



## TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

<b>PART I: GENERAL INFORMATION</b>		5. Doctor's Name and Degree <small>(for transmission purposes only)</small>	Date Being Sent
1. Injured Employee's Name		6. Clinic/Facility Name	9. Employer's Name
2. Date of Injury	3. Social Security Number	7. Clinic/Facility/Doctor Phone & Fax	10. Employer's Fax # or Email Address (if known)
4. Employee's Description of Injury/Accident		8. Clinic/Facility/Doctor Address (street address)	11. Insurance Carrier
		City                      State                      Zip	12. Carrier's Fax # or Email Address (if known)

<b>PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)</b>
<p>13. The injured employee's medical condition resulting from the workers' compensation injury:</p> <p>(a) will allow the employee <b>to return to work</b> as of _____ (date) <b>without restrictions</b>.</p> <p>(b) will allow the employee <b>to return to work</b> as of _____ (date) <b>with the restrictions identified in PART III</b>, which are expected to last through _____ (date).</p> <p>(c) has prevented and still prevents the employee <b>from returning to work</b> as of _____ (date) and is expected to continue through _____ (date). The following describes how this injury <b>prevents the employee from returning to work</b>:</p>

<b>PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)</b>																	
<p>14. POSTURE RESTRICTIONS (if any):</p> <p>Max Hours per day:    0   2   4   6   8   Other _____</p> <p>Standing _____</p> <p>Sitting _____</p> <p>Kneeling/Squatting _____</p> <p>Bending/Stooping _____</p> <p>Pushing/Pulling _____</p> <p>Twisting _____</p> <p>Other: _____</p>	<p>17. MOTION RESTRICTIONS (if any):</p> <p>Max Hours per day:    0   2   4   6   8   Other _____</p> <p>Walking _____</p> <p>Climb stairs/ladders _____</p> <p>Grasp/Squeeze _____</p> <p>Wrist flex/extension _____</p> <p>Reaching _____</p> <p>Overhead Reaching _____</p> <p>Keyboarding _____</p> <p>Other: _____</p>	<p>19. MISC. RESTRICTIONS (if any):</p> <p>Max hours per day of work: _____</p> <p>Sit/Stretch breaks of _____ per _____</p> <p>Must wear splint/cast at work</p> <p>Must use crutches at all times</p> <p>No driving/operating heavy equipment</p> <p>Can only drive automatic transmission</p> <p>No work / _____ hours/day work:</p> <p style="padding-left: 40px;">in extreme hot/cold environments</p> <p style="padding-left: 40px;">at heights or on scaffolding</p> <p>Must keep _____:</p> <p style="padding-left: 40px;">Elevated                      Clean &amp; Dry</p> <p>No skin contact with: _____</p> <p>Dressing changes necessary at work</p> <p>No Running</p>															
<p>15. RESTRICTIONS SPECIFIC TO (if applicable):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">L Hand/Wrist</td> <td style="width: 33%;">R Hand/Wrist</td> <td style="width: 33%;"></td> </tr> <tr> <td>L Arm</td> <td>R Arm</td> <td>Neck</td> </tr> <tr> <td>L Leg</td> <td>R Leg</td> <td>Back</td> </tr> <tr> <td>L Foot/Ankle</td> <td>R Foot/Ankle</td> <td></td> </tr> <tr> <td colspan="3">Other: _____</td> </tr> </table>	L Hand/Wrist	R Hand/Wrist		L Arm	R Arm	Neck	L Leg	R Leg	Back	L Foot/Ankle	R Foot/Ankle		Other: _____			<p>18. LIFT/CARRY RESTRICTIONS (if any):</p> <p>May not lift/carry objects more than _____ lbs.</p> <p>for more than _____ hours per day</p> <p>May not perform any lifting/carrying</p> <p>Other: _____</p>	<p>20. MEDICATION RESTRICTIONS (if any):</p> <p>Must take prescription medication(s)</p> <p>Advised to take over-the-counter meds</p> <p>Medication may make drowsy (possible safety/driving issues)</p>
L Hand/Wrist	R Hand/Wrist																
L Arm	R Arm	Neck															
L Leg	R Leg	Back															
L Foot/Ankle	R Foot/Ankle																
Other: _____																	
<p>16. OTHER RESTRICTIONS (if any):</p> <p>_____</p>		<p>* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.</p>															

<b>PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION</b>					
<p>21. Work Injury Diagnosis Information:</p> <p>_____</p> <p>_____</p> <p>_____</p>		<p>22. Expected Follow-up Services Include:</p> <p>Evaluation by the treating doctor on _____ (date) at _____ : _____ am/pm</p> <p>Referral to/Consult with _____ on _____ (date) at _____ : _____ am/pm</p> <p>Physical medicine ___ X per week for ___ weeks starting on _____ (date) at _____ : _____ am/pm</p> <p>Special studies (list): _____ on _____ (date) at _____ : _____ am/pm</p> <p>None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.</p>			
Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type: Initial Follow-up	Role of Doctor: Designated doctor Carrier-selected RME TWCC-selected RME	Treating doctor Referral doctor Consulting doctor Other doctor
Discharge Time					

