

RETURN-TO-WORK FORM

(Employee/Patient Sticker)

Employee/Patient Name: _____

Date of Injury: _____

Diagnosis: _____

Company: _____

DEGREE

- _____ No lifting
- _____ **Sedentary Work:** Lifting 10# maximum and occasionally lifting and/or carrying objects up to 5#
- _____ **Light Work:** Lifting 20# maximum with frequent lifting and/or carrying objects up to 10#
- _____ **Medium Work:** Lifting 50# maximum with frequent lifting and/or carrying objects up to 25#.
- _____ **Heavy Work:** Lifting 100# maximum with frequent lifting and/or carrying objects up to 50# or more.
- _____ **Very Heavy Work:** Lifting objectives in excess of 100# with frequent lifting and/or carrying objects weighing 50# or more.

Occasional: 0 to 30 reps/hr.

Frequent: >30 reps/hr.

HAND SPECIFIC

- _____ No use of injured upper extremity
- _____ Avoid extreme temperature changes
- _____ Avoid extreme wrist positions
- _____ No extreme force to be used
- _____ No vibration
- _____ Keep hand dry
- _____ May/must wear splint
- _____ Keep clean and dry

OVERHEAD WORK

	Right	/	Left
None	_____ / _____		
Limited to	_____ / _____		
Unlimited	_____ / _____		

1. _____ Work related or _____ non-work related.
2. _____ Recommend his/her return to work with **NO LIMITATIONS** on _____
3. _____ Patient is unable to work at this time. **OFF WORK UNTIL** Discharged
4. _____ May return to work on _____ with the **LIMITATION** noted on this sheet.
5. Limitations in effect until _____ **REEVALUATE** _____
6. Referrals (i.e., OT, PT, PCP, Specialist) _____

INSTRUCTIONS: _____

Physician's Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending physician and/or hospital to **release the above information** or copies thereof required in the course of my examination or treatment for the injury identified above to my employer or his representative. **I have received and understand instruction given. I assume responsibility for follow-up including notifying my employer.**

Patient's Signature: _____ Date: _____

LIMITATIONS

1. In an 8-hour day, the patient may:
 - a. **Stand/Walk**
 _____ 1-4 hrs. _____ 4-6 hrs. _____ 6-8 hrs.
 _____ Unlimited
 - b. **Sit**
 _____ 1-4 hrs. _____ 4-6 hrs. _____ 6-8 hrs.
 _____ Unlimited
 - c. **Drive**
 _____ 1-4 hrs. _____ 4-6 hrs. _____ 6-8 hrs.
 _____ Unlimited
2. Patient may repetitively use **injured hand(s)** for:
 - _____ Lifting _____ Weight limit _____ Unable
 - _____ Carrying _____ Push/pull _____ Pinch/grip
 - _____ Fine manipulation
 - _____ For assistance with light tasks
3. Patient may use **feet** for repetitive movement as in operating foot controls:
 - _____ Left: _____ Yes _____ No
 - _____ Right _____ Yes _____ No
4. Patient is able to:

	Unable	Occ	Freq.	Const.
	5-32%	33-66%	67-100%	
a. Bend	_____	_____	_____	_____
b. Squat	_____	_____	_____	_____
c. Climb	_____	_____	_____	_____
d. Twist	_____	_____	_____	_____
e. Reach	_____	_____	_____	_____
f. Kneel	_____	_____	_____	_____