INOVA™
Join the future of health.

Inova Urgent Care/Occupational Health

Date: _____

PATIENT INFORMATION

Patient Name: _____ Patient SSN: _____ Patient DOB: _____

Patient Address: _____

Patient Phone #: _____ Sex: Female Male

EMPLOYER INFORMATION

Patient Employer: _____ Employer Phone #: _____

Employer Address: _____

Supervisor or Contact Name: _____

INJURY INFORMATION

Date of Injury: _____ Body Part Injured: _____

Brief description of how injury occurred: _____

WORKER'S COMP INFORMATION

Comp Carrier Name: _____ Claim #: _____

Address to send claims: _____

Claims Adjuster or Case Manager: _____ Claims Adjuster or Case Manager Phone Number: _____

Authorization # (if applicable): _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Inova to release the following information to the authorizing company (employer) or the agent designated in their contract with Inova for the purpose of providing my employer with the employment related test results indicated below:

Information to be released/disclosed:

Audiometry Results	Medical Clearance Form	X-Ray Films/X-Ray Reports
Drug and Alcohol Test Results	Pulmonary Function Test	Respirator Medical Clearance
Health History/Physical Exam	Tuberculosis Screening/Vaccinations	
Lab/EKG	Stress Test	

I understand that I am under no obligation to sign this form. Inova may, however, condition the provision of testing on my signature of this authorization to release results to my employer, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, §164.508(b)(4). Inova may also condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signature of this authorization.

I understand that if the person or agency that receives this information is not a healthcare provider or health plan covered by HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of the form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

NOTIFICATION OF RESPONSIBILITY

In the event my workers' compensation claim is denied by my carrier, I agree to be responsible for the cost of this visit an any further care related to this visit, and additional costs associated with enforcing this agreement, including collection costs and reasonable attorney fees.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

_____

If representative, print name and relationship to patient

Attending Physician's Report

Virginia Workers' Compensation Commission
1100 DMV Drive Richmond VA 23220
See instructions on the reverse of this form.

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

Employee

1. Patient's name	2. Phone number	
3. Address	4. Date of Birth	5. Sex ☐ Male ☐ Female
	6. Social security number	

Background Information

7. Name of employer	8. Address of employer
9. Date of injury or illness	

10. Patient's account of how injury or exposure to occupational disease occurred

11. Date of first visit	12. Date of discharge	13. Person authorizing treatment

Findings and Diagnosis

14. Findings upon examination, including results of x-rays, laboratory studies, etc. Please note any prior injuries and pre-existing conditions. Provide additional comments on the reverse side of this form.

15. Diagnosis	16. Is diagnosed condition due to the occurrence described by the patient? ☐ Yes ☐ No ☐ Unknown
17. Nature of treatment	18. Dates of your treatment _____

19. Provide names and addresses of other health care providers to whom patient was referred

20. Was there any fracture or amputation? ☐ Yes ☐ No ☐ Unknown	If yes	21. Please describe		
22. Was there disability for work? ☐ Yes ☐ No ☐ Unknown	If yes	23. Date disability began	24. Date able to return to light work	25. Date able to return to regular work
26. Will there be any permanent defect or disfigurement? ☐ Yes ☐ No ☐ Unknown	If yes	27. Please describe		28. Has patient reached a maximum medical improvement? ☐ Yes ☐ No

Attending Physician

29. Name of attending physician	30. Address
31. Date of this report	Inova Urgent Care Vienna 100 Maple Avenue East Vienna, VA 22180 703-938-5300

I certify that I personally examined and treated this patient

Signature _____ M.D.

This report is required by the Virginia Workers' Compensation Act

1HEAR

Inova Staff: At the first opportunity, provide this Special Needs Form to ALL patients and companions. Use completed form to initiate appropriate action and place form in patient's chart.

Patient or companions: It is important to us to communicate thoroughly with all of our patients and companions. To ensure that we provide effective communication during your stay, please complete the information below.

In what language would you prefer to communicate with your providers?	☐ English	☐ Spanish	☐ Other (Specify) _____
Are you hard of hearing?	☐ No	☐ Yes	If your response is "No" to both questions, then sign the form below. If your response is "Yes" to one or both of the questions, then sign the form below AND complete the information on the **Deaf or Hard of Hearing Communication Request Form.**
Are you deaf?	☐ No	☐ Yes	

☐ Patient's condition does not allow and/or the companion is not available to complete the Special Needs Form.

Spoken language interpreters are available on site or by phone. If you prefer to communicate in a non English language, trained interpreters will be provided to you.

If your communication needs or those of your companion change during your stay/visit, or you need further assistance, please let your caregiver know and we will make accommodations to assist you.

_____ _____

Signature of Patient/Patient Representative/Companion Date

Print: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other _____

_____ _____

Signature of Employee Witness Date

Print: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

INOVA HEALTH SYSTEM

SPECIAL NEEDS FORM

CAT # 87498/R070811 • PKGS OF 100