PATIENT NAME DATE OF SERVICE MEDICAL RECORD NUMBER ADDRESSOGRAPH STAMP OR LABEL	OCCUPATIONAL HEALTH SERVICES 300 Pasteur Drive, M/C 5205 Stanford, CA 94305 NEW INJURY/ILLNESS REPORT

*** PLEASE FILL OUT COMPLETELY ***

Employee Information		
Name (First Middle Last):		
Home Address (street, city, zip):		
Phone number (cell/pager/home):	Email:	
Social Security # (last 4 digits **ONLY**):	☐Male ☐Female	Date of Birth: ____/____/____

Job Information	
Job title:	Employer: ☐SHC ☐LPCH ☐SU ☐Other _____
Department:	Manager/Supervisor email:
Manager/Supervisor name:	Manager/Supervisor phone (full number):
Employment type: ☐regular ☐temporary ☐housestaff ☐faculty ☐volunteer ☐student ☐other _____	
Date of Hire: ____/____/____	
Usual work schedule: hours per day: _____ days per week: _____ start time: _____ end time: _____	
Hours worked in last 24 hours: _____	Hours worked in last 40 hours (all jobs): _____

Injury/Illness Information		
Date of injury/illness: ____/____/____	Time of injury/illness: _____ ☐am ☐pm	Time began work on day of injury/illness: _____ ☐am ☐pm
What part(s) of your body was injured? _____ ☐Right ☐Left (Please complete diagram on back)		
Please describe precisely how the injury happened: (if more space is needed, see second page) _____ _____ _____ _____ _____		
Where did the injury occur (e.g. NICU, hallway near OR):		
Date reported: ____/____/_____	Reported to:	
Have you missed at least one day of work as a result of this injury/illness? ☐Yes ☐No If Yes, last date worked: ____/____/____ Date returned to work: ____/____/____ ☐Still off work		
Have you already seen a medical provider for this injury? ☐Yes ☐No If Yes, who/where/when? _____ _____		
Have you ever had a similar injury before? ☐Yes ☐No If Yes, please describe the injury. When did it occur? Who treated you for it? _____ _____ _____		
Did this injury/illness result from handling a paitent? (transporting, lifting, moving, etc.) ☐Yes ☐No		
What were you doing just before the event?		
What equipment or chemicals were you using? ☐N/A		
Was anyone else involved?		
Where there any witnesses? ☐Yes ☐No If Yes, please list: _____		
Were you using any Personal Protective Equipment? ☐Yes ☐No ☐N/A List: _____		

PLEASE CONTINUE TO SECOND PAGE

PATIENT NAME DATE OF SERVICE MEDICAL RECORD NUMBER ADDRESSOGRAPH STAMP OR LABEL	OCCUPATIONAL HEALTH SERVICES 300 Pasteur Drive, M/C 5205 Stanford, CA 94305 NEW INJURY/ILLNESS REPORT

***** PLEASE FILL OUT COMPLETELY *****

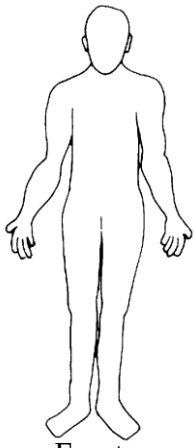
(1) Check one: □ Right-hand dominant □ Left-hand dominant □ Ambidextrous

(2) Use the symbols below to indicate on the diagrams where you have been having symptom(s).

[Burning = XXX, Numbness = ---, Pins/Needles = 000, Sharp/Stabbing = / / /, Aching = shade appropriate area]

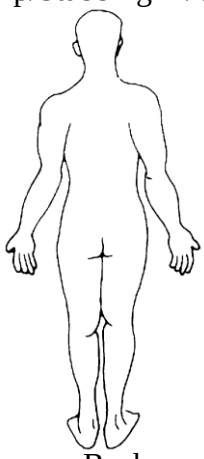
Circle part of body where injury/illness occurred

right left



Front

left right



Back

(3) Circle a number on the scale below indicating the severity of your symptom(s).

0……1……2……3……4……5……6……7……8……9……10
(no pain) (mild) (moderate) (severe)

(4) Please list any medications currently taking: _____
_____

(5) Please list any allergies to any medications: _____
_____

**use the space below to provide any additional information needed to describe injury

_____
_____
_____
_____

_____ _____/_____/_____
Employee Signature Today's Date

_____ _____/_____/_____
Clinician Signature Today's Date