Work Status Report

Patient: KAPIUS Barry **DOS:** 10 7 15
Diagnosis: _____ **DOI:** _____
Employer/Fax: _____
Insurance/Fax: _____ **Claim#:** _____

Current Work Status

__Able to return to full duty
__Able to return part time for ____hours per day
__Is working
__Unable to work from ____ to ____
__Able to return to restricted work from ____ thru ____

Limitations for Work and Daily Living Activities

If the indicated restriction(s) cannot be met, the employee should be sent home

Restricted:
__Lifting (Max LBS)
10 20 30 40 50 60
__Pushing ____LBS
__Pulling ____LBS
__Reaching Above Chest
__Reaching Overhead
__Reaching Away From Body
__R Hand Work Only
__L Hand Work Only
__Walking ____
__Standing ____
__Sitting ____

No Repetitive Motions Of:
__Hand Grasp R L
__Wrist R L
__Elbow R L
__Shoulder R L
__Foot R L
__Non Weight Bearing
__Partial Weight Bearing
__Wear Splint At All Times
__Wear Splint At Work
__Wear Splint At Night
__Other ____

Do Not Do The Following:
__Operate Machinery/Equipment
__Operate Machinery if at risk of entrapment of injured body part splint or dressing.
__Crawl
__Kneel
__Squat
__Drive

Treatment Plan

__Anti-inflammatories
__Analgesics
__Antibiotics
__Muscle Relaxants
__Rest
__Ice
__Heat
__Eye Patch
__Compression
__Elevation
__Tetanus
__Wound Care
__Cast/Fracture Care
__Splint
__Burn Care
__Tens unit
__Occupational/Physical Therapy ____times each week ____weeks
__Xray
__MRI
__CT Scan
__EMG
__Other ____

Findings-MMI-Impairment

__Objective findings present that are consistent with history and/or mechanism of injury/illness
__No objective findings present
__Pain or symptoms present
__Patient has reached maximum medical improvement
__Patient has not reached maximum medical improvement, MMI anticipated ____
__This injury or illness has resulted in impairment:
____Temporary ____Permanent ____Percent of whole body impairment ____%
__Patient has no impairment from this injury/illness

4/ 4 **Follow Up Visit** 11/24 @ 130
____**Discharged-return if the symptoms recur/worsen**

Physician Signature: _____

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