Virginia Gateway Urgent Care Center

Worker's Compensation Injury Treatment Record (ITR)

Administrative Information:

Name_____ **Date:** _____

Date of Birth_____

- ☐ **Initial Visit**
- ☐ **Follow-up _____ Date of Injury**_____
- ☐ **Chief Complaint:** _____

Check the following treatments that apply to visit:

In-House Treatments	
X-ray	
Injection/Meds	
Procedures	
Dressing/Splint	

Restrictions:

- ☐ **Limit work to _____ hours per day**
- ☐ **Rest _____ minutes every _____ hours**
- ☐ **No repetitive use of _____ hand(s)**
- ☐ **No lifting >_____ pounds (specify if extremity)**
- ☐ **No pushing/pulling (specify if extremity)_____**
- ☐ **No overhead work**
- ☐ **No driving of equipment**
- ☐ **Other restrictions:**_____
- ☐ **No climbing**
- ☐ **No crawling/kneeling**
- ☐ **No sitting>___ minutes per hour**
- ☐ **No standing>___minutes per hour**
- ☐ **No walking>___minutes per hour**

****Any Restrictions make an injury recordable****

Disposition of Work Status:

- ☐ **Return to work with no restrictions on:**_____
- ☐ **Return to work with restrictions on:**_____
- ☐ **Cannot return to work until**_____ **or next f/u visit** _____

Rationale: _____

Disposition of Follow-up Care:

- ☐ **Discharged. No follow-up at this time. Return PRN**
- ☐ **Needs f/u visit**_____
- ☐ **Referral to specialist**_____
- ☐ **Physical Therapy**
- ☐ **Chiropractor**

Provider's Signature: _____ **Date:** _____

Provider's Name Printed: _____

**THIS FORM IS TO BE SENT TO THE PATIENT'S EMPLOYER*