WORK ABILITY/ RETURN-TO-WORK

SFM
The Work Comp Experts®

Send itemized medical billings and records to:
SFM Companies, PO Box 9416, Mpls, MN 55440
Fax: (952) 838-2000 Phone: (800) 937-1181

Send this completed form with the employee.

EMPLOYEE	HEIGHT	WEIGHT	DATE OF BIRTH

EMPLOYER	DATE OF INJURY/ILLNESS

DIAGNOSIS	ICD-10 CODE

History, mechanism of injury, and findings:

Work related injury/illness? ☐ No ☐ Yes ☐ To be determined

Any pre-existing conditions affecting this injury/illness? ☐ No ☐ Yes, description:

Permanent partial disability? ☐ No ☐ Yes,_____%

Maximum Medical Improvement reached? ☐ No ☐ Yes, date reached_____

RETURN TO WORK

☐ Return to work with ***no limitations*** on _____/_____/_____
MO DAY YR

☐ Return to work ***with limitations*** on _____/_____/_____ through _____/_____/_____
MO DAY YR MO DAY YR

_____ **has light-duty work available. Please call** _____ at ( ) _____ **if you plan to take this employee off work.**

☐ Unable to work from _____/_____/_____ through _____/_____/_____
MO DAY YR MO DAY YR

EMPLOYEE'S CAPABILITIES

BODY PART AFFECTED: ☐ Neck ☐ Upper back ☐ Lower back ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot

☐ Other _____

SIDE AFFECTED: ☐ Left ☐ Right ☐ Both

	Not at all	Rare	Occa-sional 0-33%	Fre-quent 34-66%	Contin-uous 67-100%
Lift/Carry					
0-9 lbs	☐	☐	☐	☐	☐
10-19 lbs	☐	☐	☐	☐	☐
20-29 lbs	☐	☐	☐	☐	☐
30-39 lbs	☐	☐	☐	☐	☐
40-49 lbs	☐	☐	☐	☐	☐
No lift from floor	☐	☐	☐	☐	☐
Push/Pull without resistance					
0-19 lbs	☐	☐	☐	☐	☐
20-40 lbs	☐	☐	☐	☐	☐
> 40 lbs	☐	☐	☐	☐	☐
Bend	☐	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐	☐
Kneel/squat	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Stand/walk	☐	☐	☐	☐	☐
Ladder/stair climb	☐	☐	☐	☐	☐

Hand, wrist and shoulder activities

	Not at all	Rare	Occa-sional 0-33%	Fre-quent 34-66%	Contin-uous 67-100%
Avoid prolonged, repetitive or forceful:					
Gripping/grasping	☐	☐	☐	☐	☐
Repetitive wrist motion	☐	☐	☐	☐	☐
Reaching:					
Above shoulder	☐	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐	☐
Below shoulder	☐	☐	☐	☐	☐

Restrictions (circle):

Keyboarding (hrs/shift) 0 1-2 3-4 5-6 7

Writing (hrs/shift) 0 1-2 3-4 5-6 7

Total spread out evenly over shift at_____intervals

Change positions every
- ☐ As needed
- ☐ Half hour
- ☐ One hour
- ☐ Two hours

☐ Worksite stretches, i.e., per handout

☐ Exercises ☐ Other_____

Comments

INSTRUCTIONS

☐ Keep wound clean and dry. Change dressing every_____

☐ Medication_____

☐ Ice_____ min._____ ☐ Heat_____ min._____

☐ Splint/brace_____

☐ Referral_____

*Follow-up appointment scheduled for*_____

THIS TREATMENT HAS BEEN DISCUSSED WITH THE EMPLOYEE

CLINIC	CLINIC ADDRESS	LICENSE / REGIS.#	DATE OF EXAM

HEALTH CARE PROVIDER NAME (PRINTED)	HEALTH CARE PROVIDER SIGNATURE	PHONE	FAX

Physician please see reverse ➥

ATTENTION PHYSICIANS:

Your patient's employer offers transitional, light-duty work. Please contact the employer if you plan to take this employee off work.

Please complete the form on the back of this sheet, or a similar form, to document any work restrictions.