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

Information Release Authorization

REASON FOR VISIT:

___On-the-job injury ___Job related illness
___Follow-up appointment ___ Drug screen
___Physical ___Other:

Other Physician	Date	Time
Street		
City	St	Zip

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

Company Name | Authorized by | Title | Tel | Ext

Employee Name | Date of birth | Home Tel

Job Title | Full-time Part-time

Resulting Injury | Date of Injury | Time AM PM

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

Prescriptions | Hand Dominance Yes No

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