**State of Oklahoma**

**Workers’ Compensation Return to Work Form**

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

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

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 has reached maximum medical improvement (MMI) and 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 has NOT reached (MMI) and 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

1. \_\_\_\_\_ DO NOT: Operate Machinery \_\_\_\_\_ Crawl \_\_\_\_\_ Kneel \_\_\_\_\_ Squat \_\_\_\_\_

 Drive any vehicle \_\_\_\_\_ Climb \_\_\_\_\_ Bend \_\_\_\_\_ Stoop \_\_\_\_\_

1. \_\_\_\_\_ Fully describe restrictions (i.e. duration, nature of limitation, etc.) add extra pages if needed:

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

Patient requires follow up treatment on: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_