Diagnosis

Instructions:

Disposition:

- ☐ Return to work **without restrictions** ☐ immediately ☐ on / /
- ☐ Disabled ☐ until / / ☐ or until next appointment
- ☐ Return to work with the following **restrictions** on / / for ____ days/weeks. If box **not** checked, that activity is not restricted
  - ☐ Stand/Walk for ____ hrs/day for ____ hrs at one time
  - ☐ Sit ____ hrs/day for ____ hrs at one time
  - ☐ Drive automatic ____ hrs/day for ____ hrs at one time
  - ☐ Change positions every ____ hours

Upper Extremities	**Right**	**Left**	
☐ Lifting/Carrying	____	____	pounds
☐ Pushing/pulling	____	____	pounds
☐ Grasping	☐	☐	
☐ Fine manipulation	☐	☐	
☐ Reaching	☐	☐	

Lower Extremities	**Occasionally**	**Never**
☐ Bend	☐	☐
☐ Squat	☐	☐
☐ Kneel	☐	☐
☐ Climb	☐	☐
☐ Twist	☐	☐

- ☐ Under care for illness ICD9 from / / until / /
- ☐ Environmental Restrictions: List
- ☐ Treatment or Rx possibly affecting work? Describe
- ☐ Using assistive devices? List
- ☐ Other instructions or restrictions
- ☐ Physical Therapy: ____ times/week for ____ weeks
- ☐ Referrals: Appt. with
  Specialty:
  When:
- ☐ Follow-up appointment:

These restrictions are in effect until / / or until employee is seen on follow-up on: / / at am/pm at

Provider Signature

Employer Contacted Yes ☐ No ☐ on / / (date) by ____ (init)

- ☐ Final interpretation of x-rays taken will be made by the radiologist. If any new abnormalities become apparent, you will be notified.
- ☐ If you have any questions or problems, call CONNCare at the above telephone numbers. If you require urgent medical attention and CONNCare is closed, go to the Emergency Department at The William W. Backus Hospital.
- ☐ I have received and fully understand the instructions given to me by the medical provider.

Patient Signature

Date 4/19/07

CC 251 Rev 4/04

♦ White - Patient ♦ Yellow - Medical Record ♦ Pink - Employer