# CorVel Work Ability Report

**Today's Date** _____

☐ **New** ☐ **Follow Up**

**CorVel Enterprise Comp**
PO BOX 540220, Omaha, NE 68154
800-825-9543 Fax 866-427-2691

**Fax completed form to:**
**CorVel:** 866-427-2691
**FSPM:** 402-444-6378

## Employee Section

Name _____ Last 4 Digits of SSN _____

Home Address _____ City _____ State _____ Zip _____ Home Phone _____

Sex (male/female) _____ Occupation _____ Department _____

Scheduled Hrs/Week _____ Supervisor's Name _____ Work Phone _____

Date of Injury/Illness _____ Time Work Shift Began _____ Time of Incident _____

Describe the injury or illness in detail and indicate the part of body affected. (BE SPECIFIC; i.e. 2" laceration to right forearm, low back strain, etc.)

Any pain/discomfort on other parts of your body, in addition to the injured site? Please describe:

How did the accident or injury occur? What were you actually doing?

Name the object or substance that directly caused the injury, or any safety concerns you may have:

## Provider Section

Provider Name _____ Provider Phone _____

**Injury Treatment**

Diagnosis/Condition _____

Treatment Plan _____

**RELATIVE TO THE ABOVE CONDITION(S) ONLY, please identify:**

☐ **Return to Work - No Restrictions Date** _____
☐ **No Work Until** _____
☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/ or carrying such articles as dockets, ledgers, and small tools.
☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 30 pounds.
☐ **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 30 pounds.
☐ **Medium-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.

☐ **These restrictions are in effect until:** _____

1. In a 8-hour work day, patient may:
   a. Stand/Walk ☐ Occasionally ☐ Frequently ☐ Consistently
   b. Sit ☐ Occasionally ☐ Frequently ☐ Consistently
   c. Drive ☐ Occasionally ☐ Frequently ☐ Consistently

2. Patient may use hand(s) for repetitive:
   ☐ Single Grasping ☐ Pushing/Pulling ☐ Fine Manipulation

3. Patient may use foot/feet for repetitive motion:
   ☐ Frequently ☐ Consistently

4. Patient is able to: Occasionally, Frequently, Consistently

| | None | 1-33% | 34-66% | 67-100% |
|---|---|---|---|---|
| a. Bend | ☐ | ☐ | ☐ | ☐ |
| b. Squat | ☐ | ☐ | ☐ | ☐ |
| c. Climb | ☐ | ☐ | ☐ | ☐ |
| d. Twist | ☐ | ☐ | ☐ | ☐ |
| e. Reach | ☐ | ☐ | ☐ | ☐ |

5. Other Restrictions:

**Is further treatment requried for this injury?** ☐ **Yes** ☐ **No** **Next Evaluation: Date** _____ **Time** _____
**Patient Instructions/Comments** _____
**Provider's Signature** _____ **Date** _____
**Employee Signature** _____ **Date** _____