

The NC Family Doctor
1728 Fordham Blvd Suite 151 Rams Plaza
Chapel Hill, NC 27514
Phone: (919) 968-1985 Fax: (919) 942-0038

Every visit requires employer or insurance company authorization

Chart # _____ - _____ WC

Today's Date: _____ UDS Required? No Yes (If yes, must have a Lab Corp COC form)

Injured Employee: _____ SS# _____

Date Of Injury: _____ Nature of Injury _____

Employer Name: _____ Phone # (____) _____

Authorizing Party: _____ Fax# (____) _____

Ins Co: _____ Phone # (____) _____

Mailing Address: _____

Did employer submit Form 19 (First Report of Injury) to their Worker's Compensation Carrier?

Circle: NO YES* *(Claim Number _____)

If NO, when and by whom will the Form 19 Be submitted to the Workers Compensation Carrier?

Date: _____ Name: _____

Injured Employee's Name: _____

Disposition:

_____ Patient may return to work without restrictions

_____ Patient may return to work with the following restrictions: _____

_____ Patient will be unable to work for: _____ day(s).

_____ Patient requires referral to Specialist: _____

(Employee to obtain approval through Employer / Worker's Compensation Carrier)

Diagnosis: _____

Treatment: _____

Provider's Signature

Date

Copy Given To Patient

Copy Faxed To Employer

Copy Mailed To Employer