**Work Ability Form**

Employee must return this form to Supervisor immediately after medical treatment. Physicians: Please fax this form to Supervisor.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Employee Information** | | | | | |
| **Patient Name** | | | | **Phone Number:** | |
| **Employer:** | | | | **SSN:** | |
| **Injury Date/Time:** | **Date of Exam:** | **Time In:** | | | **Time Out:** |
| **Employee Authorization for Release of Medical Records**  I, , authorize all medical personnel who have treated me, and their staff, to release medical records and to discuss my medical status and work ability with my employer and/or their representative, including representatives from the insurance company and claims administrator.    Employee Signature Date | | | | | |
| **Injury Type** | | | | | |
| **Injury Type:** 🞎 New injury 🞎 No injury/illness found  🞎 Aggravation/recurrence of existing injury | | | | | |
| **Exam Type:** 🞎 First aid only🞎 Initial evaluation/treatment 🞎 Follow up  🞎 Consultation only🞎 Other (specify): | | | | | |
| **Body Part(s) Injured:** | | | | | |
| **Diagnosis:** | | | | | |
| **Treatment** | | | | | |
| **Medication(s):** | | | | | |
| **Further Treatment Needed:** 🞎 Yes 🞎 No 🞎 As needed basis | | | | | |
| **Patient is Permanent and Stationary:** 🞎 Yes 🞎 No | | | | | |
| **Permanent Disability Expected:** 🞎 Yes 🞎 No 🞎 Unknown  Note: This opinion is *not* binding as the patient’s condition may improve or worsen in the future. | | | | | |
| **Treatment:** 🞎 Physical therapy 🞎 Hand therapy 🞎 Other (specify): | | | | | |
| **Testing:** 🞎 CT scan 🞎 MRI 🞎 EMG 🞎 X-ray  🞎 Other (specify): | | | | | |
| **Testing Date/Time:** | | | | | |
| **Referred for Evaluation with:** | | **Clinic:** | | | |
| **Work Ability** | | | | | |
| **Job Description Reviewed:** 🞎 Yes 🞎 No | | **Job Analysis Video Reviewed:** 🞎 Yes 🞎 No | | | |
| **Work Status:**   **Medical Providers Initials**  🞎 Return to full duty with no restrictions on (date).  🞎 Return to work with restrictions (see below) on (date) for days. 🞎 Remain off duty until (date). | | | | | |
| **Physical Restrictions**  **Indicate restriction by checking box and entering limitation information (e.g.: frequency, duration, weight, etc.).** | | | | | |
| **Activity** | **Work Restriction** | | **Home Restriction** | | |
| **Keyboarding/Typing** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Squat/Kneel** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Sit** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Drive** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Stand** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Walk** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Bend** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Stoop** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Climb Ladders** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Climb Stairs** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Push/Pull** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Grip/Grasp** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Twist** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Reach Overhead** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Use Machinery** | 🞎 Limitation: | | 🞎 Limitation: | | |
| **Lift** | 🞎 Limitation:  🞎 0 – 10 lbs  🞎 11 – 25 lbs  🞎 26 – 40 lbs  🞎 More than 40 lbs | | 🞎 Limitation:  🞎 0 – 10 lbs  🞎 11 – 25 lbs  🞎 26 – 40 lbs  🞎 More than 40 lbs | | |
| **Carry** | 🞎 Limitation:  🞎 0 – 10 lbs  🞎 11 – 25 lbs  🞎 26 – 40 lbs  🞎 More than 40 lbs | | 🞎 Limitation:  🞎 0 – 10 lbs  🞎 11 – 25 lbs  🞎 26 – 40 lbs  🞎 More than 40 lbs | | |
| **Assistive Device(s) Required:** 🞎 Yes 🞎 No  Type: Length of Time: | | | | | |
| **Environmental (i.e. avoid dust, etc.)** | | | | | |
| **Other Precautions:** | | | | | |
| **Next Appointments** | | | | | |
| **Comments:** | | | | | |
| **Next Appointment Date/Time:** | | **Clinic:** | | | |
| **Medical Provider Signature** | | | | | |
| **The contents of this report are true and correct to the best of my knowledge.**    Medical Provider Name Signature Date | | | | | |
| **Clinic Name:** | | **Phone Number:** | | | |