Pottawattamie County

Injured Worker Restrictions

(Information in Box Completed by Patient or Nursing Staff)

Injured Worker's Name: ______________________ Injured Worker's Date of Birth: __________

Date/Onset of Injury/Illness: ______________________

Injured Worker's Employer: ______________________ Employer Phone #: __________

Brief Diagnosis of Injury: ______________________

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Services Completed: ☐ **Office Visit** ☐ **Sutures** ☐ **X-Ray** ☐ **Drug Screening**

Injured worker has been advised of the following regarding Return to Work:

1. ☐ Return to work **IMMEDIATELY** with **NO RESTRICTIONS** - ☐ **Released from care / MMI** / ☐ Continued Monitoring
2. ☐ Medication has been prescribed *(please indicate any restrictions on the injured workers daily work activities as a result of the medication).*
3. ☐ No Return to Work until: ______/______/______ ***(no work until this date and no medical restrictions after this date).***
4. Return to Work with temporary work restrictions beginning (date) _____/_____/_____ and ending _____/_____/_____.
   Next scheduled appointment will determine any modifications to restrictions or treatment plan, see below for next apt. date and time.
5. ☐ Recommendation of Transitional Work Schedule/ Routine by treating Provider- See Notes Below or Attached Note(s)

Restrictions/Work Accommodations:

- ***During the workday, injured worker may****: (notate all pertinent instructions for restrictions,* ***Including Part A, B & C as applicable.****)*

Stand / Walk ☐ None or At No Time ☐ 1-4 Hours ☐ 4-6 Hours ☐ 6-8 Hours ☐ 8-12 Hours ☐ 12-16 Hours

Sit ☐ Unlimited ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours

A. Lifting/Carrying Restrictions: ***(Occasionally: up to 1/3 of work day, frequently: up to 2/3 of work day)***

☐ **Sedentary – Sit Down Work Only** – *lifting no more than 10 lbs. maximum at any time, all work must be performed seated*

☐ **Minimal Light Work** – *lifting 10 lbs. maximum & occasionally lifting and/or carrying such articles as files, ledgers & small tools*

☐ **Light Work** – *lifting 20 lbs. maximum with frequent lifting and or carrying of objects weighing up to 10 lbs.*

☐ **Light Medium Work** – *lifting 30 lbs. maximum with frequent lifting and/or carrying objects weighing up to 10 lbs.*

☐ **Medium Work** – *lifting 50 lbs. maximum with frequent lifting and/or carrying objects weighing up to 40 lbs.*

☐ **Light Heavy Work** – *lifting 75 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 40 lbs.*

☐ **Heavy Work** – *lifting 100 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 40 lbs.*

B. Other/Additional Restrictions

Location of Injury: ☐ **Right or** ☐ **Left** / ☐ **Hand** ☐ **Arm** ☐ **Leg** ☐ **Foot** ☐ **Other:** ______________

Upper Extremities:

☐ No repetitive gripping, grasping, pinching, squeezing

☐ No operation of vibratory machinery/equipment

☐ No lifting above shoulder level

☐ No lifting from floor to shoulder level

☐ No lifting from floor to waist level

☐ Limiting Push/Pull activities to ________ lbs. and under

☐ NO USE OF EFFECTED Arm/Hand/ and/or Keep in sling or brace at all times

Lower Extremities:

☐ No squatting or kneeling

☐ No standing on or climbing of stairs

☐ No standing on or climbing of ladders

☐ No use of foot pedal operated machinery

☐ No stooping or bending at the waist

C. Transitional Work - ☐ *Not Applicable- Does not apply at this time.*

☐ 2 hours Unrestricted work per day for ___ **week(s)**. Able to work remaining daily schedule under Restrictions? ☐ YES ☐ NO **Effective Date:** _______

☐ 4 hours Unrestricted work per day for ___ **week(s).** Able to work remaining daily schedule under Restrictions? ☐ YES ☐ NO **Effective Date:** _______

☐ 6 hours Unrestricted work per day for ___ **week(s).** Able to work remaining daily schedule under Restrictions? ☐ YES ☐ NO **Effective Date:** _______

☐ 8 hours Unrestricted work per day for ___ **week(s).** Able to work remaining daily schedule under Restrictions? ☐ YES ☐ NO **Effective Date:** _______

Notes ***(or Other Functional Limitations or Modifications necessary in the Injured Workers Employment)***: ______________

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Next Scheduled Follow-Up (date/time): ☐ **N/A** ______________________

Referral to another provider/specialist or Physical Therapy? ☐ **N/A** ☐ **Yes** ☐ **No** (If Yes, who? ______________)

______________________ ______________ ______________________

Healthcare Provider Signature | Date/Time | Healthcare Provider Printed Name

Employee Signature: ______________________ Date: ______________ ☐ Approved

Supervisor Signature: ______________________ Date: ______________ ☐ Denied

PERMANENT PART OF MEDICAL RECORD