Colorado Special Districts Property and Liability Pool

Physical Restrictions / Workability Form

CSD Pool Member District Name:_____

Injured Worker's Name:_____ Today's Date:_____

Claim No.: _____ SS: _____ DOB: ____/____/____ Phone: _____

Date of Injury: _____/_____/_____ Injury Description: _____
_____
_____

Diagnosis: _____
_____

Current physical restrictions recommended: _____
_____

Patient can return to work with the following physical restrictions:

Lifting Max _____lbs.	Hands/Wrists _____min/hr	Walking _____hrs/day _____min/hr
Carrying Max _____ lbs.	Foot/Leg _____ min/hr	Standing _____ hrs/day _____min/hr
Pushing Max _____ lbs.	Keystroking _____min/hr	Sitting _____hrs/day _____min/hr
Pulling Max _____ lbs.	Do not use _____	Change activity every _____ minutes
Full Time _____	Part-Time _____	**(specify any time/hours/day restrictions)**

Do Not:		**Restrictions:**
____Operate Machinery	____Climb Stairs	____Non-Weight bearing crutches
____Drive	____Climb Poles	____Wear splint at all times
____Crouch or bend over	____Climb Ladders	____Wear splint at work
____Crawl	____Reach overhead	____Wear splint at night
____Squat	____Reach over shoulder	____Keep dressings clean and dry
____Kneel	____Reach away from body	____Change dressings every _____hrs.

Medical Condition/Diagnosis:

____Improved	____Objective findings are consistent with history and or mechanism of injury
____Stable	____No objective findings are present
____Worse	____Pain and symptoms present

Maximum Medical Improvement (MMI):

_____Pt is at MMI _____Pt is not at MMI but is anticipated to be in _____weeks.

Treatment Plan:_____
_____
_____

Referral to: _____ Specialist in:_____ Phone:_____

Physical Therapy: _____ Frequency: _____

Diagnostic Tests:_____ CT Scan _____ EMG/NCV_____ **Return clinic app't:_____/_____/_____**

Employer Notified:_____ (Date) Insurance Notified:_____ (Date) Restriction Form to Patient:_____ (Date)

Physician Signature: _____ Printed Name:_____

Clinic Contact: _____ Direct Ph: _____ Date: _____