

PROVIDER EXAMINATION REPORT

Name: _____ Date of Exam: _____
Date of Injury: _____ Date of Birth: _____
Employer: _____ Occupation: _____

History as Related by Patient:

Are your findings consistent with history and type of injury? Yes No Unsure
Is the injury work related? Yes No Unsure
Are there any current conditions that may affect recovery? Yes No Unsure

Please Explain: _____

Diagnosis: _____

Treatment Plan: _____

Patient Status: ___ Return to work with restrictions (see below)
___ May return to full duty work
___ Unable to return to work

If unable to return to work full duty, anticipated date of return to full duty: _____

Work Status: (Circle the level of limitation if applicable)

Lifting:

___ Sedentary <10 lbs occasionally and up to 5 lbs frequently
___ Light 10-20 lbs occasionally and up to 10 lbs frequently
___ Medium 20-50 lbs occasionally and up to 20 lbs frequently
___ Heavy 50-100 lbs occasionally and up to 50 lbs frequently
___ Very Heavy >100 lbs occasionally and up to 100 lbs frequently

Bending None Occasional Frequent Constant

Squatting None Occasional Frequent Constant

Kneeling None Occasional Frequent Constant

Climbing No fixed stairs No Ladders

Reach Not with Right Not with Left

Grasping Not with Right Not with Left

Pushing/Pulling Not with Right Not with Left

Sit None Occasional Frequent Constant

Stand None Occasional Frequent Constant

Walk None Occasional Frequent Constant

Drive None Occasional Frequent Constant

Other: _____

Next Appointment Date and Time: _____

Health Care Provider Signature: _____ Date: _____

