# Work Ability/Return to Work

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| NOTE TO EMPLOYEE: Immediately provide a copy of this report to: |  |

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| Employee Information |

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| Employee Name (Last, First, Middle) |  |
| SS# |  |
| Supervisor |  |
| Department |  |
| Job Title |  |
| Date of Injury/Illness |  |
| Diagnosis |  |
| ICD-9 Code |  |

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| History and Findings |

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| Is this a work-related injury/illness? |  |
| Is this a permanent partial disability? If yes, indicate percentage of permanent partial disability. |  |
| Are there any pre-existing conditions affecting this injury/illness? If yes, describe. |  |
| Is maximum medical improvement reached? If yes, indicate date reached. |  |

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| Return to Work | | | | | | | | | | | | | | | | | |
| Is employee able to return to work with no limitations? If yes, indicate date. | | | | |  | | | | | | | | | | | | |
| Is employee able to return to work with limitations? If yes, indicate date(s). | | | | |  | | | | | | | | | | | | |
| Is employee unable to return to work? If yes, indicate date(s). | | | | |  | | | | | | | | | | | | |
| Do these restrictions apply to home environment? If no, explain. | | | | |  | | | | | | | | | | | | |
| Body Part Affected | | | | | | | | | | | | | | | | | |
| From: | PMD: | | |  | | | | | | Dated: | | | |  | | | |
| IME: | | |  | | | | | | Dated: | | | |  | | | |
| Body Part Affected: | Left |  | Right | |  | | Both |  | | Neck |  | Upper Back | | |  | Lower Back |  |
| Shoulder |  | Elbow | |  | | Wrist |  | | Hand |  | Leg | | |  | Knee |  |
| Ankle |  | Foot | |  | | Other |  | | | | | | | | | |
| Restrictions | | | | | | | | | | | | | | | | | |
|  | | | | | | Not At All | | | Occasional (0-33%) | | | | Frequent (34-66%) | | | Continuous (67-100%) | |
| *Lift/Carry* | | | | | | | | | | | | | | | | | |
| 0-09 lbs. | | | | | |  | | |  | | | |  | | |  | |
| 10-19 lbs. | | | | | |  | | |  | | | |  | | |  | |
| 20-29 lbs. | | | | | |  | | |  | | | |  | | |  | |
| 30-39 lbs. | | | | | |  | | |  | | | |  | | |  | |
| 40-49 lbs. | | | | | |  | | |  | | | |  | | |  | |
| No lift from floor | | | | | |  | | |  | | | |  | | |  | |

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| *Push/Pull Without Resistance* | | | | | | |
| *0-19 lbs.* | |  |  |  |  | |
| *20-40 lbs.* | |  |  |  |  | |
| *>49 lbs.* | |  |  |  |  | |
| No patient transfers, lifts or boosts | |  |  |  |  | |
| *Bending/Twisting/Kneeling/Standing/Climbing* | | | | | | |
| Bend | |  |  |  |  | |
| Twist/turn | |  |  |  |  | |
| Kneel/squat | |  |  |  |  | |
| Stand/walk | |  |  |  |  | |
| Ladder/stair climb | |  |  |  |  | |
| *Hand, Wrist, and Shoulder Activities Avoid Prolonged, Repetitive and/or Forceful:* | | | | | | |
| Gripping/grasping | |  |  |  |  | |
| Repetition wrist motion | |  |  |  |  | |
| Reaching: | |  |  |  |  | |
| Above shoulder height | |  |  |  |  | |
| At shoulder height | |  |  |  |  | |
| Below shoulder height | |  |  |  |  | |
| Restrictions | |  |  |  |  | |
| Keyboarding (hrs./shift) | |  | | | | |
| Writing (hrs./shift) | |  | | | | |
| Total spread out evenly over shift at \_\_\_ intervals. | |  | | | | |
| Change positions every \_\_\_. | |  | | | | |
| *Other* | | | | | | |
| Latex-free/powder-free gloves? | |  | | | | |
| Work site stretches (per handout)? | |  | | | | |
| Other exercises? | |  | | | | |
| **Prognosis** | | | | | | |
| On schedule (indicate expected full recovery date) |  | | | | |
| Delayed recovery |  | | | | | |
| Full recovery not expected |  | | | | | |
| Comments |  | | | | | |
| **Instructions** | | | | | | |
| Keep wound clean and dry. Change dressing every \_\_\_. |  | | | | | |
| Medication |  | | | | | |
| Ice for \_\_\_ min. |  | | | | | |
| Heat for \_\_\_ min. |  | | | | | |
| Splint / brace |  | | | | | |
| Referral |  | | | | | |
| **Return to Clinic / Treatment Plan Confirmation** | | | | | | |
| Return to clinic on: |  | | | | | |
| Has this treatment plan been discussed with the employee? |  | | | | | |
| **Signatures** | | | | | | |
| Health Care Provider Signature |  | | | | | |
| License / Registration # |  | | | | | |
| Name & Address of Health Care Facility (Street, City, State, Zip) |  | | | | | |
| Date of Exam |  | | | | | |
| Released To Work |  | | | | | |
| Signature |  | | | | | |
| Date |  | | | | | |
| Employee Signature |  | | | | | |