

WORK ABILITY/ RETURN-TO-WORK



Send itemized medical billings and records to:
SFM Companies, PO Box 9416, Mpls, MN 55440
Fax: (952) 838-2000 Phone: (800) 937-1181

Send this completed form with the employee.

EMPLOYEE	HEIGHT	WEIGHT	DATE OF BIRTH
EMPLOYER	DATE OF INJURY/ILLNESS		

DIAGNOSIS	ICD-10 CODE
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History, mechanism of injury, and findings:

Work related injury/illness? ☐ No ☐ Yes ☐ To be determined

Any pre-existing conditions affecting this injury/illness? ☐ No ☐ Yes, description:

Permanent partial disability? ☐ No ☐ Yes, _____ %

Maximum Medical Improvement reached? ☐ No ☐ Yes, date reached _____

RETURN TO WORK

☐ Return to work with **no limitations** on _____ / _____ / _____
MO DAY YR

☐ Return to work **with limitations** on _____ / _____ / _____ through _____ / _____ / _____
MO DAY YR MO DAY YR

_____ has light-duty work available. Please call _____ at () _____ if you plan to take this employee off work.

☐ Unable to work from _____ / _____ / _____ through _____ / _____ / _____
MO DAY YR MO DAY YR

EMPLOYEE'S CAPABILITIES

BODY PART AFFECTED: ☐ Neck ☐ Upper back ☐ Lower back ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot

☐ Other _____

SIDE AFFECTED: ☐ Left ☐ Right ☐ Both

	Not at all	Rare	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%		Not at all	Rare	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%	Comments
Lift/Carry						Hand, wrist and shoulder activities						
0-9 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid prolonged, repetitive or forceful:						
10-19 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gripping/grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20-29 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive						
30-39 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	wrist motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40-49 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching:						
No lift from floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Push/Pull without resistance						At shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
0-19 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Below shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20-40 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restrictions (circle):						
> 40 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Keyboarding (hrs/shift)	0	1-2	3-4	5-6	7	
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Writing (hrs/shift)	0	1-2	3-4	5-6	7	
Twist/turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total spread out evenly over shift at _____ intervals						
Kneel/squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change positions every						
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> As needed						
Stand/walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Half hour						
Ladder/stair climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> One hour						
						<input type="checkbox"/> Two hours						
						<input type="checkbox"/> Worksite stretches, i.e., per handout						
						<input type="checkbox"/> Exercises <input type="checkbox"/> Other _____						

INSTRUCTIONS

☐ Keep wound clean and dry. Change dressing every _____

☐ Medication _____

☐ Ice _____ min. ☐ Heat _____ min.

☐ Splint/brace _____

☐ Referral _____

Follow-up appointment scheduled for _____

THIS TREATMENT HAS BEEN DISCUSSED WITH THE EMPLOYEE

CLINIC	CLINIC ADDRESS	LICENSE / REGIS.#	DATE OF EXAM
HEALTH CARE PROVIDER NAME (PRINTED)	HEALTH CARE PROVIDER SIGNATURE	PHONE	FAX

ATTENTION PHYSICIANS:

Your patient's employer offers transitional, light-duty work. Please contact the employer if you plan to take this employee off work.

Please complete the form on the back of this sheet, or a similar form, to document any work restrictions.