Work Status Report

PATIENT INFORMATION:

Patient Name: _____
Social Security #: _____
Company: _____

Date of Visit: _____
Time In: _____
Time Out: _____

WORK STATUS:

☐ Return to Regular Work Effective ☐ Today ☐ On _____ ☐Not a Work Related Injury
☐ Modified Work (see restrictions below) ☐ Today ☐ On _____
☐ Unable to Return to Work, Estimated Duration _____
☐ Other _____

RESTRICTIONS:

☐ May lift up to _____ pounds
☐ May push/pull up to _____ pounds ☐ with ☐ w/o wheels
☐ Limited use of: ☐ Right ☐Left , ☐ hand ☐ arm
☐ No use of: ☐ Right ☐ Left , ☐hand ☐ arm
☐ Repetitive Hand Movement limited to _____ ☐ min./hour ☐hours/day
☐ Rotate job tasks to avoid continuous or Repetitive hand activity
☐ Patient should work with affected part in ☐ Splint ☐ Cast
☐ No overhead lifting or reaching with the ☐ Left arm ☐ Right arm
☐ Wound must stay clean, dry, and covered
☐ Dressing changed daily _____
☐ No working below waist level.
☐ Should be sitting _____ % of time.
☐No driving or operation of any vehicle, mobile equipment, or machinery.
☐ No work at heights or near moving machinery.
☐ Limit nonstop standing or walking to no more than _____.
☐ Limit nonstop sitting to no more than _____.
☐ Alternate sitting and standing as needed for pain control.
☐ No repetitive bending or stooping.
☐ No repetitive kneeling or squatting.
☐ No Climbing of ☐ Stairs ☐ Ramps ☐ Ladders
☐ No exposure to ☐ Cold ☐ Heat ☐ Water ☐ Chemicals ☐ Oil ☐ Paint ☐ Dust ☐ Solvents ☐ Welding ☐Coolants
☐ Minimum/Limited use of _____.
☐ No use of _____.

Other Instructions: _____
_____

PLAN:

☐ Return to Occupational Health for appointment listed below. ☐ Discharged / Final Visit

Referred to Specialist for:	Consult	Assumption of Care	Appt: _____
Rehabilitation Ordered:	Physical Therapy	Occupation Therapy	Work Hardening____ X/Week
Special Tests Pending:	EMG/NCV's	MRI	Bone Scan Other: _____

DIAGNOSIS AND COMMENTS: _____
_____
_____
_____

I hereby acknowledge receipt of the instructions indicated above.

_____ _____
Patient Signature Date

Faxed Work Status to: _____on_____by_____
Copies to: White – Patient Record Yellow – Company Pink – Patient

Next Appointment:
Date_____ Time _____

_____
Medical Provider Signature

Work Status Report
8120-0154
Orig: 2/2013 Rev: 8/2013

BUSINESS HEALTH CENTER
A Service of Lawrence Memorial Hospital

Patient Label