## PATIENT'S WORK RESTRICTIONS

## NAME OF PATIENT:

J. CRAWLING K. HAND USE SSN:

<ol> <li>Check the frequence</li> </ol>	y and number of hour	rs per day the patient is a	able to	do th	ne fo	volla	ving	1:		
ACTIVITY	CONTINUOUS	INTERMITTENT	1	2	3	4	5	6	7	8
A. SITTING										
B. WALKING										
C. STANDING										
D, BENDING										
E. SQUATTING										$\top$
F. CLIMBING										Т
G. KNEELING										
H. TWISTING										
I. LIFTING										

2. Check SUSTAINED OR CONTINUOUS STA	NDARD WORKIN	IG CONDITION	lifting rootrictions:
□ 0 - 10 lbs □ 11 - 20 lbs □ 21 - 50 lbs	□ 51 - 75 lbs	□ 76+ lbs	illung restrictions.
3. Does Patient have HAND or ARM RESTRIC	THE PERSON NAMED IN COLUMN TO SERVICE AND ADDRESS OF THE PERSON NAMED IN COLUMN TO SE	□ YES	□NO
	uent Gripping;		
	Manipulation;	D Repetitive Ma	ushing and Pulling;
			ovement/ Production Work
4. Does Patient have LEG or FOOT RESTRICT		□ NO	
If "YES," indicate Restriction type: □ Pro	longed Walking/S	tanding;	□ Pushing and Pulling Leg Controls;
□ Operation of Machinery or Vehicle □ Rep			☐ Cane or Crutch suggested
5. Does Patient have BACK RESTRICTIONS?	□ YES	□ NO	
If "YES", indicate Restriction type: ☐ Si	tting without Brea	ıks at will;	□ Standing without Breaks at Will;
☐ Riding in or Driving Machinery/Vehicles; ☐ C	peration of Mach	inery or Vehicle	□ Work involving Vibration
<ol><li>The Patient HAS restrictions concerning: □A</li></ol>	bility to ride/comn	nute in vehicle m	ore than 20-30 minutes   Heat/Cold
humidity, dampness   High Speed/Producti	on Work   Expos	sure to Dust, Fur	mes or Gas    Cardiac conditon/Fatigue
□ Visual Senses □Hearing Condition □ Stres	ss/mental Condition	on □ Cogni	tive Deficits
7. Are Interpersonal Relations adversely effecte	d by Patient's res	trictions?	□ YES □ NO
If "YES", indicate type: Appropriate response to	Coworkers	□ Irritability	□ Withdrawal □ Anxiety
Ability to respond to simple instructions and s	upervision	□ Depression	□ Medication side effects
Other:	*		
8. Can the Patient SUSTAIN work EIGHT hours	per day?	□ YES	□NO
If not eight hours, how many?	Man acces		
9. Should the patient take breaks/rest periods as	s the patient deen	ns necessary?	□ YES □ NO
10. Does the Patient have Chronic Pain?	□ YES	□ NO	
What part of the body has chronic pain?			
11. Has Patient reached maximum medical impr	rovement?	□ YES (	(Indicate when):
			Estimate when):
PHYSICIAN NAME:		PHYSICIAN SIG	
			7.1.1.01.E.
ADDRESS:	TELEPHONE:	DATE:	