

Date: \_\_\_\_\_ Revised Date: \_\_\_\_\_

Business Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Number of Employees: \_\_\_\_\_

### **WORK INJURY TREATMENT PROTOCOLS**

Do you require post-accident drug screens?  Yes  No

Are you an E-Screen participant?  Yes  No  Unknown

Limited Duty Available:  Yes  No

**Evan Swanson, M.D. for Follow up**

**AdventHealth Ottawa Orthopedic Care**

Is referral authorization required?  Yes  No

Contact Information: \_\_\_\_\_

**Ransom Gollier Rehabilitation Physical Therapy, Occupational Therapy, Work Conditioning**

Is referral authorization required?  Yes  No

Contact Information: \_\_\_\_\_

**AdventHealth Ottawa Imaging Department for X-rays including MRI**

Is referral authorization required?  Yes  No

Contact Information: \_\_\_\_\_

Designated Pharmacy: \_\_\_\_\_

Guarantor: \_\_\_\_\_

Work Comp Carrier Address: \_\_\_\_\_

Other Key Contact Persons or Special Instructions: \_\_\_\_\_