

WORKER COMPENSATION DISCHARGE INSTRUCTIONS

COMPANY _____

NAME _____

ADDRESS _____

DATE _____

CHART # _____

FIRST CARE WORKER COMPENSATION DISCHARGE INSTRUCTIONS

These guidelines have been prepared to aid in your care. If you fail to improve, become worse, or have problems, please return to FIRST CARE or NORTHPORT HOSPITAL-DCH to be rechecked or to see your doctor. The following orders apply to you:

- | | |
|---|---|
| _____ Bed rest as needed | _____ No weight bearing on injured leg (see Crutch Walking sheet) |
| _____ Ice for 20 minutes 3-4 times daily | _____ Raise the injured part |
| _____ Keep dressing clean and dry (see Wound sheet) | _____ Watch for signs of infection (fever, redness, drainage) |
| _____ Moist heat _____ times daily | |

INSTRUCTIONS FOR WORK

You may return to: Regular duty on _____
 Restricted duty _____
 No work

- | | |
|---|--|
| <input type="checkbox"/> Dry work only | <input type="checkbox"/> No frequent wrist movement |
| <input type="checkbox"/> No bending, stooping, or twisting | <input type="checkbox"/> One hand / one arm work |
| <input type="checkbox"/> No squatting or kneeling | <input type="checkbox"/> No lifting |
| <input type="checkbox"/> Work as bandages / splints allow | <input type="checkbox"/> No riding |
| <input type="checkbox"/> No driving of car or other motorized vehicle | <input type="checkbox"/> No pushing or pulling allowed |
| <input type="checkbox"/> No prolonged standing or walking | |

MEDICATION _____

DIAGNOSIS _____ PHYSICIAN SIGNATURE _____

FOLLOW UP

_____ Return for recheck on _____ (Date) between 9:00 am and 6:00 pm

_____ Referred to _____

_____ Appointment date / time _____

Status with referral Physician:

Diagnosis _____

Return to work _____

Treatment _____

Person notified at company _____

I have read and understand the above instructions. It is my responsibility to give this form to my employer and inform him/her of my illness/injury.

Patient _____ Date _____ Witness _____

* Separate Discharge Instruction Sheet