group will contact you with appointment date and location.)**

☐ Evaluate and Treat. (Note specific treatment orders. frequency of treatment, etc.): _____

_____

_____

X-ray and Imaging Procedure: ☐ See attached order

Instructions (if applicable): _____

Specialist: ☐ See attached referral

Pharmacy: ☐ See attached prescription

Insurance: Indiana University Worker's Compensation
Billing Address:
Attn: IU Work Comp,
8520 Allison Pointe Blvd,
Suite 200,
Group # WCIU24120,
Indianapolis, IN 46250

_____ _____ _____
Provider Signature Printed Name Date

INDIANA UNIVERSITY

Occupational Injury/Illness Report

HUMAN RESOURCES

IMPORTANT INFORMATION—PLEASE READ BEFORE COMPLETING THIS FORM. This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. Submit completed report to IU Workers' Compensation by email at workcomp@iu.edu or by fax to (812) 855-2720. Type or print all information legibly.

SECTION 1—Employee Information

Employee Name:	Employee 10-Digit ID:	Date of Birth:
Campus:	Department:	Pay Frequency: ☐ Hourly ☐ Bi-Weekly ☐ Monthly
Employee's Regular Work Schedule (e.g. 8 a.m. -5 p.m., M-F):		
Home Phone:	Office Phone:	
Supervisor's Name:	Supervisor's Email:	

SECTION 2—Injury Information

Date of Accident:	Time of Accident: ☐ AM ☐ PM	Date Reported to Supervisor:
Exact Place of Accident:		
Cause of Injury (e.g. trip and fall, lifting a box, etc.):		
Nature and Extent of Injury (e.g. sprain, laceration, etc.):		
Injured Body Part (e.g. left hand, lower back, etc.):		
Narrative Description of Incident and Injury:		
Treated by (Doctor Name):	Treated at (Hospital/Clinic Name):	
Witnesses, If Any:		

SECTION 3—Signatures

Employee's Signature:

Supervisor's Signature:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This will authorize you to disclose to Indiana University Human Resources Worker's Compensation Services or it's representatives, information you may have regarding my condition while under your observation or treatment at any time, including medical history and findings, consultation, prescriptions, treatment, x-ray, special consultation reports, diagnosis and prognosis, and copies of all hospital and medical records.

A copy of this Authorization shall be considered as effective and valid as the original.

GINA Notification to Health Care Providers:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or receive genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature_____

Address_____

City_____State___Zip_____

DOB_____

Date_____