

NUTHERA

Work Status / Restrictions Form

Date: _____ Visit type: Initial Follow-up Return-to-work

PATIENT INFORMATION

Patient name: _____

Date of birth: _____

Date of injury: _____

Claim type: OWCP / Federal Workers' Comp State Workers' Comp Personal Injury Other

Claim / case #: _____

EMPLOYER INFORMATION

Employer / agency: _____

Supervisor name: _____

Supervisor phone: _____

Job title: _____

DIAGNOSIS / CONDITION(S)

1. _____

2. _____

3. _____

WORK STATUS

- Regular duty, no restrictions
- Regular duty with restrictions (complete restrictions below)
- Modified / light duty (complete restrictions below)
- Unable to work at this time

SPECIFIC RESTRICTIONS

Activity	Restriction / Limit	Frequency
Lifting	<input type="checkbox"/> None <input type="checkbox"/> Up to ___ lbs <input type="checkbox"/> No lifting	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant
Carrying	<input type="checkbox"/> None <input type="checkbox"/> Up to ___ lbs <input type="checkbox"/> No carrying	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant

Pushing / pulling	<input type="checkbox"/> None <input type="checkbox"/> Up to ___ lbs <input type="checkbox"/> Avoid	<input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant
Sitting	<input type="checkbox"/> No limit <input type="checkbox"/> Up to ___ min at a time	With breaks every ___ min
Standing	<input type="checkbox"/> No limit <input type="checkbox"/> Up to ___ min at a time	With breaks every ___ min
Walking	<input type="checkbox"/> No limit <input type="checkbox"/> Up to ___ min at a time	Terrain restrictions: _____
Bending / stooping	<input type="checkbox"/> None <input type="checkbox"/> Avoid <input type="checkbox"/> Minimal	<input type="checkbox"/> Occasional <input type="checkbox"/> Avoid
Reaching / overhead	<input type="checkbox"/> None <input type="checkbox"/> Avoid <input type="checkbox"/> Minimal	<input type="checkbox"/> Occasional <input type="checkbox"/> Avoid
Climbing	<input type="checkbox"/> None <input type="checkbox"/> Stairs only <input type="checkbox"/> Avoid ladders	
Driving	<input type="checkbox"/> No restriction <input type="checkbox"/> Restricted <input type="checkbox"/> Not cleared	
Other	_____	_____

DURATION OF RESTRICTIONS

Restrictions effective: _____ Through: _____

Re-evaluate on: _____

ADDITIONAL CLINICAL NOTES

Provider signature: _____ Date: _____

Provider name (printed): _____

Credentials: _____

Patient signature: _____ Date: _____