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	_____/_____

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

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: _____

This form provided by courtesy of Bellin Health System.