

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

Released for Work?	Please select ONE of the following: (Note - Temporary, alternative and full duty return dates are subject to reassessment).	
	<input type="checkbox"/> Condition Unchanged from Last Report	
	<input type="checkbox"/> Patient/Employee Released to Full Duty	Effective Date
	<input type="checkbox"/> Patient/Employee Released to Modified Duty (SEE WORK ABILITIES)	Effective Date
	<input type="checkbox"/> Time Loss Authorized - objective findings indicate worker should remain off work	Effective Date
	<input type="checkbox"/> Anticipated date patient/employee can perform temporary alternate work	Anticipated Date
<input type="checkbox"/> Anticipated date patient/employee can return to full duty	Anticipated Date	

Work Abilities for Temporary or Permanent Modified Work (Please Mark Choices In All Categories)	Total Number of Hours/Day Patient/ Employee May Work:	Number of Hours										NR = Not Restricted	Patient/Employee <input type="checkbox"/> Should / <input type="checkbox"/> Must
	_____ days per week	Sit	0	1	2	3	4	5	6	7	8	NR	<input type="checkbox"/> Sit / <input type="checkbox"/> Stand / <input type="checkbox"/> Walk Every
	_____ hours per day	Stand	0	1	2	3	4	5	6	7	8	NR	_____ hours
		Walk	0	1	2	3	4	5	6	7	8	NR	

	Never	Occasionally	Frequently	Continuously	Permanent Upon MMI
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"/>
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"/>
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"/>
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"/>
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"/>
Bending	<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"/>
Squatting	<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"/>
Lifting 01-10 lbs.	<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"/>
Lifting 21-25 lbs.	<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"/>
Lifting 51-70 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Signatures	Patient/Employee Signature	Date	Medical Status Form 8/31/11
	Health Care Provider's Signature	Date	

This page is for PATIENT/EMPLOYEE and EMPLOYER