

WHITTIER, CA 90601 LOS ANGELES, CA 90067 ENCINO, CA 91436

EMPLOYEE NAME _____

FURN DATE _____

CLINIC # _____

DIAGNOSIS: _____

PATIENT STATUS:

This patient's condition has:

- Improved as expected. Improved, but slower than expected. not improved significantly.
 worsened. plateaued, no further improvement is expected. been determined to be non-work related.

Briefly describe any change in objective or subjective complaint: _____

TREATMENT ADMINISTERED:

- Office Visit/injury Treatment Physical Therapy _____
 Medication _____ Surgery Indicated _____
 Referred for Diagnostic Test Type of Surgery _____

DISABILITY STATUS:

- Patient discharged as cured.

Please supply a brief narrative report if any of the below apply:

- Patient will be permanently precluded from engaging in his/her usual and customary occupation.
 Patient's condition is permanent and stationary.
 Patient will have permanent residuals. Patient will require future medical care.

WORK STATUS:

- Instructed to return to work at once with no limitations
 Off the balance of this shift only. May return to work next shift.
 Off work. Estimated period of temporary disability:
 Off work. Return to work date: _____
 Return to work with following instruction:

- | | |
|---|--|
| <input type="checkbox"/> No work of or above shoulder level | <input type="checkbox"/> No climbing, bending or stooping |
| <input type="checkbox"/> Limited use of right/left hand | <input type="checkbox"/> Sit down job |
| <input type="checkbox"/> Right/left handed work only | <input type="checkbox"/> No prolonged standing or walking |
| <input type="checkbox"/> Weight lifting restrictions: | <input type="checkbox"/> No constant bending or stooping |
| <input type="checkbox"/> Up to 10 lbs. | <input type="checkbox"/> Limited cervical flexion and extension |
| <input type="checkbox"/> Up to 25 lbs. | <input type="checkbox"/> No repetitive pulling or pushing |
| <input type="checkbox"/> Up to 50 lbs. | <input type="checkbox"/> No repetitive grasping or thrusting right/left hand |

YOUR NEXT APPOINTMENT IS: MON. TUES. WED. THURS. FRI. SAT.

DATE: _____ TIME: _____

PLEASE TELEPHONE IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

Physician's Name: _____

Signature: _____

Date: _____