CCMSI

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State of North Carolina Workers' Compensation Program
Supervisor's Initial Medical Treatment Authorization | Medical Provider's Report

Supervisor: Please complete Section A and give to injured employee to take with them to the authorized treating medical provider. **This form authorizes their initial care.** The remainder of the form is to be completed by the medical provider and should be returned to the employee's supervisor or agency workers' compensation administrator within 24 hours after treatment.

Section A: Patient Information	
Employing Agency/University:	Today's Date:
Employee First/Last Name:	Employee Phone:
Supervisor/Manager Name:	Supervisor/Manager Phone:
Date of Injury:___/___/___ Time of Injury:___:____ am pm	Location of Injury (if known):
Initial Treating Provider/Facility Name, Address, Phone Number:	

Authorized Treatment Facilities: Supervisor/Manager please direct your employee to a local network provider based on location. For a complete list of network providers, visit **https://www.talispoint.com/login/**. Username: strata Password: SONC99
Hospital Emergency Rooms should only be used for extreme injuries or after-hours treatment that cannot wait.

Treating Medical Provider: PLEASE COMPLETE SECTIONS B through E.

Section B: Diagnosis, Treatment, and Medication Information

Diagnosis(es) for treated body parts:

Treatment Provided:	**List medication(s)/prescription(s)/sample(s) given (include dose):**

Section C: Work Status Information

☐ Patient may **return to work without restrictions** on ___/___/___ (date). **Skip to Section E.**
☐ Patient may **return to work with restriction(s) shown in Section D. on ___/___/___ (date)**
☐ Patient may **not return to work as of ___/___/___ (date)** until a follow-up appointment described in Section E.

Section D: Work Restrictions Information

Posture Restrictions (if any) ☐ **NO restrictions** (a/t=as tolerated)

Max hrs. allowed per day	a/t	Max hrs allowed per day	a/t
Standing_____	☐	Squatting/Kneeling_____	☐
Sitting _____	☐	Stooping/Bending _____	☐
Twisting _____	☐		

Other:

Movement Restrictions (if any) ☐ **NO restrictions** (a/t=as tolerated)

Max hrs allowed per day	a/t	Max hrs allowed per day	a/t
Walking _____	☐	Grasping/squeezing _____	☐
Climbing _____	☐	Wrist Flex/Extension _____	☐
Reaching _____	☐	Overhead Reaching _____	☐

Other:

Above Restrictions apply to: ☐ L Hand ☐ L Wrist ☐ L Arm ☐ L Shoulder ☐ R Hand ☐ R Wrist ☐ R Arm ☐ R Shoulder
☐ Neck ☐ Back (upper) ☐ Back (lower) ☐ L Foot ☐ L Ankle ☐ L Knee ☐ L Leg ☐ R Foot ☐ R Ankle ☐ R Knee ☐ R Leg
Other:

Lift or Carry Restrictions (if any) ☐ **NO Restrictions** ☐ May not lift or carry objects more than _____ lbs for more than _____ hours/day
☐ No lifting or carrying Other:

Push or Pull Restrictions (if any) ☐ **NO Restrictions** ☐ May not push or pull objects more than _____ lbs for more than _____ hours/day
☐ No pushing or pulling Other:

Additional Restrictions:

Section E: Follow up appointments

☐ Patient has **return appointment on** ___/___/___(date) at ___:____ ☐ AM ☐ PM

Medical Provider – You must contact CCMSI at 888-596-8771 for referral authorization.

_____ _____ _____
Medical Provider's Signature **Date** **Medical Provider's Name (print)**

See separate "State of North Carolina First Fill Prescription Card Form" for first prescription drug fill details and participating pharmacies.