PHYSICIAN'S EMPLOYABILITY REPORT

Patient's name: **Period of time covered by this report:**

Patient's SSN **From___ To___**

1. Treatment dates: First date: _________ Frequency_________

2. Diagnoses:

3. a. Have these medical conditions lasted or can they be expected to last at least three months? ❒ Yes ❒ No

   b. Have your patient's medical conditions lasted or can they be expected to last more than three months? ❒ Yes _________ months

   If yes, please explain:

4. Describe in detail your patient's symptoms (complaints, including pain).

5. Describe in detail your patient's signs (clinical findings).

6. Give any laboratory and other test results.

7. Describe the treatment your patient has received, including medications and dosage.

8. Do any of the medications have any side-effects or limit your patient's activities?
❒ Yes ❒ No If yes, please explain.

9. Prognosis:

10. Considering your patient’s medical condition, please indicate your patient's ability to do the following on a regular and sustained basis.

(A) During an 8 hour workday, can your patient:

SIT ❒ No limitation
❒ Limited (*Check one*)
❒ 6 hours continuously
❒ 4-6 hours continuously
❒ 2-4 hours continuously
❒ 0-2 hours continuously

❒ Unable to sit for more than ____ without alternating position (please state reason, e.g., pain, stiffness, need to elevate leg, etc.).

STAND &/OR WALK
❒ No limitation
❒ Limited (*Check one*)
❒ 6 hours continuously
❒ 4-6 hours continuously
❒ 2-4 hours continuously
❒ 0-2 hours continuously

❒ Unable to stand/ walk for more than ______ without stopping to rest (please state reason, e.g., shortness of breath, pain, dizziness):

For the following questions please use these definitions:

Occasionally = 1% to 33% of an 8-hour workday
Frequently = 34% to 66% of an 8-hour workday
Continuously = 67% to 100% of an 8-hour workday

(A)

LIFT:	Never	Occasionally	Frequently	Continuously
0-5 lbs.	❐	❐	❐	❐
6-10 lbs.	❐	❐	❐	❐
11-20 lbs.	❐	❐	❐	❐
21-25 lbs.	❐	❐	❐	❐
26-50 lbs.	❐	❐	❐	❐

(B)

CARRY:	Never	Occasionally	Frequently	Continuously
0-5 lbs.	❐	❐	❐	❐
6-10 lbs.	❐	❐	❐	❐
11-20 lbs.	❐	❐	❐	❐
21-25 lbs.	❐	❐	❐	❐
26-50 lbs.	❐	❐	❐	❐

(C)

	Never	Occasionally	Frequently	Continuously
BEND	❐	❐	❐	❐
SQUAT	❐	❐	❐	❐
CLIMB	❐	❐	❐	❐
REACH	❐	❐	❐	❐

(D) Can your patient use **HANDS** for repetitive action such as:

	Simple Grasping	Pushing and Pulling of Arm Controls	Fine Manipulation
Right	❐ Yes ❐ No	❐ Yes ❐ No	❐ Yes ❐ No
Left	❐ Yes ❐ No	❐ Yes ❐ No	❐ Yes ❐ No

(E) Can your patient use **FEET** for repetitive movements, as in pushing and pulling of leg controls:

Right	**Left**
❐ Yes ❐ No	❐ Yes ❐ No

11. What restrictions in the following activities are caused by your patient's medical condition?

RESTRICTIONS	**None**	**Mild**	**Moderate**	**Total**
Unprotected heights	❐	❐	❐	❐
Being around moving machinery	❐	❐	❐	❐
Exposure to marked changes in temperature and humidity	❐	❐	❐	❐
Driving a motor vehicle	❐	❐	❐	❐
Exposure to dust, fumes & gases	❐	❐	❐	❐

12. Does your patient have to lie down during the day? ❐ Yes ❐ No
If yes, for how long and why.

13. Does your patient have any condition which does or could produce pain? ❐ Yes ❐ No
If yes, please explain.

14. Does your patient's condition interfere with the ability to attend work on a regular basis, for example due to inability to commute daily by public transportation or due to frequent absences? ❐ Yes ❐ No If yes, please explain:

15. Is mandatory participation in a work activity on a regular basis consistent with your current treatment plan for this patient? ❐ Yes ❐ No

16. Additional comments:

Date: ____________________

Physician's signature: ______________________________

[print name] ______________________________

Specialty/ Title ______________________________

License No. ______________________________

Address ______________________________

____

Telephone number ______________________________
(Area code)

srs 1/01