Medical Follow-Up Form

Patient's Name: ____ DOB: ______________________

Dear Doctor: The employee named above was seen by our staff for a work related examination. In order for an Industrial Employee to obtain or maintain certification when a medical condition is present, the patient must obtain medical follow-up from his/her personal physician documenting that the condition is diagnosed, treated, and under control.

The employee has been informed of the rationale for this follow up request. By signing below, he/she gives approval to WorkFit Medical, LLC to share documentation concerning this case with his/her personal physician.

We thank you in advance for completing this form and faxing it back to WorkFit Medical, LLC at one of the fax numbers listed below.

Employee Signature ____ Date: ____________________

Comments/Condition:____
____
____
Requested by:

Please Complete and Verify:

1. The above named patient is under my medical supervision for the above condition and has been seen at my office within the last 6 months. ☐ Yes ☐ No Date of last visit: _______________
2. Diagnosis: ____
3. Has the condition been addressed or treated and stabilized? ☐ Yes ☐ No
   (If no, please comment on stability of the condition) ____
   ____
4. Current Treatment (if medications, please attach list) ____
   ____
5. In your opinion, can the above stated patient safely function in a work environment with this condition and/or while on the medication listed above? ☐ Yes ☐ No
   (If no, why not?)____
6. Does this patient have any other condition(s) which would interfere with his/her ability to safely function in a work environment? ☐ Yes ☐ No (If yes, what?) ____

Doctor's Signature: ____ Date: ____________________
Doctor's Printed Name: ____ Office Phone: ____________________
Office Street Address: ____ Office Fax: ____________________
City __________________________________ State: ______ Zip: ____________________

(WorkFit use only)

Date Reviewed: _____________

Provider Signature: _________________________

☐ Employee meets follow-up requirements for ____ months.

☐ Employee does not meet follow-up requirements.

☐ Other: ____

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