PRIME TREATMENT REFERRAL FORM

To Be Completed by Employer:

Medical Facility/Doctor _____ Date _____

Address _____

Telephone _____

This authorization is issued to you to provide initial medical treatment to the employee named below who has reported an occupational injury.

Employee Name _____

Address _____

Social Security Number _____

Occupation _____

Date of Injury _____ Time of Injury _____

Type of Injury _____

Workers' Compensation Administrator **KEENAN & ASSOCIATES**

Employer Name **AROMAS-SAN JUAN USD**

Address **2300 San Juan Hwy, San Juan Bautista, CA 95045**

Employer Contact **Ariane Zamudio** Telephone **831-623-4500 ext 1212**
(Return-to-Work Coordinator or Supervisor)

Instructions to Medical Provider:

1. Call the employer contact named above immediately to discuss availability of modified duty if the employee has any injury-related physical restrictions that may affect the employee's ability to return to full duty.
2. Send the completed Doctor's First Report (5021), all medical bills and corresponding reports to Keenan & Associates at the address listed above.
3. Contact Keenan & Associates immediately if any of the following apply:
   - Questionable Injury
   - Diagnostic Imaging Request
   - Consultation Request
   - Surgery/Hospitalization Request

TO BE COMPLETED BY THE PHYSICIAN:

Employee Name: _____

Date of Injury: _____

PHYSICAL ABILITIES ASSESSMENT

[Enter District Name] and Keenan & Associates promotes the use of a transitional work program to help rehabilitate injured workers. The type of work performed in the transitional, modified duty program must be within the doctor's restricted release.

Please designate ABILITIES in the following way:
Never=0% Occasionally=1-33% Frequently=34-66% Continuously=67-100%

1. **Lift: (Note Weight)_____**
2. **Carry: (Note Weight)_____**
3. **Sitting—Push/Pull: _____**
4. **Standing—Push/Pull:_____**
5. **Bending:_____**
6. **Squatting:_____**
7. **Crawling:_____**
8. **Climbing:_____**
9. **Overhead Reaching:**

Number of Hours for Each Activity (Note: Total does not have to equal 8 hours)

1. **Sitting:_____**
2. **Standing:_____**
3. **Walking:_____**
4. **Alternately Sit/Stand:_____**
5. **Hands: Simple Grasping_____Firm Grasping_____Fine Manipulation**
6. **Feet: (Use of feet in regards to Operating Foot Commands)_____**
7. **Activities:**
   - **Driving Personal Vehicle_____**
   - **Driving Company Vehicle_____**
   - **Riding in Motorized Vehicles_____**
   - **Working Full Time_____**
   - **No Restrictions _____**

Estimated Date Of Return To Work Full Duty_____

Next Appointment Date and Time_____

Physician Signature_____Date_____

Physician Name _____(Please Print)

PHYSICIAN: Please complete and return to employee. Please fax a copy of this form to the ASJUSD Human Resources Department, 831-623-4907.