# 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  |  |