WORKER'S COMPENSATION VERIFICATION FORM

WellLife By Schneck 100 N Walnut St, Seymour, IN
Phone: 812-523-5185 Fax: 812-523-3826

PATIENT INFORMATION: **EPISODE#: _____ DATE:_____**

Name _____Birthdate _____ S.S. #: _____

Address _____Telephone _____

INJURY REPORT:

Date of Injury: _____ Time of Injury: _____

Location Where Injury Occurred (department name, company vehicle, etc): _____

Description of Injury/Accident: _____

_____

Body Part Injured: _____

EMPLOYMENT INFORMATION (At time of injury):

Job Title*: _____ ***Please send/attach job description of injured team member.***

Employer: _____ Contact: _____

Telephone: _____ Fax #: _____

Address _____

WORKER'S COMPENSATION INSURANCE CO. INFORMATION:

Name: _____ Claim #: _____

Address: _____

Case Adjuster: _____ Telephone: _____

Email: _____ Fax #: _____

Nurse Case Manager: _____ Telephone: _____

Email: _____ Fax #: _____

Next Scheduled Appointment Date & Time: _____

____ Send copy with the patient ____ Fax/email form with progress notes to claim adjuster ____ Fax/Email form to employer

WORKER COMPENSATION WORK STATUS FORM

Visit Date: _____

Team Member Name: _____ **Date of Birth:** _____

WORK STATUS: ☐ No restrictions ☐ Restrictions as noted below ☐ RTW Immediate ☐ RTW Date: _____

Worker can (related to work injury)	None	Seldom 0-1 hour	Occasional 1-3 hours	Frequent 3-6 hours	Constant 6 or more hours
Sit					
Stand/Walk					
Climb ladder/stairs					
Twisting					
Bending/Stooping					
Squatting/Kneeling					
Crawling					
Reaching (Left/Right/Both)					
Work above shoulders (Left/Right/Both)					
Keyboarding					
Grasping (Left/Right/Both)					
Operate foot controls (Left/Right/Both)					

LIFTING/PUSHING/PULLING:

	Never	Seldom(0-1 hr)	Occasional (1-3 hrs)	Frequent (3-6 hrs)	Constant
	____ pounds	____ pounds	_____pounds	_____ pounds	_____ pounds
Lifting (Left/Right/Both)					
Carry (Left/Right/Both)					
Push/Pull (Left/Right/Both)					

PLAN: _____

Working diagnosis: _____ **Progress:** ☐ As expected ☐ Slower than expected

Current rehab: ☐ PT/OT ☐ Work hardening ☐ Home exercises PT/OT ☐ Home exercises with handouts given

Medications: ☐ OTC Naproxen every 12 hours with food ☐ OTC ibuprofen every 8 hours with food

☐ OTC acetaminophen 1000mg every 8 hours ☐ Prescription: _____

Non-pharmacological treatments: ☐ Cold application ☐ Heat application ☐ Non-rigid splint/wrap ☐ Rigid splint

☐ Elevation of extremity ☐ Alternate sitting and standing as needed

Pending Work Comp Service Approvals: ☐PT/OT ☐CT ☐MRI ☐Referral/Other: _____

Follow up in _____

☐ **Follow up appointment:** _____ ☐ **Released from care** ☐ **Referred to** _____

Provider Signature: _____ **Date:** _____

Melissa Anderson, NP Michelle Michael, PA Brilyn Banister, PA