

# Medical Status Form

## Instructions

August 31, 2011

The purpose of the Medical Status Form is to:

- 1) facilitate communication between a worker with a work-related injury or occupational disease, the employer, and the health care provider for Stay at Work/Return to Work; and
- 2) provide necessary medical status to the insurer.

The Medical Status Form is a statutory requirement. HB 334 (Section 28) says, "The department shall create a medical status form to be provided to a health care provider providing treatment for a compensable injury or occupational disease." An insurer may request additional information not contained in the form from the health care provider.

The treating physician (or a designee) is now required to complete the form following every office visit with the worker.

This two-page form is designed to transmit the correct and essential information to the appropriate parties easily and accurately.

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## PAGE ONE

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### Clear Form button

This will remove all the entered or completed contents on the form.

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### Patient/Employee Info

Enter Patient/Employee Name, Date of Injury, Claim Administrator Number, and Date of Next (scheduled) Visit

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### Provider Information and Timestamp

Enter name and address of Health Care Provider

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### Timestamp for Health Care Provider Use

Health Care Provider may enter timestamp if necessary

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## Released for Work?

The Medical Status Form will only allow for one option to be selected. Check the applicable box and enter the effective date. See below for steps for each option.

### Condition Unchanged from Last Report

Select this box only if a previous form was provided to the insurer and the condition has not changed. Caution: The insurer may request additional information if this box is selected depending on the information provided on the previous form.

### Patient/Employee Released to Full Duty

If selected, enter the effective date and skip to the questions at the bottom of the next section (Work Abilities for Temporary or Modified Work).

### Patient/Employee Released to Modified Duty

If selected, enter the effective date and continue to the next section (Work Abilities for Temporary or Modified Work).

### Time Loss Authorized

If selected, enter the Anticipated Dates for temporary alternate work and for return to full duty and skip to the questions at the bottom of the next section (Work Abilities for Temporary or Modified Work).

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## Work Abilities for Temporary or Modified Work

This section must be completed if Patient/Employee Released to Modified Duty was checked in the previous section. All categories should be completed.

### Total Number of Hours/Days

Enter both number of days per week and number of hours per day

### Number of Hours (Sit/Stand/Walk)

Circle the maximum number of hours for each activity the patient/employee is limited to per day.

### Alternating activity

Check the appropriate boxes and enter the frequency in number of hours.

### Work Abilities (Never/Occasionally/Frequently/Continuously/Permanent upon MMI)

Check the appropriate box for each activity, including those indicating Left, Right or Both

If the patient/employee is at maximum medical improvement, enter abilities that are permanent

### Is the patient/employee involved in treatment and/or medication related to the work-related injury/occupational disease that might affect their ability to work safely in any capacity?

**A response is required.** Check the appropriate box. If yes, please explain, as requested.

### Will the patient/employee be required to use any devices or braces?

**A response is required.** Check the appropriate box. If yes, please explain, as requested.

### Additional comments specific to patient/employee's work abilities

**A response is not required.** Use this area to indicate any unaddressed limitations, such as driving restrictions.

### Can the employee return to the time of injury occupation?

**A response is required.** Check the appropriate box. Use this area to indicate if the patient/employee is released to the time of injury occupation as of the date of this evaluation.

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## Signatures

*The signature of the patient/employer is for the sole purpose of acknowledging receipt of the information on the form.*

Complete and date as indicated.

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**The information above is automatically transferred to the second page of the form which is for the patient/employee and employer only.**

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**The bottom section on Page One contains private information for the medical provider, insurer, and patient/employee only and is not given to the employer.**

### Diagnosed condition

Enter the diagnosed condition

### Treatment plan to increase functional improvement until next appointment

Enter the treatment plan between this date and date of next scheduled visit. Provide documentation of improved function or expectations of improved function based on treatment plan.

### Identity of medication prescribed

Enter the medication prescribed

### Anticipated maximum medical improvement (MMI) date

Enter a date

### Actual maximum medical improvement (MMI) date

If the patient/employee is at MMI, enter date

**Perm WP Impairment Rating**

If the patient/employee is at MMI, enter the permanent whole person impairment rating according to the 6th Edition of the AMA Guides to Permanent Impairment

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**PAGE TWO**

As stated above, this page (for the patient/employee and employer) is auto filled with the information from the appropriate sections on Page One.

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