The Clinic at Elm Lake Work Status Report

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Company_____Employee_____Date_____Time_____

Original Diagnosis	Treatment/Medications

FOLLOW UP INFORMATION

Progress Summary	Follow-up diagnosis
Date Of Injury: _____/_____/_____	
Was Patient treated by anyone else? Yes No	Whom:

REFERRAL INFORMATION

Referral? Yes No	To Whom?
Referral Request Completed? Yes No	Appointment Time

RETURN TO WORK

☐ FULL DUTY	☐ *SEE BELOW	☐ MAY NOT return to work at this time
☐ MAY ☐ MAY NOT return to work to seeing specialists	Date of Anticipated Return to Full Duty____/____/_____ Date of Anticipated MMI ____/____/_____	

*RESTRICTIONS

____ No	____ Limited	Use of Right / Left Hand Arm Leg Foot	
____ No	____ Limited	Overhead Work	Other: _____
____ No	____ Limited	Pushing/Pulling	_____
____ No	____ Limited	Reaching/Grasping	_____
____ No	____ Limited	Standing/Walking	_____
____ No	____ Limited	Climbing Stairs or Ladders	_____
____ No	____ Limited	Sitting	_____
____ No	____ Limited	Bending or Twisting	_____
____ No	____ Limited	Squatting or Kneeling	_____
____ No	____ Limited	Lifting _____ Pounds	_____
____ No	____ Limited	Requiring Optimal Vision	_____
____ No	____ Limited	Operating Equipment/parts/machinery/driving	

_____ Keep Wound Clean and Dry _____ Wear Splints at All Times _____ Medication Warning --- **May Cause Drowsiness**

Follow up with Physician Date _____/_____/_____

STAFF CHECKLIST

Drug Screen: Yes No

WSR: ____ Faxed _____ Mailed _____ Given to Employee Date: ____/____/____ Time _____

_____ Employer Called : Date ___/___/___ Time: _____ Contact: _____

Physician Signature _____

Staff Signature _____

Patient Signature _____