Westlake Village Urgent Care

OCCUPATIONAL AND FAMILY MEDICAL

Westlake Village Urgent Care
2900 TOWNSGATE RD, Suite #103
Westlake Village, CA 91361
805-379-9125 or 379-9175
Fax: 805-379-2311
wvuc101@gmail.com

REASON FOR VISIT: ☐ On-the-job injury ☐ Job related illness ☐ Follow-up appointment ☐ Drug screen ☐ TB Test ☐ Physical ☐ Other:_____

INJURY REPORT *(To be completed by Supervisor/Manager prior to treatment)*

Company Name	Authorized by	Title	Tel	Ext

Employee Name	Job Title
Date of birth	Full-time Part-time
Home Tel	Date of Injury / Time AM PM
Resulting Injury	Date Injury Reported / Time AM PM

Description of Occurrence

MEDICAL PROVIDER ASSESSMENT AND TREATMENT | Time In AM PM | Time out AM PM | First Aid Only

Diagnosis	ICD10 Code	Aggravation of pre-existing condition? Yes No
	Hand Dominance Yes No	
	Prescriptions	

Medications/Supplies Dispensed

Keep injured part elevated for ____ days

☐ Apply ice every ____ hours for ____ days

☐ Wear: ___Ace wrap ___Splint ___Brace ___Support

☐ Re-Wrap Ace if too tight

☐ Must wear gloves when handling food

☐ *Be on the alert for the following signs of infection and contact our office immediately if they occur*
Redness Red Streaks Heat Swelling Drainage Pain

☐ Keep dressing clean and dry

Additional comments:

DISPOSITION ☐ Able to work full duty ☐ Unable to work ☐ Able to work with restrictions below (and/or above)

Avoid Use	Limited Use	Comments	Avoid Use	Limited Use	Comments
☐ R. Arm	☐ R. Arm		☐ Standing	☐ Standing	
☐ L. Arm	☐ L. Arm		☐ Walking	☐ Walking	
☐ R. Leg	☐ R. Leg		☐ Weight Bearing	☐ Weight Bearing	
☐ L. Leg	☐ L. Leg		☐ Stooping	☐ Stooping	
☐ No lifting over	☐ 10 lbs. ☐ 25 lbs. ☐ _____ lbs.		☐ Bending	☐ Bending	
☐ Do not drive vehicle	☐ Confine to home		☐ Climbing	☐ Climbing	
☐ Do not operate machinery	☐ Other work restrictions:				

☐ Case closed/Released from care ☐ Discharge as cured with no notable disability and no future medical. ☐ Refer to Specialist ☐ Consult ☐ Recheck in _____ days

Next appointment date	Time	AM PM	Physician: Sonia Devgan-Kacker, MD
Medical Provider Signature			Date
Status Given by	To	Time	Date

I hereby authorize the Physician, and/or hospital to disclose any information concerning my condition to my employer or their agent, and hereby release the above mentioned parties from any liability arising from such disclosure regarding this visit and any subsequent follow-up treatment.

Employee's Signature Date