

DAMERON HOSPITAL OCCUPATIONAL INJURY CLINIC

10-17-05

WORK STATUS REPORT - WORKSHEET

Employee Name: Anderson, Tiffany X		Date of this Examination: 10/17/2005	
Employer: SJ Mosquito and Vector		Clinic Case Number: 78225	
DIAGNOSIS: _____			
CLINICAL STATUS: <input type="checkbox"/> Q1: Improved, as expected <input type="checkbox"/> Q2: Improving slowly <input type="checkbox"/> Q3: No significant change <input type="checkbox"/> Q4: Worse			
PT/OT: <input type="checkbox"/> W1: Continue as prescribed <input type="checkbox"/> W2: 3x/wk - 2 week <input type="checkbox"/> W3: 3x/wk - 1 week <input type="checkbox"/> W4: One visit <input type="checkbox"/> W5: Non-DHA PT			
RECOMMENDED EVALUATION / DIAGNOSTIC STUDIES: <input type="checkbox"/> E1: MRI <input type="checkbox"/> E2: CT Scan <input type="checkbox"/> E3: NCS <input type="checkbox"/> E4: Work Conditioning <input type="checkbox"/> E5: Epidurals <input type="checkbox"/> E6: Ergo Evaluation			
REFERRAL / CONSULT:			
<input type="checkbox"/> R10: Orthopedist	<input type="checkbox"/> R14: General Surgeon	<input type="checkbox"/> R18: ENT	<input type="checkbox"/> R22: Health Club
<input type="checkbox"/> R11: Ophthalmologist	<input type="checkbox"/> R15: Neurologist	<input type="checkbox"/> R19: Dermatology	<input type="checkbox"/> R23: Urology
<input type="checkbox"/> R12: Neurosurgeon	<input type="checkbox"/> R16: Psych	<input type="checkbox"/> R20: Pain Mgmt	<input type="checkbox"/> R24: Acupuncture
<input type="checkbox"/> R13: Hand Specialist	<input type="checkbox"/> R17: Physiatrist	<input type="checkbox"/> R21: Dentist	<input type="checkbox"/> R25: Podiatrist
WORK STATUS: <input checked="" type="checkbox"/> Full work duties <input type="checkbox"/> Off balance of shift, modified work <input type="checkbox"/> No work until next appt. <input type="checkbox"/> Modified work duties <input type="checkbox"/> Off balance of shift, full work duties <input type="checkbox"/> Current WS until Specialist appt.			
WORK RESTRICTIONS:			
<u>No lift / carry >:</u> <input type="checkbox"/> A09: 50# <input type="checkbox"/> A10: 10-15# <input type="checkbox"/> A11: 30# <input type="checkbox"/> A12: 5#		<u>No prolonged:</u> <input type="checkbox"/> A15: Stand/Walk <input type="checkbox"/> A16: Sitting	
<u>Lower Extremity</u> <input type="checkbox"/> A18: No crawl / kneel / squat <input type="checkbox"/> A19: No climbing ladders <input type="checkbox"/> A20: Use crutches as directed <input type="checkbox"/> A21: Elevate as directed <input type="checkbox"/> A22: Use cane as directed		<u>Other Back/Neck</u> <input type="checkbox"/> A13: No frequent lift, bend, twist, stoop at waist <input type="checkbox"/> A14: Limit twist / bend at neck <input type="checkbox"/> A17: Desk / sedentary only	
<u>Upper Extremity</u> <input type="checkbox"/> S10: Wear splint / sling as directed <input type="checkbox"/> S11: No frequent / repetitive use of wrist / hand <input type="checkbox"/> S12: No heavy pushing or pulling <input type="checkbox"/> S13: No use of arm above shoulder <input type="checkbox"/> S14: No forceful hand grasp <input type="checkbox"/> S15: No use of injured body part		<u>Miscellaneous</u> <input type="checkbox"/> S16: Limited use of injured body part <input type="checkbox"/> S17: May advance work activities as tolerated <input type="checkbox"/> S18: Keep dressing clean and dry <input type="checkbox"/> S19: No operating company vehicles <input type="checkbox"/> S20: No exposure to heat <input type="checkbox"/> S21: No exposure to cold <input type="checkbox"/> S22: No exposure to chemical, vapors, fumes <input type="checkbox"/> S23: No welding <input type="checkbox"/> S24: Avoid physical altercations <input type="checkbox"/> S25: Avoid wearing latex gloves <input type="checkbox"/> S27: Limit keyboarding: 45 min/hr <input type="checkbox"/> S28: Limit keyboarding: 4 hr/day	
PR STATUS:			
<input type="checkbox"/> PR-1: Periodic Report	<input type="checkbox"/> PR-4: Change in Tx Plan	<input type="checkbox"/> PR-7: Discharge	
<input type="checkbox"/> PR-2: Change in Work Status	<input type="checkbox"/> PR-5: Referral/Consult	<input type="checkbox"/> PR-8: Request by Adjuster	
<input type="checkbox"/> PR-3: Change in Pt. Condition	<input type="checkbox"/> PR-6: Surgery/Hospitalization	<input type="checkbox"/> PR-9: Other: _____	
DISPOSITION: <input type="checkbox"/> D1: Consult <input type="checkbox"/> D2: Final Discharge without residuals, PR-2 to follow <input type="checkbox"/> D5: Referral / Transfer of care <input type="checkbox"/> D4: Final Discharge with residuals, PR-3 to follow <input type="checkbox"/> D6: Non-occupational, refer to PMD <input type="checkbox"/> D3: First Aid			
Next scheduled appointment: <u>Thurs</u>		Provider Initial: <u>dly</u>	

✓ (1) N.S. incl. Temp.
 ✓ (2) CRC.

DHHSR Worksheet, Revised 4/22/04