

HEALTH OFFICE / ER  
**SUPERVISORS REFERRAL FORM**

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Job Title: \_\_\_\_\_ Shift Hours: \_\_\_\_\_ Phone: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Cost Code: \_\_\_\_\_ Department Name: \_\_\_\_\_

**REASON FOR REFERRAL:**

Illness on Duty     **Injury on Duty Report below and on back of form**     Physical Examination     Immunization

Clearance to Return to Duty     TB or Communicable Disease Exposure     Other (Brief Description) \_\_\_\_\_

Comments: \_\_\_\_\_

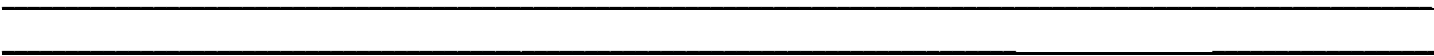


**INJURY ON DUTY REPORT**

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ Accident Location: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Hospital #: \_\_\_\_\_ Physician: \_\_\_\_\_

Describe accident and injury in detail: \_\_\_\_\_



Name of Supervisor Notified: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**SUPERVISOR'S REPORT**

Unsafe practice/hazard involved? Yes \_\_\_ No \_\_\_ If so, explain \_\_\_\_\_

Maintenance request prioritized? Yes \_\_\_ No \_\_\_ Date: \_\_\_\_\_

**TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT**

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_



**HEALTH OFFICE USE ONLY**

Time arrived: \_\_\_\_\_ Time seen: \_\_\_\_\_ Time discharged: \_\_\_\_\_

Duty Status Date(s): Excused for: \_\_\_\_\_ Return to light duty: \_\_\_\_\_ Return to full duty: \_\_\_\_\_

Follow-Up: (date) Health Office: \_\_\_\_\_ Private MD: \_\_\_\_\_ Worker's Comp: \_\_\_\_\_

Discharge Instructions/Restrictions: \_\_\_\_\_

Instruction sheet given : \_\_\_\_\_

Nurse / Examiner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I UNDERSTAND THE ABOVE INSTRUCTIONS AND MY RESPONSIBILITY FOR COMPLYING WITH THEM**

EMPLOYEE SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

# **Injury on Duty**

## **Accident Investigation Form**

### **Questions for Managers To Determine Long-Term Corrective Measures:**

- Have I focused on the system processes that reinforced the employees' behavior?
- Was this injury the result of a specific event or cumulative events?
- Was the employee working a double shift or scheduled to work a double shift?
- What positive reinforcement has been done to encourage safe patient handling?
- Have managers actually reinforced certain behaviors by allowing them to exist?
- What is the time/order relationship between variables; i.e. cause and effect?
- Have all possible alternative explanations been eliminated to determine cause and effect?

### **Equipment**

1. Did the equipment malfunction?  No If yes,  *MaxiMove*  *Sara 3000*  *SaraPlus*  
 *Stedy*  *HoverMatt*  *MaxiSlide*
2. Was the right piece of equipment readily available for the need?  No  Yes
3. Was the right size of sling readily available for the need?  No  Yes
4. What size sling was used?  XXL  XL  L  M
5. Did patient's weight exceed equipment capacity, resulting in a manual lift?  No  Yes

### **Profile**

1. What was the transfer/lift/positioning profile for the patient?  No lifting equipment  
 *MaxiMove*  *Sara 3000*  *SaraPlus*  *Stedy*  *HoverMatt*  *MaxiSlide*
2. How many staff were present at the time of the lift/repositioning?  One  Two  More
3. Was the transfer/lift done differently than the profile?  No  Yes  
If yes, why? \_\_\_\_\_
4. Can caregiver who completed the patient profile demonstrate the correct procedure?  Yes  No

### **Injured Caregiver**

1. Can the injured caregiver demonstrate correct lifting/repositioning procedure?  Yes  No
2. If "no" was the Return Demonstration Checklist used and signed? Date \_\_\_\_\_  No

### **Unit Manager**

1. What procedural/management steps are being taken to prevent a recurrence?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Diligent Consultant Review**

Comments: