

Uniform Workability Report Form

(Instructions on Back)

Company Name _____ Contact _____
Phone _____ After 5pm _____ Fax _____
Employee _____ Emp ID/Case #/SSN _____
Date & Time of Injury _____ Shift _____ Date Injury Reported _____
Provider _____ Appt. Date & Time _____ Return Visit
Address _____ Phone _____

Subjective Complaint _____

ATTENDING PHYSICIAN: Please fill out this form each time you examine the employee. Give a copy to the employee and FAX the completed form to the Employer listed above. A copy of this form should accompany your bill. Before any referral is made for further treatment or diagnostic tests, contact the Employer.

1. Initial Diagnoses _____ ICD 9 Codes _____

- (Check) Disorders of Bursae & tendons Carpal tunnel syndrome Pain in knee
 Shoulder sprain/strain Displacement of intervertebral disc Low back pain
 Contusion of shoulder Other _____

Does Patient have NEW neurological deficit? Yes No

First injury/condition of this type Yes No

If no:

Date of previous injury or condition _____

Work days lost in the last year for injury or condition _____ days

2. Treatment Plan (check all that apply)

- None Surgery
 Physical Therapy Frequency: _____ Times per week for _____ weeks
 Occupational Therapy Frequency: _____ Times per week for _____ weeks
 Chiropractor Frequency: _____ Times per week for _____ weeks
 Medications _____ Prescriptions _____
 Equipment _____ Walking aids _____

3. Diagnostic Tests (check all that apply)

- None X-Ray CAT scan Nerve conduction tests
 MRI EMG Other _____

Referral to other providers: Provider _____ Appt Date _____ Time _____

- None Neurosurgeon Orthopedic surgeon Physiatrist
 Neurologist Rheumatologist Other _____

4. Work Status:

- Able to return to full duty immediately
 Able to return to modified duty immediately (or on _____) with the following restrictions:
 No exposure to cold, heat, water/dampness, paint, dust, welding No work around high speed or moving machinery
 Keep affected area clean and dry No repetitive pushing/pulling No climbing of stairs/ladders
 May lift up to _____ pounds No operating of mobile equipment No kneeling or squatting
 Should be sitting _____ % of time May reach to shoulder level only
 No work requiring bending of _____ Limited use of _____
 Other _____
 Estimated time to return to full duty _____ days

Recommended work conditioning plan to progress from modified duty to full duty: Comment _____

- Unable to work at this time with any accommodation
 Explain current physical capabilities _____
 Estimated time to return to full/modified duty _____ days

5. Restricted activity (at home)

- None Bed rest _____ days
 As Above Limit exercise or activity _____ days

6. Is it your initial impression that this was a job-related injury?

- Yes No Not Certain

7. Return visit recommended on _____ at _____ (time)

Person at this location for employer to contact for information on employee's health status: _____

Physician Signature _____ Date _____ Facility _____

Instructions

Purpose :

The Uniform Workability Report Form provides a standard form to increase the participation of the employer in medical and social intervention of the injured employee. Its emphasis is on simplicity, involvement of all relevant constituencies and timely intervention.

Instructions :

1. The Employer should complete the top portion of the Uniform Workability Report through the line titled 'Subjective Complaint' after a reported work related injury has occurred.
2. The Employer will give this form to the employee and the employee will deliver it to the designated health care provider. If the employee requires emergency care, the Employer will follow-up with paperwork at a later time.
3. The attending physician will complete the remaining portion of this form after the injured employee is examined. Key areas to complete are:

Initial Diagnoses
Treatment Plan
Diagnostic Tests/Referrals
Work Status
Restricted Activity
Initial Impression
Return Visit
Physician's Signature

4. The physician's office should FAX to the employer the completed form including treatment plans.
5. If additional visits are required, Repeat steps 1-4.
6. The Employer will then send a copy of the Uniform Workability Report to the Mid-America Coalition on Health Care. Please note that as long as the identifier 'Emp ID/Case #/SSN' is completed, each employer has the option to omit the identifier 'Employee Name'. This document is the primary form that will be used to track pertinent data regarding the effectiveness of this process. Please remit all copies of forms to:

Steven C. Abele
Data Administrator
Mid-America Coalition on Health Care
3406 Broadway
Kansas City, MO 64111
Facsimile (816) 531-0575

The Employer may submit all forms at the frequency that is most conducive to the operations of their business. The Coalition asks that completed forms be submitted at the end of each month, though the Employer may choose to submit the forms more frequently.