

MEDICAL STATUS FORM

Employer Contact Information (Optional)

Employee Info	Employee's Name (Last, First) _____	Date of Birth (mm/dd/yyyy) _____	Provider _____
	Claim Number _____	Date of Injury (mm/dd/yyyy) _____	Timestamp _____
			Provider Contact Information _____

Released for Work?	<input type="checkbox"/> Employee Released to Full Duty	Date _____	To _____
	<input type="checkbox"/> Employee Released to Modified Duty (See Work Abilities)	Date _____	To _____
	<input type="checkbox"/> Employee May Work Limited Hours: _____ Hours Per Day	Date _____	To _____
	<input type="checkbox"/> Employee May Work Part-time:	Date _____	To _____
	<input type="checkbox"/> Employee Not Released to Work	Date _____	To _____
	<input type="checkbox"/> Capacity Duration (Estimate Days):	<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> 30+ <input type="checkbox"/> Permanent	

Modified Work Abilities	Blank Space = Not Restricted (NR)			Continuous	Frequent	Occasional	Never	
	Hand/Wrist	L	R	B				
	Grasping	L	R	B				
	Pushing/Pulling	L	R	B				
	Fine Manipulation	L	R	B				
	Reaching	L	R	B				
	Bending							
	Climbing							
	Lifting 01-10 lbs.							
	Lifting 11-20 lbs.							
	Lifting 21-25 lbs.							
	Lifting 26-50 lbs.							
Lifting 51-70 lbs.								
Signatures	Number of Hours Employee May:			Sit	Stand	Walk		
	List Other Restrictions:							
	Employee Signature _____				Date _____			
	Provider Signature _____				Date _____			

Copy of Medical Status Form to Employee

Date of Next Visit: _____

Treatment Plan	Employee Progress:	As Expected/Better Than Expected Expected Slower Than Expected	<input type="checkbox"/> Treatment Concluded by Provider: _____
	Current Rehab:	PT OT Home Exercise Other: _____	<input type="checkbox"/> Max. Medical Improvement (MMI): _____
	Surgery:	Not Indicated Possible Planned	Care Transferred To: _____
	Comments:		Consultation Needed With: _____
			Study Pending: _____
		Medications: _____	
		Opioids Prescribed for: Acute Pain Chronic Pain	
		Diagnosis: _____	