ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Company Name

Patient's N (Middle Initial) | Date of Injury/Illness: 11-2-09

TO BE COMPLETED BY ATTENDING PHYSICIAN - PLEASE CHECK

DIAGNOSIS/CONDITION (Brief Explanation): Cervical disc herniation c̄ progressive radiculopathy

I saw and treated this patient 3-30-10 (Date) and based on the above description of the patient's current medical problem:

1. ☐ Recommend his/her return to work with no limitations on ______ (Date)
2. He/she is totally incapacitated at this time. Patient will be re-evaluated on ______ (Date)
3. ☑ He/She may return to work on Full time duty 3-30-10 → 40 hrs/wk. (Date) with the following limitations:

CHECK ONLY AS RELATES TO ABOVE CONDITIONS

☑ Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls

☐ Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ Light Heavy Work. Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8-hour work day, patient may:
   - a. Stand/Walk: ☐ None ☐ 1-4 hours ☐ 4-6 hours ☑ 6-8 hours
   - b. Sit: ☐ 1-3 hours ☐ 3-5 hours ☑ 5-8 hours
   - c. Drive: ☐ 1-3 hours ☐ 3-5 hours ☑ 5-8 hours
2. Patient may use hand(s) for repetitive: ☐ Single Grasping ☐ Fine Manipulation ☐ Pushing & Pulling — (R) Hand only
3. Patient may use foot/feet for repetitive movements as in operating foot controls: ☑ Yes ☐ No
4. Patient may:

	Not at all	Occasionally	Frequently
a. Bend	☐	☐	☑
b. Twist	☐	☐	☑
c. Squat	☐	☐	☑
d. Climb	☑	☐	☐
e. Reach	☑ (L) UE	☐	☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS: Pt needs cervical decompression/fusion.

4. ☑ These restrictions are in effect until Surgery (Date) or until patient is reevaluated on ______ (Date)
5. Referred to: ☐ None ☐ Private Physician ______ (Doctor) ☐ Return Here ______ (Date & Time) ☐ A Consultant ______ (Doctor, Date & Time)

Physician's Signature: [signature] | Date: 3-30-10

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or his representative.

Patient's Name | Date

DISTRIBUTION OF FORM: WHITE - Employer CANARY - Doctor PINK - Employee

5 S .ast Chance Gulch
P.C 1759
Helena, MT 59604-4759
Phone: 406-444-6500
Fax: 406-444-5963
www.montanastatefund.com

...K CAPACITY

Name of Physician: ____

Date of Exam: ____

PATIENT MUST COMPLETE THIS SECTION OF THE FORM

Patient's Name (Please Print) ____ Birthdate ____

Social Security Number ____ Claim Number ____

"I understand the health care information relevant to my workers' compensation or occupational disease claim may be released to Montana State Fund or an agent of Montana State Fund, as provided in 39-71-604 and 50-16-527, MCA."

Employee Signature: ____ Date ____

PROVIDER MUST COMPLETE THIS SECTION OF THE FORM

Is the worker medically stationary (MMI)? Yes ✓ No ___ Date 9/23/07 Impairment Rating: Yes ✓ No ___ Rating: 2%
Anticipated Date of MMI: ____ Anticipated Impairment: ____

DISPOSITION (Circle only one)
Release with no restrictions (date) 9/23/09
Patient may not work until (date) ____ or ☐ Cleared by consulting physician
Restricted duty until (date) ____ or ☐ Cleared by Consulting physician

PROVIDER MUST COMPLETE SECTION BELOW WHEN RESTRICTED DUTY IS CHECKED ABOVE

Restrictions: *The worker is released to return to work in the following range for lifting, carrying, pushing/pulling (mark X where applies)*

Pounds	0-10 lbs	10-25 lbs	25-50 lbs	>50 lbs
Occasionally				
Frequently				

(Please circle the appropriate restrictions)

	Never	Occasionally	Repetitively
Bend			
Squat			
Climb			
Crawl			

STANDING: No Standing
Standing permitted, but limited to 2 Hours 4 Hours 6 Hours

SITTING: No Sitting
Sitting permitted, but limited to 2 Hours 4 Hours 6 Hours
Alternate Sitting/Standing: For ____ minutes every ____ hours

REPETITIVE: Repetitive grasping/holding/manipulating with right/left/either hand limited to: ____

MOTION: Repetitive reaching above shoulder height with right/left/either arm limited to: ____

Comments ____

Follow-Up: Surgery ____ Date: ____
Referred to ____ Date: ____

Next scheduled appointment date: ____

Provider's Signature [signature] Date: 9/23/09

Please Fax this Form to (406) 444-5963 or Mail to P.O. Box 4759 – Helena, MT 59604-4759

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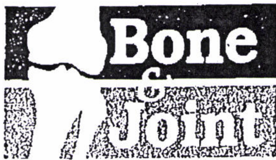

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WORK STATUS REPORT

Patient Name [redacted] DOB: ________ Claim #: ____________

Date of Office Visit: 11/23/04 Next Appt.: 6 Weeks
Days Weeks Months

Diagnosis: ______________________

_____ Released to work: WITHOUT RESTRICTIONS _____ Medically Stationary

_____ NO WORK until next evaluation

Anticipated Return to Work Date: __________ Anticipated MMI Date: __________

_____ Released to work WITH THE FOLLOWING RESTRICTIONS:

_____ Limit work to _____ hours per day.

_____ No pushing, pulling, or lifting in excess of ___10 ___20 ___30 ___40 ___50 pounds.

_____ No twisting, climbing, or stooping.

_____ No work with the left arm / right arm / above or at shoulder level.

_____ No work requiring repeated motion of the head.

_____ No repetitive movements or gripping with the left / right wrist / hand.

_____ Move around or sit when necessary for comfort.

_____ No walking on rough or uneven ground.

_____ No working at unprotected heights.

_____ The patient needs walking aids (e.g. crutches, splints, other).

_____ Must wear splint or brace when working.

_____ Keep would clean and dry.

_____ Sedentary work with ability to change positions.

_____ No kneeling, crawling or squatting.

✓ Other
sit down, light duty, no lifting, no bending, no twisting

The patient has been referred to: _____ Physical Therapy _____ Occupational Therapy _____ Other

Facility: ______________________

MD Signature: [signature] MD