

WORK ABILITY REPORT

PATIENT: _____ Soc Sec No: _____ CHART NO: _____

DATE OF INJURY: _____ EMPLOYER: _____ TODAY'S DATE: _____

DIAGNOSIS: _____

<input type="checkbox"/> Return to work with no limitations on _____ <input type="checkbox"/> Return to work limitations from _____ through _____ <input type="checkbox"/> Totally disabled from work from _____ through _____ <input type="checkbox"/> Continue same limitations as prior report through _____	Work-related Illness/Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> To be determined
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Work Limitations		Not at all	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
<u>PATIENT CAN</u>					
Lift/carry up to	10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	11-20 lbs	<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"/>
	51-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat/kneel		<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"/>
Reach above shoulder level		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach below knee level		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand or walk		<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"/>

Hand and Wrist Activities						
Left <input type="checkbox"/>	Right <input type="checkbox"/>	Both <input type="checkbox"/>	Not at all	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
			<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"/>	<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"/>
RESTRICTIONS (CIRCLE)						
Keyboarding (hrs/shift).....			0...	1-2..	3-4..	5-6..7-8
Writing (hrs/shift)			0...	1-2..	3-4..	5-6..7-8
CHANGE POSITIONS EVERY						
<input type="checkbox"/> Half hour						
<input type="checkbox"/> One hour						
<input type="checkbox"/> Two hours						
<input type="checkbox"/> Slight impairment - avoid driving/operating heavy equipment						

Instructions

Keep wound clean and dry Change dressing every: _____

Apply ice/hot pack for 20 minutes every _____ hours for _____ days

Splint/appliance applied to: _____

Medications: _____

Patient referred to: _____ Appointment date: _____ Time: _____

Physical Therapy _____ X / week Location: _____

Return to Stillwater Medical Group on: _____ **Time:** _____

Comments

Provider Name (Print) _____ Provider Signature _____

Instruction sheet:

Burn care Time discharged: _____ AM
 Wound care _____ PM
 Head injury
 Crutch walking Nurse Initials: _____
 Other _____

EMPLOYEE:
 MN Rule 5221.0410 Subpart 6D
Promptly upon receipt, employee shall submit this form to the employer or insurer.