

Section A: Patient Information
Employing Agency/University:

Employee First/Last Name:



www.ccmsi.com SONC@CCMSI.COM

Today's Date:

Employee Phone:

PO Box 669527 CHARLOTTE NC 28266 Phone: 888-596-8771 Fax: 217-477-6631

## 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.

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:	
<b>Authorized Treatment Facilities:</b> Supervisor/Manager please direct your employee to a local network provider based on location. For a complete list of network providers, visit <a href="https://www.talispoint.com/login/">https://www.talispoint.com/login/</a> . Username: strata Password: SONC99	
Hospital Emergency Rooms should only be used for extreme	
Treating Medical Provider: PLEASE COMPLETE SECTIONS B through E.  Section B: Diagnosis, Treatment, and Medication Information	
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/	
☐ Patient may return to work with restriction(s) shown in Sec☐ Patient may not return to work as of// (date) unt	
Section D: Work Restrictions Information	ii a lollow-up appointment described in Section E.
Posture Restrictions (if any)    NO restrictions (a/t=as tolerated)	Movement Restrictions (if any) ☐ NO restrictions (a/t=as tolerated)
Max hrs. allowed per day a/t Max hrs allowed per day a/t	Max hrs allowed per day a/t Max hrs allowed per day a/t
Standing	Walking Grasping/squeezing □
Sitting D Stooping/Bending D	Climbing
Twisting	Reaching   Overhead Reaching
Other:	Other:
Above Restrictions apply to: ☐ L Hand ☐ L Wrist ☐ L Arm ☐	
□ 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) DO Restrictions D 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   Ibs for more than   hours/day	
Push or Pull Restrictions (if any) □ NO Restrictions □ May not □ No pushing or pulling Other:	: push or pull objects more than lbs for more than nours/day
Additional Restrictions:	
Section E: Follow up appointments	
☐ Patient has <b>return appointment on</b> //(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.