# 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 | **Provider Info** | 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).

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

_____days per week

_____hours per day

| Number of Hours | | | | | | | | | | *NR = Not Restricted* |
|---|---|---|---|---|---|---|---|---|---|---|
| Sit | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | NR |
| Stand | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | NR |
| Walk | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | NR |

Patient/Employee ☐ Should / ☐ Must ☐ Sit / ☐ Stand / ☐ Walk Every _____ hours

| | Never | Occasionally | Frequently | Continuously | Permanent Upon MMI |
|---|---|---|---|---|---|
| | *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 ☐L☐R☐B | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grasping ☐L☐R☐B | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pushing/Pulling ☐L☐R☐B | ☐ | ☐ | ☐ | ☐ | ☐ |
| Fine Manipulation ☐L☐R☐B | ☐ | ☐ | ☐ | ☐ | ☐ |
| Reaching ☐L☐R☐B | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bending | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kneeling | ☐ | ☐ | ☐ | ☐ | ☐ |
| Squatting | ☐ | ☐ | ☐ | ☐ | ☐ |
| Climbing | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting 01-10 lbs. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting 11-20 lbs. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting 21-25 lbs. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting 26-50 lbs. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting 51-70 lbs. | ☐ | ☐ | ☐ | ☐ | ☐ |

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 |
|---|---|
| Health Care Provider's Signature | Date |

Medical Status Form 8/31/11

**This page is for PATIENT/EMPLOYEE and EMPLOYER**