Medical Release Form:

Patient's Name: _____ Appointment Date: _____/_____/_____
Physician's Name: _____ Next Appt Date: _____/_____/_____
Referral To: _____ Appointment: _____/_____/_____
Employer Contact: _____ Phone Number: _____
Diagnosis / Condition: _____
Date of Injury: _____/_____/_____ Work Related: (Yes) (No) (Not Determined)
RETURN TO WORK STATUS:
Totally Off Work From: _____/_____/_____ To: _____/_____/_____
RESTRICTIONS START: _____/_____/_____ (Re-evaluate at next Appointment-See above)
FULL RELEASE: _____/_____/_____ MEDICALLY STABLE: _____/_____/_____

Please complete physical limitations worksheet below or approve attached job specific forms:

Time of injury Position: ***Approved ( )*** ***Disapproved ( )***
Transitional Position: ***Approved ( )*** ***Disapproved ( )***

Check only if there is a Restriction:

	Not at All	Rarely (<1%)	Occasionally (1% to 33%)	Frequently (34% to 66%)	Continuously (67% to 100%)
☐ Lift up to: 0-5 lbs	☐	☐	☐	☐	☐
6-10 lbs	☐	☐	☐	☐	☐
11-25 lbs	☐	☐	☐	☐	☐
26-50 lbs	☐	☐	☐	☐	☐
☐ Stand hours per day_____ OR	☐	☐	☐	☐	☐
☐ Walk hours per day _____ OR	☐	☐	☐	☐	☐
☐ Sit hours per day _____ OR	☐	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐
☐ Stoop	☐	☐	☐	☐	☐
☐ Kneel (RT) (LT)	☐	☐	☐	☐	☐
☐ Crouch	☐	☐	☐	☐	☐
☐ Climb	☐	☐	☐	☐	☐
☐ Twist	☐	☐	☐	☐	☐
☐ Arm Use (RT) (LT)	☐	☐	☐	☐	☐
☐ Arm Reach Shoulder or Below (RT)	☐	☐	☐	☐	☐
☐ Arm Reach Shoulder or Above (RT)	☐	☐	☐	☐	☐
☐ Drive to/from work yes) (no);at	☐	☐	☐	☐	☐
☐ Push/Pull _____lbs	☐	☐	☐	☐	☐
☐ Grasping / Handling (RT) (LT)	☐	☐	☐	☐	☐
☐ Fine Manipulation / Fingering (RT)	☐	☐	☐	☐	☐
☐ Working with Moving Equipment	☐	☐	☐	☐	☐

☐ Start Working (4 , 6) _____ Increase by (1, 2, 4) _____ Hours per day per week.
☐ Other Restrictions (Please specify): _____
_____

Are the restrictions/limitations marked of a permanent nature? (YES) (NO)

By signing this document, I am verifying this information has been reviewed with me by the provider.

Physician Signature: _____ Date: _____

Print Name: _____ Date: _____

Patient Signature: _____ Date: _____