



1661 St Anthony Ave  
Saint Paul, MN 55104-7633  
Phone: 651-968-5300 Fax: 651-646-0205

# REPORT OF WORKABILITY

Date 10/01/2014

Appointment Time 10:00

Employee Ruth Ogud

Patient ID XXX-XX-4993

DOB 01/01/1971

DOI 09/15/2014

MCO \_\_\_\_\_

Employer Corporate Management Group

Contact person Dan Zezza

Fax # \_\_\_\_\_

Diagnosis R leg contusions

- Work related      **Permanent Disability?**       Likely     Not likely     Undetermined
- Not work related
- Undetermined      **MMI?**       No       Yes    If yes, give date \_\_\_\_\_

ART \_\_\_\_\_  
TI \_\_\_\_\_  
TO \_\_\_\_\_

- Employer Contacted?
- Yes       No
- Faxed       Phoned

- Return to work with **no limitations** on \_\_\_/\_\_\_/\_\_\_
- Return to work **with limitations** on 10-1-14 through 10-15-14
- Unable** to work from \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_

### Avoid the following hand and wrist activities

	Left	Right	Both
Operate power/vibrating tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coarse manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Torquing/crimping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping-light/heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoid use of hand(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-stretched arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No operating forklift			
<input type="checkbox"/> No operating machinery			
<input type="checkbox"/> No driving motor vehicle			

### EMPLOYEE'S RESTRICTIONS

	NOT AT ALL	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%		NOT AT ALL	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%
<b>Lift/Carry:</b>					<b>Bend</b>				
0-10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	___degrees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Twist/Turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kneel/Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Sit</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
					<u>Stand/Walk</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Push/Pull:</b>					Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-25 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Ladder/Stair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-75 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rotate Activities/Positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Lift with palms up
- Change positions as needed
- Lift from mid thigh to mid chest

COMMENTS/TREATMENT: \_\_\_\_\_

- Keep wound clean and dry. Change dressing every \_\_\_\_\_  First Aid
- Medication ibuprofen can walker  Over Counter Meds
- Ice  Heat  Elevate  Splint/Brace  Crutches  Head injury sheet  Wound care sheet given
- Physical Therapy \_\_\_\_\_

Specialist Referral \_\_\_\_\_

Return to Clinic on 2/1/15

Date 10-15-14 Time \_\_\_\_\_

Date 10-15-14 Time 11:00am

The above has been discussed with the employee.

Signature \_\_\_\_\_

John Kipp, MD Physician