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: **DOB:** _____

☐ 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: