Employee:
SS#:
DOI:
DOB:

Patient's Restrictions & Capabilities

Please complete the following assessment based upon your clinical findings. Items that you cannot evaluate should be marked N/A.

In an eight (8) hour workday, the patient can:		Continuously	With Rest
SIT	1 2 3 4 5 6 7 8	_____	_____
STAND	1 2 3 4 5 6 7 8	_____	_____
WALK	1 2 3 4 5 6 7 8	_____	_____

LIFT	Never	Occasionally (Up to 33%)	Frequently (34%-66)	Continuously (67%-100%)
10 lbs	_____	_____	_____	_____
11-20 lbs	_____	_____	_____	_____
21-50 lbs	_____	_____	_____	_____
51-100 lbs	_____	_____	_____	_____
CARRY	_____	_____	_____	_____
10 lbs	_____	_____	_____	_____
11-20 lbs	_____	_____	_____	_____
21-50 lbs	_____	_____	_____	_____
BEND	_____	_____	_____	_____
SQUAT	_____	_____	_____	_____
CRAWL	_____	_____	_____	_____
CLIMB	_____	_____	_____	_____
BALANCE	_____	_____	_____	_____
REACH	_____	_____	_____	_____
DRIVING	_____	_____	_____	_____

HANDLING	Simple Grasping	Fine Manipulation	Light / Medium / Heavy (select level) Pushing and Pulling
Right	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Left	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

ACTIVITY RESTRICTIONS INVOLVING:	Total	Moderate	Mild	No Restriction
Fixed / Moving Machinery	_____	_____	_____	_____
Cold Climate	_____	_____	_____	_____
Hot Climate	_____	_____	_____	_____
Wet / Humid	_____	_____	_____	_____
Noise	_____	_____	_____	_____
Dust / Fumes	_____	_____	_____	_____
Use of Powered Equipment	_____	_____	_____	_____
Vibration	_____	_____	_____	_____

Patient released to return to work with restrictions Date: _____
Estimated return to work without restrictions Date: _____
Restrictions effective through Date: _____
Has patient reached maximum medical improvement YES / NO Date: _____
Are the above stated restrictions permanent YES / NO Date: _____
Can patient work full time? YES / NO **Part Time: #hr/day _____** Date: _____

COMMENTS:

_____
_____
_____
_____

Physician Signature: _____ Date: _____