

WORK INJURY REPORT



☐ New case

☐ Follow-up

Zurich Ref. No. : _____

Injured's name: _____

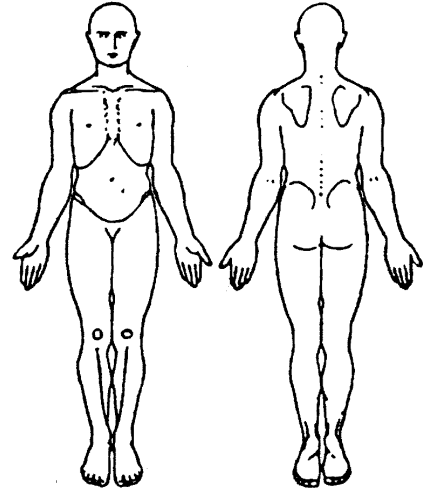
Consultation date: _____

Date of Injury: _____

Diagnosis : _____

HKID no. (the letters
and first 4 digits): _____

Present History - *complaints and progress*



Past Medical History

MEDICAL RECOMMENDATION

Referral

☐ A & E of _____ Hospital

☐ Specialist : _____

☐ Physiotherapy No. of sessions: _____

☐ Occupational therapy No. of sessions: _____

☐ Others: _____

Return to Work:

☐ Return to pre-injured duty

☐ Return to work with light duty (please complete Return-To-Work Plan)

☐ Change to other permanent role (please complete Return-To-Work Plan)

Sick Leave : *(please issue a separate sick leave certificate)*

From: _____ to: _____

☐ Zurich panel

☐ H.A

☐ Private Dr

Maximum Medical Improvement

☐ Yes

☐ No

If no, please advise the anticipated date: _____

Fit for MAB

☐ Yes

☐ No

☐ Next follow up date: _____ ☐ No further follow up medical consultation is needed

Other recommendations: _____

☐ Prescription (Drug Name): _____

Doctor Signature with chop

Date: