Twin Rivers URGENT CARE

EMPLOYEE'S RETURN TO WORK FORM
Must be completed by provider

Patient's Name: _____ Date of Onset: _____

Date(s) of Treatment: _____

History: _____

Name(s) of other physician(s) or medical providers who have served on case: _____

_____

Diagnosis: _____

Treatment (Proposed or completed): _____

Medication(s): _____

Prognosis: _____

First day off work: _____ **Estimated** return to work date: _____

Actual Return to Work **without** restrictions: _____

Return to work **with** reduced schedule:

Number of hours per day: _____ Number of days per week: _____

Beginning: _____ Ending: _____

☐ Return to work with the following restrictions: Beginning: _____ Ending: _____

☐ Lifting (weight)	0-10 lbs	11-25 lbs	26-40 lb.	41-50 lbs	+ 50 lbs
Lifting					
From floor	25%	50%	75%	100%	
From waist level	25%	50%	75%	100%	
Over the shoulder/head	25%	50%	75%	100%	
☐ Pushing/pulling (weight)	0-10 lbs	11-25 lbs	26-40 lbs	41-50 lbs	+50 lbs
☐ Pushing/pulling frequency	25%	50%	75%	100%	
☐ Standing	25%	50%	75%	100%	
☐ Sitting	25%	50%	75%	100%	
☐ Walking	25%	50%	75%	100%	
☐ Climbing	25%	50%	75%	100%	
☐ Bending 18" from body	25%	50%	75%	100%	
From shoulder level	25%	50%	75%	100%	
☐ Kneeling/Squatting	25%	50%	75%	100%	

☐ No operating moving machinery
☐ No driving

Additional instruction: _____

_____

Date of next office visit: _____

Medical Provider's Name: _____

Medical Provider's Signature: _____ Date: _____

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