



## WORKABILITY

Clinic: \_\_\_\_\_ Provider Phone No. \_\_\_\_\_

Employee Name: \_\_\_\_\_ PSU ID #: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Type of Visit:  Initial  Follow-Up Date of 1<sup>st</sup> Treatment: \_\_\_\_\_

**Work/Visit Instructions:** The following written instructions have been discussed and given to the patient.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Work Status:**  Released on \_\_\_\_\_.
- May return to work without restrictions on \_\_\_\_\_.
- Unable to work.
- May return to work with the following restrictions on \_\_\_\_\_.
- |  |  |
|--|--|
| <input type="checkbox"/> No use of left/right _____      | <input type="checkbox"/> No lifting                |
| <input type="checkbox"/> Limited use of left/right _____ | <input type="checkbox"/> Weight limit _____ lbs.   |
| <input type="checkbox"/> Limited standing/walking        | <input type="checkbox"/> Sitting work only         |
| <input type="checkbox"/> Limited bending/twisting        | <input type="checkbox"/> No driving                |
| <input type="checkbox"/> Limited squatting/kneeling      | <input type="checkbox"/> Limited Rigorous Grasping |
| <input type="checkbox"/> Other _____                     |  |

**Referrals:** \_\_\_\_\_

**Follow-up:** \_\_\_\_\_

**PLEASE FAX A COPY OF THIS FORM TO PENN STATE OCCUPATIONAL MEDICINE AT (814) 865-5337 and give a copy to the Employee for their work unit.**

A Penn State University Workability Form has been provided to me. I have read and understand the visit instructions. I have been instructed to contact my Supervisor today and provide him/her with a copy of this form. I authorize Penn State Occupational Medicine to receive complete medical information from the above Provider.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Print Name of Health Care Provider**