



WORKERS COMPENSATION VISIT INFORMATION FORM

Last	First	MI	DOB/AGE	PCP

Date of Visit: _____	Employer Name: _____	Job Title: _____
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Case Manager/Nurse Reviewer attended the appointment. Name: _____

DIAGNOSIS

RIGHT LEFT BILATERAL _____
 RIGHT LEFT BILATERAL _____

TREATMENT

Referred to PT/OT _____
 Testing Ordered. Type: _____
 Medical Devices. Type: _____
 Surgery Date: _____ / _____ / _____
 Medication: Type: _____
 Other: _____

Activity Status

UNABLE to return to work effective _____ Until _____ Next Visit _____
 Return to MODIFIED DUTY effective _____ Until _____ with RESTRICTIONS* Next Visit _____
 Return to FULL DUTY effective _____

***RESTRICTIONS:**

Employee Cannot Use Right / Left _____
Employee Cannot Operate: Electrical Equipment / Machinery / Vehicle Walk Climb Stairs/Ladder
Employee Cannot: Bend/Stoop Twist Kneel Work Overhead Push/Pull > _____ lbs.

APPROXIMATE LIFTING / TOLERANCE CAPABILITIES*:

If absolute tolerances need to be defined, a Functional Capacity Evaluation is recommended.
 Sedentary (up to 10 lbs)
 Light (up to 20 lbs)
 Medium (up to 50 lbs)
 Heavy (up to 100 lbs)
 Very Heavy (>100 lbs) **NEXT APPOINTMENT DATE:** _____

**As defined by the U.S. Dept of Labor*

Provider Signature _____ Date _____
 Medical Assistant _____ Date _____

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