

MEDICAL STATUS FORM

This form is intended to: 1) facilitate communication between a worker with a work-related injury or occupational disease, the employer, and the health care provider for Stay at Work/Return to Work; and 2) provide necessary medical status to the insurer.

Patient/Employee Name (Last, First)	Date of Birth (mm/dd/yyyy)	Date of Injury (mm/dd/yyyy)	Timestamp for Health Care Providers Provider Info
Date of Next Visit	Claim Administrator Number	Health Care Provider Name & Address	

Please select **ONE** of the following: (Note - Temporary, alternative and full duty return dates are subject to reassessment).

Condition Unchanged from Last Report
 Patient/Employee Released to Full Duty
 Patient/Employee Released to Modified Duty (SEE WORK ABILITIES)
 Time Loss Authorized - objective findings indicate worker should remain off work
 Anticipated date patient/employee can perform temporary alternate work
 Anticipated date patient/employee can return to full duty

Total Number of Hours/Day Patient/ Employee May Work:	Number of Hours								Patient/Employee <input type="checkbox"/> Should / <input type="checkbox"/> Must <input type="checkbox"/> Sit / <input type="checkbox"/> Stand / <input type="checkbox"/> Walk Every _____ hours		
	NR = Not Restricted	0	1	2	3	4	5	6		7	8
Sit _____ days per week		0	1	2	3	4	5	6	7	8	NR
Stand _____ hours per day		0	1	2	3	4	5	6	7	8	NR
Walk _____ hours per day		0	1	2	3	4	5	6	7	8	NR

Never Occasionally Frequently Continuously Permanently
Example of an eight hour work day: NEVER equals 0%, OCCASIONALLY equals 1% to 33% (1-2.6 hours), FREQUENTLY equals 34% to 66% (2.6-5.2 hours), and CONTINUOUSLY equals 67% to 100% (5.3+ hours).

Hand/Wrist Work <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Manipulation <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 01-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 11-20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 21-25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 26-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 51-70 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Work Abilities for Temporary or Permanent Modified Work (Please Mark Choices In All Categories)

Is the patient/employee involved in treatment and/or medication related to the work-related injury/occupational disease that might affect their ability to work safely in any capacity? No Yes If Yes, please explain _____

Will the patient/employee be required to use any devices or braces? No Yes If Yes, please explain _____

Additional comments specific to patient/employee's work abilities _____

Can the patient/employee return to work at time of injury occupation? No Yes

Patient/Employee Signature	Date
Health Care Provider's Signature	Date

Medical Status Form 9/19/11

This section contains private information for the MEDICAL PROVIDER, INSURER AND PATIENT/EMPLOYEE ONLY and is NOT to be given to EMPLOYER

Diagnosed Condition _____

Treatment plan to increase functional improvement until next appointment _____

Identity of medication prescribed _____

Anticipated MMI date _____ Actual MMI date _____ Perm WP Impairment Rating _____ %

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Date of Injury (mm/dd/yyyy)	Date of Birth (mm/dd/yyyy)	Health Care Provider Name & Address	
Date of Next Visit	Claim Administrator Number	Provider Info	

Please select **ONE** of the following: (Note - Temporary, alternative and full duty return dates are subject to reassessment).

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	0	1	2	3	4	5	6	7		8
Sit _____ days per week	0	1	2	3	4	5	6	7	8	NR
Stand _____ hours per day	0	1	2	3	4	5	6	7	8	NR
Walk _____ hours per day	0	1	2	3	4	5	6	7	8	NR

	Never			Occasionally			Frequently			Continuously			Permanent Upon MMI
	0	1	2	3	4	5	6	7	8	9	10	11	
Hand/Wrist Work <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Reaching <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 01-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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This page is for PATIENT/EMPLOYEE and EMPLOYER