

REPORT OF WORKABILITY

To Be Completed by Physician

MN Only-The information on this form must be provided to the employee as required by Minn.Rule 5221.1410, Subp 6.
 NOTE to EMPLOYEE: You must promptly provide a copy of this report to your Employer.

Employee Sandra Olson SS # _____ DOB 11/24/61 MO DAY YR DOI 1/1 MO DAY YR

Describe clinical findings: Lumbar Radiculopathy
Facet Arthropathy

Diagnosis _____
 Work Related Not Work Related Undetermined
 Permanent Disability Likely Not Likely Undetermined
 WI/ End of Healing: NO YES If yes, give date _____
 MN/ MMI: NO YES If yes, give date _____

Return to work with no limitations on 1/1/15 Next scheduled shift
 Return to work with limitations on 11/19/15 through Next M.D. Visit
 Unable to work from 1/1/15 through 1/1/15

EMPLOYEE'S CAPABILITIES

	EMPLOYEE'S CAPABILITIES					EMPLOYEE'S CAPABILITIES			
	Not at all	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%		Not at all	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%
Lift/Carry					Bend				
0 - 10 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input 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 checked="" type="checkbox"/>	<input 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"/>	Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull					Stand/Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0 - 25 lbs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overhead reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26 - 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ladder/stair climb	<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"/>	Rotate Activities/Positions	<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"/>					

AVOID the following hand & wrist activities:

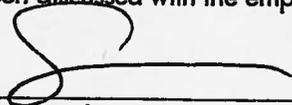
Operate power/vibrating tools	Left	Right	Both
Coarse manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Torquing, crimping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping-light/heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One-handed work only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-stretched arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

No operating forklift
 No operating machinery
 No driving motor vehicle

Comments _____

Keep wound clean and dry. Change dressing every _____
 Medication As directed (as directed) May cause drowsiness.
 Ice Heat Elevate Splint/Brace Crutches Neck/lumbar support Stretching exercises
 Physical therapy TX/week Frequency _____
 Specialist referral _____ Date _____ Time _____
 Return to Clinic on 6 weeks Date 12/18/15 Time 10:15 am

The above has been discussed with the employee.


 Physician
 Sherief Mikhail, MD, MPH

11/09/2015
 Date

Minnesota Spine Rehab
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 360 Sherman Street
 St. Paul MN 55102