

Cal Poly Pomona Foundation, Inc.  
Medical Service Report

Date of Exam:	Injury Date:	Employee's Name:
Unit/Dept.:		
Diagnosis:		
Doctor's Comments:		

**MEDICAL STATUS OF EMPLOYEE:**

- Discharged. No further visits are necessary  
 Patient's condition is not related to an industrial injury or illness. Referred to private Physician.

**TREATMENT ADMINISTERED:**

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Office Visit/Injury Treatment | <input type="checkbox"/> Physical Therapy    | <input type="checkbox"/> First Aid |
| <input type="checkbox"/> Redress                       | <input type="checkbox"/> Tetanus Toxoid Only |                                    |
| <input type="checkbox"/> Referred to Specialist:       | <input type="checkbox"/> Medication: _____   |                                    |
| Dr. _____  | Specialty: _____                             |                                    |

**WORK STATUS:**

- Instructed to return to work at once with no limitations.  
 Off the balance of this shift only. May return to work next shift.  
 Off the balance of this shift. To be re-evaluated in the clinic before the next shift with regard to work status.  
 Estimated period of treatment. \_\_\_\_\_  
 Off work. Estimated period of total disability: \_\_\_\_\_  
 Off work. Return to work date: \_\_\_\_\_  
 Off work until specialist treatment: \_\_\_\_\_  
 Return to work with the following instructions:
- |   |   |
|---|---|
| <input type="checkbox"/> No overhead lifting/reaching   | <input type="checkbox"/> No climbing, bending or stooping |
| <input type="checkbox"/> Limited use of right/left hand | <input type="checkbox"/> Sit down job.                    |
| <input type="checkbox"/> Right/left handed work only    | <input type="checkbox"/> No prolonged standing or walking |
| <input type="checkbox"/> Weight lifting restrictions:   | <input type="checkbox"/> No constant bending or stooping  |
| <input type="checkbox"/> Up to 10 lb.                   | <input type="checkbox"/> Keep wound clean and dry         |
| <input type="checkbox"/> Up to 25 lb.                   | <input type="checkbox"/> Keep splint/tape on.             |
| <input type="checkbox"/> Up to 50 lb.                   | <input type="checkbox"/> Other: _____                     |

Doctor's signature: \_\_\_\_\_  
Address: \_\_\_\_\_

Your next appointment is:  
 Mon.  Tues.  Wed.  Thurs.  Fri.  
Date: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.  
Please telephone in advance if you will be unable to keep this appointment.