Work Status Report

Patient: KAPPUS BARRY **DOS:** 11 20 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

[signature] **Follow Up Visit** 12/18/ @ 1:45
_____**Discharged-return if the symptoms recur/worsen**

Physician Signature: _____

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