Eastern North Carolina School for the Deaf

Employee Referral for Medical Treatment

(To be presented to the Health Care Provider or Emergency Room)

Our employee, _____, had an illness or injury during work. This brief document provides 1) basic information regarding the injured worker and the injury; 2) distribution information for bills and medical notes; 3) contact information for claims; and 4) a form for reporting your diagnosis back to us. Sedgwick provides our workers' compensation claims handling.

Date of injury ___/___/_____
What the employee was doing immediately before the incident _____
_____
_____
What happened _____
_____
Injured body part(s) _____
Specific item (if any) causing the injury _____

Employer signature _____ Employee signature _____
Contact name _____ Phone _____ Date signed ___/___/_____
Employer address _____

PLEASE GIVE THIS FORM BACKTO EMPLOYEE. If employee cannot return to work, EMAIL OR FAX COMPLETED FORM TO: kaitlyn.jones@esdb.dpi.nc.gov OR melissa.paderick@esdb.dpi.nc.gov or to FAX 252.234.1145

Health Care Provider:

1. The employee must be examined by the health care provider/physician signing this form.
2. Please examine and give necessary treatment to this employee who reported an occupational injury/illness, then complete the necessary information below.
3. If you release this employee for restricted work, please specify activities to be avoided (i.e., bending, lifting, climbing, prolonged standing, operation of motor vehicles, etc.) and give associated parameters.

Provider's name, address, _____
Phone number _____
_____

After the employee has been examined by the health care provider, please send medical bills and medical notes to

Sedgwick (855.233.8672) with the Claim Number (if no claim #, please use SSN)

Diagnosis *(please indicate appropriate)*

This employee may return to:

- ☐ **Regular duty on ____/____/____,**
- ☐ **Restricted duty on ____/____/____ with the following restrictions:** _____
  _____
- ☐ **No further treatment is required**
- ☐ **Follow up appointment required – next visit ___/___/___**
- ☐ **Referral to another physician: _____(contact Sedgwick Claims Dept at 855.233.8672 for authorization for the referral).**

Physician's Signature _____ **Date:** ___/___/_____