**Work Ability Form**

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

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| **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 🞎 UnknownNote: 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 🞎 NoType: 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:** |