Protective Insurance Company
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Work Restriction Sheet

Adjuster:____________________ Phone/Fax:____________________
Case Manager:____________________ Phone/Fax:____________________

Employee Name:____________________ DOB: __________ Claim #: __________ Phone: __________
Physician: ____________________ Phone/Fax: ____________________ Date: __________

1. Current Clinical Status

A. Working Diagnosis: ____________________ DOI: __________
B. Is condition felt to be work-related? ❑Yes ❑No ❑Uncertain
C. In-Office Procedures:____________________
D. Follow-up Recommendation:______ Days______ Weeks______ Months______ Next Appointment:__________
E. Reached MMI ❑Yes ❑No

2. Tests Recommended:

A. Type of tests: ____________________
B. Brief Rationale:____________________
____
____
C. Follow-up after test completion:__________Days

3. Treatment Recommended:

A. Type of Treatment: ❑ OT ❑ PT ❑ Surgery
B. Rationale: Conservative Management ❑
Failure to Improve ❑
Post-Operative Routine ❑
C. Frequency__________ Duration__________

4. Surgery Recommended:

____
____

5. Physical Limitations for Work Activities

A. Off work unil____________________
B. Light duty from ______ to ______(see chart)
If no light duty, then off work
Return to Full Duty____________________
C. Part-time / Full activity__________Hrs./Day
D. Employer notified ❑Yes ❑No

❑ **Lifting/Carrying- Maximum lbs.**	**100-75**	**74-50**	**49-35**	**34-20**	**19-11**	**10-0**
frequently	❑	❑	❑	❑	❑	❑
occasionally	❑	❑	❑	❑	❑	❑

❑ **Movement Limitations**	**Bend**	**Twist**	**Squat**	**Kneel**	**Climb**	**Drive**
frequently (34-66%)	❑	❑	❑	❑	❑	❑
occasionally (0-33%)	❑	❑	❑	❑	❑	❑
not at all	❑	❑	❑	❑	❑	❑

❑ **Restricted Use of Hand/Arm** Right ❑ Left ❑ Both ❑

	Grip	**Pinch**	**Push/Pull**	**Reach Above Shoulder**
frequently (34-66%)	❑	❑	❑	❑
occasionally (0-33%)	❑	❑	❑	❑
not at all	❑	❑	❑	❑

❑ **No Reaching Above Chest Level**
❑ **Restricted Standing/Walking** __________ Hrs. per Day ❑ **Restricted Sitting** __________Hrs. per Day
❑ **No Work in a Cold Environment**
❑ **No Knife and No Hook**
❑ **Temperature Restrictions:** (explain) ____________________
❑ **Sterlization/Contamination Restrictions:** (explain) ____________________
❑ **Other** ____________________
____

M.D. Signature____________________