

PHYSICIAN'S WORKER STATUS REPORT

For Employees of The State of Connecticut
PER-WC-208 REV. 09/09

**State of Connecticut
Department of Administrative Services
Workers' Compensation Division**

INSTRUCTIONS

- 1. To be completed (both pages) by Initial Care Physician or Attending Physician and provided to the injured worker as part of the office visit.
- 2. Mail or fax copy to State of Connecticut Third Party Claim Administration Company within 24 hours of the office visit.
 - GAB Robins North America, Inc., 800 Connecticut Boulevard, East Hartford, Connecticut 06108
Fax: (860) 291-9875
Phone: (860) 256-3400

Employee Name

State Agency and Location

Date of Office Visit: ____/____/____

Date of Injury: ____/____/____

Initial Visit Follow-Up Visit

TIME ARRIVED: _____ TIME DEPARTED: _____ Injury/Illness causally related to worker's employment? Yes No

Diagnosis: _____

Evidence of pre-existing condition: Yes No (If Yes, explain): _____

Treatment Plan: _____

Follow-Up Visit/Treatment needed with this office? Yes No If Yes: Next appointment date: ____/____/____

Referral to Specialty needed? Yes No If Yes, Type of Specialty: _____

Referral Appointment made? Yes No Name: _____ Date: ____/____/____

Patient Work Disposition (Please check the appropriate work disposition)

The State of Connecticut makes every effort to return an injured worker to restricted duty employment.

- 1. ____ Patient is capable of full and regular duty (effective date) ____/____/____ (Skip items a-d below).
- 2. ____ Patient is not capable of any form of gainful employment (as of date) ____/____/____
- 3. ____ Patient is capable of working a Recoup Post. (Department of Correction only) (effective date) ____/____/____
- 4. ____ Patient is capable of modified/restricted work as indicated below (effective date) ____/____/____

Note: In terms of a normal work day; Occasionally = Up to 33%, Frequently = Up to 66%, and Continuously = Up to 100%

	Never	Occ.	Freq.	Cont.	No Restrictions
a. Patient is able to:					
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: In terms of a normal work day; Occasionally = Up to 33%, Frequently = Up to 66%, and Continuously = Up to 100%

	Never	Occ.	Freq.	Cont.	No Restrictions
b. Patient is able to lift					
Up to 10lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-24lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25-34lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35-50lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-74lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75-100lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Occ.	Freq.	Cont.	No Restrictions
c. Patient is able to carry					
Up to 10lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-24lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25-34lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35-50lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-74lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75-100lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Occ.	Freq.	Cont.	No Restrictions
d. Patient is able to use hands					
(left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/>)					
Keyboard Typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

e. Is patient involved with treatment and/or medication that might affect his/her ability to work?
 No
 Yes: Explanation: _____

f. Will patient be required to use any assistive devices or braces while working regular or modified/restricted duty?
 No
 Yes: Explanation: _____

The above Restrictions are in effect until: ____/____/____

Physician Comments: _____

Physician Name & Address: _____ **Signature:** _____
 (Please Print) _____ **Date:** ____/____/____

Authorization to Release Information

I hereby authorize this Medical Provider to release my information acquired in the course of my examination or treatment for the above injury to my employer or it's representative.

Patient's Name (Print) _____ **Patient's Signature** ____/____/____ **Date**