

Adjuster: _____ Phone/Fax: _____

Case Manager: _____ Phone/Fax: _____

Work Restriction Sheet

Employee Name: _____ DOB: _____ Claim #: _____ Phone: _____

Physician: _____ Phone/Fax: _____ Date: _____

1. Current Clinical Status

A. Working Diagnosis: _____ DOI: _____

B. Is condition felt to be work-related? Yes No Uncertain

C. In-Office Procedures: _____

D. Follow-up Recommendation: _____ Days _____ Weeks _____ Months _____ Next Appointment: _____

E. Reached MMI Yes No

2. Tests Recommended:

A. Type of tests: _____

B. Brief Rationale: _____

C. Follow-up after test completion: _____ Days

3. Treatment Recommended:

A. Type of Treatment: OT PT Surgery

B. Rationale: Conservative Management

Failure to Improve

Post-Operative Routine

C. Frequency _____ Duration _____

4. Surgery Recommended:

5. Physical Limitations for Work Activities

A. Off work until _____

B. Light duty from _____ to _____ (see chart)

If no light duty, then off work

Return to Full Duty _____

C. Part-time / Full activity _____ Hrs./Day

D. Employer notified Yes No

<input type="checkbox"/> Lifting/Carrying- Maximum lbs.	100-75	74-50	49-35	34-20	19-11	10-0
frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
occasionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Movement Limitations	Bend	Twist	Squat	Kneel	Climb	Drive
frequently (34-66%)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
occasionally (0-33%)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
not at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Restricted Use of Hand/Arm	Right <input type="checkbox"/>		Left <input type="checkbox"/>		Both <input type="checkbox"/>	
	Grip	Pinch	Push/Pull	Reach Above Shoulder		
frequently (34-66%)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
occasionally (0-33%)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
not at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> No Reaching Above Chest Level						
<input type="checkbox"/> Restricted Standing/Walking _____ Hrs. per Day	<input type="checkbox"/> Restricted Sitting _____ Hrs. per Day					
<input type="checkbox"/> No Work in a Cold Environment						
<input type="checkbox"/> No Knife and No Hook						
<input type="checkbox"/> Temperature Restrictions: (explain) _____						
<input type="checkbox"/> Sterlization/Contamination Restrictions: (explain) _____						
<input type="checkbox"/> Other _____						

M.D. Signature _____