WorkLink

Work Status Form for Injured Employee

Memorial Hermann Health Solutions

Section A - General Information

Injured Worker Name:	Claim Number:
Employer Name:	Date of Injury:
Occupation/Title:	Date of Birth:

Section B - Return to Work Status (Please Choose One)

☐ Employee can return to work to perform the essential function of the position per the job description as of ______________________ (Date) **WITHOUT restrictions.**

☐ Employee can return to work on a temporary transitional duty basis provided the work is consistent with the activity restrictions identified in Section C: __________________ (Date) which are expected to last through ____________________ (Date).

☐ Employee is unable to return to work per the job description ______________________ (Date) and is expected to last through ________________ (Date)

Section C - Employee is released to temporary transitional duty with the following Activity Restrictions (Choose all that apply)

EMPLOYEE IS ABLE TO WORK 4 _____ 6 _____ 8 _____ 12 _____ TOTAL HOURS PER DAY.

Posture Restrictions (if any)			Motion Restrictions (if any)		
☐ Standing		Hours	☐ Walking		Hours
☐ Sitting		Hours	☐ Climbing stairs/ladders		Hours
☐ Kneeling/Squatting		Hours	☐ Grasping/Squeezing		Hours
☐ Bending/Stooping		Hours	☐ Wrist flexion/extension		Hours
☐ Pushing/Pulling		Hours	☐ Reaching		Hours
☐ Twisting		Hours	☐ Overhead Reaching		Hours
☐ Other		Hours	☐ Keyboarding		Hours

Driving Restrictions (if any):

☐ No driving/operating heavy equipment

☐ Night time restrictions

☐ Can only drive automatic transmission

Restrictions Specific To (if any):

☐ Left Arm	☐ Left Hand/Wrist
☐ Right Arm	☐ Right Hand/Wrist
☐ Neck	☐ Back
☐ Left Leg	☐ Left Foot/Ankle
☐ Right Leg	☐ Right Foot/Ankle

Medication Restrictions (if any):

☐ Medication may make drowsy (possible safety/driving issues)

Misc. Restrictions (if any)

☐ Must use crutches at all times	☐ Must wear splint/cast at work
☐ No work/ _______ hours/day work:	☐ Sit/Stretch Breaks of _____ per _____
☐ at heights or on scaffolding	☐ Must keep ____________________
☐ in extreme hot/cold environments	☐ Clean & Dry ☐ Elevated

Lift/Carry Restrictions (if any):

☐ May not lift/carry objects more than ____ lbs for more than _____ hours per day.

☐ May not perform any lifting/carrying

Other Restrictions (if any):

Activity restrictions are to be complied with while you are at work and also outside of work.

Section D - Employee Treatment/Follow-Up Information (Fill in or Check all that apply)

Diagnosis Code:	Diagnosis Description:	Is the injury work related? (check one) ☐ Yes ☐ No

Is there any further treatment needed? ☐ Yes ☐ No | If yes, what treatment ______________________________ (please list) and for how long _____________

☐ The injured employee has reached MMI as of _______________________ (Date) | ☐ Diagnostic Study (Please Specify) ________________________________

☐ Follow up visit on ___________________ (date) at _______ : _______ am/pm | ☐ Referral to Specialist ____

☐ Receive Physical Therapy _______ X per week for _______ weeks | ☐ Work Conditioning ☐ Work Hardening ☐ Pain Management _____ X per week for ______ weeks

Physician Name (Please Print):	Date of Visit:
Physician Signature:	Employee's Signature:

Fax the completed report to WorkLink immediately after each visit to (713) 338-6590).

PLEASE GIVE A COMPLETED COPY OF THE FORM TO THE INJURED WORKER

***Please fill out all relevant information on the form. Our company takes a proactive approach to returning the injured worker back to work. Utilizing the information on this form, we assign employees to temporary transitional duty work assignments.**
***Please do not bill or collect any money from the injured employee.**
***Send ALL bills to WorkLink.**
***Please call (713) 338-6519 Option 4 for billing and/or pharmacy information.**