

Work Status Report

Patient: KAPRINS (60873) DOS: 12/18/15
 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:	No Repetitive Motions Of	Do Not Do The Following:
<input type="checkbox"/> Lifting (Max LBS) 10 20 30 40 50 60	<input type="checkbox"/> Hand Grasp R L <input type="checkbox"/> Wrist R L <input type="checkbox"/> Elbow R L <input type="checkbox"/> Shoulder R L <input type="checkbox"/> Foot R L	<input type="checkbox"/> Operate Machinery/Equipment <input type="checkbox"/> Operate Machinery if at risk of entrapment of injured body part splint or dressing.
<input type="checkbox"/> Pushing _____ LBS <input type="checkbox"/> Pulling _____ LBS	<input type="checkbox"/> Non Weight Bearing <input type="checkbox"/> Partial Weight Bearing	<input type="checkbox"/> Crawl <input type="checkbox"/> Kneel <input type="checkbox"/> Squat <input type="checkbox"/> Drive
<input type="checkbox"/> Reaching Above Chest <input type="checkbox"/> Reaching Overhead <input type="checkbox"/> Reaching Away From Body	<input type="checkbox"/> Wear Splint At All Times <input type="checkbox"/> Wear Splint At Work <input type="checkbox"/> Wear Splint At Night	
<input type="checkbox"/> R Hand Work Only <input type="checkbox"/> L Hand Work Only <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sitting	<input type="checkbox"/> Other _____	

Treatment Plan

<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Compression	<input type="checkbox"/> Occupational/Physical Therapy
<input type="checkbox"/> Analgesics	<input type="checkbox"/> Elevation	_____ times each week
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Tetanus	_____ weeks
<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Wound Care	<input type="checkbox"/> Xray
<input type="checkbox"/> Rest	<input type="checkbox"/> Cast/Fracture Care	<input type="checkbox"/> MRI
<input type="checkbox"/> Ice	<input type="checkbox"/> Splint	<input type="checkbox"/> CT Scan
<input type="checkbox"/> Heat	<input type="checkbox"/> Burn Care	<input type="checkbox"/> EMG
<input type="checkbox"/> Eye Patch	<input type="checkbox"/> Tens unit	<input type="checkbox"/> 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

Follow Up Visit _____
 Discharged-return if the symptoms recur/worsen

Physician Signature: _____

MORRY A. OLENICK, M.D.

◆ HAND AND PLASTIC SURGERY ◆

9195 Grant St, Ste 301 • Thornton, Colorado 80229
 (303) 287-7007 • Fax: (303) 287-2230