**Town of Vienna**

**Return to Work Form**

**Completed form is to be returned to employer following each patient visit.**

Employee’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appt. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_ Brief diagnosis of injury/illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RETURN TO WORK STATUS**

**Release:** (check only one)

1. \_\_\_\_\_ Patient is unable to return to work.
2. \_\_\_\_\_ **Full Duty Release**: employee is released from active medical care.
3. \_\_\_\_\_ **Full Duty Release without Temporary restrictions:** employee is able to work full duty without restrictions, *but is not released from active medical care.*
4. \_\_\_\_\_ **Light Duty Release with Temporary Restrictions**: employee can return to **Light Duty Work** with the

following temporary restrictions: (COMPLETE RESTRICTIONS SECTION)

5. \_\_\_\_\_ Will medication use prohibit driving or operation of heavy equipment? YES \_\_ NO \_\_

**Restrictions**: (check all that apply and fully describe below)

|  |  |  |  |
| --- | --- | --- | --- |
|  | \_\_\_\_\_ No Restrictions | \_\_\_\_\_ Temporary Restrictions | \_\_\_\_\_ Permanent Restrictions |
| 1. | \_\_\_\_\_ Restricted lifting/carrying (maximum weight in pounds) \_\_\_\_\_\_ other \_\_\_\_\_ | frequency \_\_\_\_\_ |
| 2. | \_\_\_\_\_ Restricted pushing/pulling of \_\_\_\_\_ lbs. |  |  |  |  |  |  |  |
| 3. | \_\_\_\_\_ Restricted reaching: above chest \_\_\_\_\_ | overhead \_\_\_\_\_ away from body \_\_\_\_\_ other \_\_\_\_\_ |
| 4. | \_\_\_\_\_ Restricted to one-handed duty. No use of: | right hand \_\_\_\_\_ | left hand \_\_\_\_\_ |  |
| 5. | \_\_\_\_\_ Restricted: walking \_\_\_\_\_ | standing \_\_\_\_\_ | sitting (describe) \_\_\_\_\_ | partial wt bearing (describe) \_\_\_\_\_ |
| 6. | \_\_\_\_\_ Wear splint at: all times \_\_\_\_\_ | work \_\_\_\_\_ | at night (describe) \_\_\_\_\_ |  |
| 7. | \_\_\_\_\_ No more than \_\_\_\_\_ repetitive movements per \_\_\_\_\_ day or \_\_\_\_\_ hour of : |  |
|  | Hand Grasp L \_R \_ Wrist L \_R \_ Elbow Flexion L \_R \_ | Shoulder L\_ R\_ | Foot L\_ R\_ Torso Flexion |
| 8. | \_\_\_\_\_ DO NOT: Operate Machinery \_\_\_\_\_ | Crawl \_\_\_\_\_ | Kneel \_\_\_\_\_ | Squat \_\_\_\_\_ |
|  | Drive any vehicle \_\_\_\_\_ | Climb \_\_\_\_\_ | Bend \_\_\_\_\_ | Stoop \_\_\_\_\_ |  |  |
| 9. | \_\_\_\_\_ Fully describe restrictions (i.e. duration, nature of limitation, etc.) add extra pages if needed: |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient requires follow up treatment as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_