SUMMIT ORTHOPEDICS

WORK / ACTIVITY STATUS

McCormack, Catherine
DOB :09/15/64 Patient ID # 1138658
Anderson MD, Robert O DR # 106
09/08/2014
Woodlake Clinic

DATE 9 / 8 / 14

Patient Name: ____ **Chart #:** ____

Diagnosis: ____

Injured Upper Extremity ____ Right ____ Left

Work Related: ____ yes ____ no ____ unknown

- ☐ Patient is able to return to normal work duty without restriction on ____/____/____.
- ☐ Patient is unable to return to work
- ☒ Patient is able to return to light duty on 9 / 8 / 14.
- ☐ Patient is able to return to work with the following restriction:

____ Patient must keep the injured site/cast/splint clean and dry.

____ Patient may/may not drive.

____ Patient must keep the injured upper extremity elevated.

____ Patient must keep the injured upper extremity casted/splinted.

____ Patient work hours per day ____ 2 ____ 4 ____ 6 ____ 8 ____ No overtime

____ Patient should alternate job duties every ____ min./hr. with ____ minute breaks.

____ Patient may work with the RIGHT / LEFT upper extremity only.
(circle)

Regarding the injured RIGHT / LEFT upper extremity:
(circle)

P No repetitive grasping, twisting, pushing, or pulling

Patient may grip/pinch	____ Not at all	____ 1x/hr.	____ 2-10x/hr.	____ 10-20x/hr.	____ 60x/hr.	
Patient may lift/carry	____ Not at all	____ 1x/hr.	____ 2-10x/hr.	____ 10-20x/hr.	____ 60x/hr.	
Patient may lift/carry	____ 0-5 lbs.	A 0-10 lbs.	____ 0-20 lbs.	____ 0-50 lbs.		
Patient may reach above shoulder level	____ Not at all	____ 1x/hr.	____ 2-10x/hr.	____ 60x/hr.		

Additional Restrictions: ok to ice doughnuts

☒ Follow up with physician 4 wks

Physician Signature

7900 (8/11)

SUMMIT ORTHOPEDICS

For Summit Orthopedics to submit a workers' compensation claim for a visit, all of the information below must be complete. If any of the fields are blank the patient will still be responsible for any charges until all of the required data is received by Summit Orthopedics. Please complete the form and fax to the fax number below or call the information to the phone number below.

Patient Name: _____

Patient Date Of Birth: _____

Employer at the time of injury: _____

Workers' Compensation Carrier: _____

WC Insurance Company Address: _____

_____

Adjusters Name: _____

Adjusters Phone #: _____ **Adjusters Fax #:** _____

Claim #: _____ **Date of Injury: Month- Day-Year** _____

Injured area of body: _____

Once again, until all of the above information is received by Summit Orthopedics a claim cannot be submitted to the workers' compensation carrier, the patient will receive bill for visits pertaining to the workers' compensation claim. Please submit the information to the numbers below as soon as possible.

Thank you.

Phone # 651-968-5050

OR

Fax # 651-968-5900