UPMC WorkPartners
Providing Health & Productivity Solutions

PHYSICIAN ENCOUNTER COMMERCIAL

Return Fax to: ❑ WorkPartners Commercial Client Department 412-454-8717

Please Fax Completed Form to the Above Department the Day of the Appointment

Appt Date: _____ Employer: _____

Patient Name: _____ SS# or DOB: _____

Diagnosis: _____ DOI: _____

Return to Work Status:

Able to return to pre-injury job: ❑ No ❑ Yes (Effective: _____)

Able to return to work **with the following restrictions**: ❑ No ❑ Yes (Effective: _____)

❑ **Sedentary** Maximum lifting and/or carrying of *up to 10 lbs*.; walking and standing occasionally.

❑ **Light** Maximum lifting of *up to 20 lbs*. with frequent lifting/carrying of up to 10 lbs. or a negligible amount; significant walking or standing may be required or may involve sitting with a degree of pushing and pulling.

❑ **Medium** Maximum lifting of *up to 50 lbs.* with frequent lifting/carrying of up to 25 lbs.; frequent standing and walking.

❑ **Heavy** Maximum lifting of *up to 100 lbs.* with frequent lifting/carrying of up to 50 lbs.; frequent standing and walking.

❑ **Very Heavy** Lifting objects *over 100 lbs*. and frequent lifting/carrying of 50 lbs. or more; frequent standing and walking.

In a shift, employee is able to: ❑ **No restrictions on these tasks**

Sit: 1 2 3 4 5 6 7 8 9 10 11 12 hours/day
❑ Continuously ❑ With breaks

Stand: 1 2 3 4 5 6 7 8 9 10 11 12 hours/day
❑ Continuously ❑ With breaks

Walk: 1 2 3 4 5 6 7 8 9 10 11 12 hours/day
❑ Continuously ❑ With breaks

❑ No **lift/carry** over _____ lbs ❑ May use **right/left** hand—fine manipulation

❑ No **push/pull** over _____ lbs ❑ May use **right/left** hand—grasping

❑ No use **right/left** foot ❑ No use **right/left** hand

❑ No extreme temperatures ❑ No direct patient care

❑ No overhead work ❑ No bend ❑ No climb ❑ No crawl ❑ No kneel ❑ No squat ❑ No twist

❑ May drive **standard** shift ❑ May drive **automatic** shift ❑ May drive up to _____ hrs/day

❑ No driving

❑ Other: _____

Diagnostic Procedures (fax scripts):

❑ MRI ❑ CT Scan ❑ EMG/NCV ❑ Bone Scan ❑ Other

Treatment Plan (fax scripts):

❑ PT/OT ❑ Medication ❑ Injection ❑ Other: _____

❑ Splint ❑ Brace ❑ Ambulatory Assistive Device:

❑ Surgery: _____ Date: _____ Hospital: _____

❑ Referral: _____ Call UPMC WorkPartners at 1-800-633-1197.

Follow-up Care:

❑ Next appointment date: _____ Time: _____ ❑ PRN

PHYSICIAN SIGNATURE: _____ DATE: _____

PATIENT SIGNATURE: _____ DATE: _____

I understand that my employer is entitled to a copy of this report under Pennsylvania Workers' Compensation Law.