Physician Capabilities Form

Appt Date: _____

UPMC WorkPartners
Providing Health & Productivity Solutions

Fax this form to WorkPartners at 412-454-8717
WorkPartners: 1-800-633-1197

ABOUT THE PATIENT

Name: _____ Date of Birth: _____

Employer: _____ Date of Injury: _____

Social Security Number: _____ Diagnosis: _____

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/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 *more than 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
☐ No **push/pull** over _____ lbs
☐ No use **Right/Left** foot
☐ No extreme temperatures
☐ May use **Right/Left** hand for fine manipulation
☐ May use **Right /Left** hand for grasping
☐ No use **Right/Left** hand
☐ No direct patient care
☐ No overhead work ☐ No bending ☐ No climbing ☐ No crawling ☐ No kneeling ☐ No squatting ☐ No twisting
☐ May drive up to ____ hrs/day
☐ May drive **standard** shift ☐ May drive **automatic** shift ☐ No driving
☐ Other: _____

DIAGNOSTIC PROCEDURES (PRESCRIPTIONS MUST BE FAXED TO 412-454-8717)

☐ MRI ☐ CT Scan ☐ EMG/NCV ☐ Bone Scan ☐ Other _____

TREATMENT PLAN (PRESCRIPTIONS MUST BE FAXED TO 412-454-8717)

☐ PT/OT ☐ Medication ☐ Injection ☐ Other: _____
☐ Splint ☐ Brace ☐ Ambulatory Assistive Device: _____
☐ Surgery: _____ Date: _____ Hospital: _____
☐ Referral: _____ **Call WorkPartners: 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.