SCHNECK
ORTHOPEDICS & SPORTS MEDICINE

WORKER'S COMPENSATION VERIFICATION

PATIENT INFORMATION: **EPISODE:** _____

Name _____**Birthdate** _____ **S.S. #:** _____

Address _____**Telephone** _____

EMPLOYMENT INFORMATION (At time of injury)

Employer: _____ **Contact:** _____

Telephone: _____ **Fax #:** _____

Address _____

Description of accident: _____

Date of Injury: _____ **X-Rays Obtained:** _____**Drug Screen Required: YES NO**

WORKER'S COMPENSATION INSURANCE CO. INFORMATION:

Name: _____ **Claim #:** _____

Address: _____

Case Adjuster: _____ **Telephone:** _____

Email: _____ **Fax #:** _____

Nurse Case Manager: _____ **Telephone:** _____

Email: _____ **Fax #:** _____

RESTRICTIONS & TREATMENT

_____ **NO RESTRICTIONS** _____ **WITH RESTRICTIONS **These Restrictions apply to home and/or work****

# Hours	6-8	4-5	1-3	0		>15 X/day	10-15 X/day	1-10 X/day	0 X/day
Standing					0-10 lbs				
Push/Pull					11-25 lbs				
Bending					26-50 lbs				
Reaching					>50 lbs				
Grasping									

RESTRICTION NOTES: _____

RETURN TO WORK DATE (RTW): _____

MEDICATION PRESCRIBED TODAY: _____

DIAGNOSTIC TESTING PREFORMED TODAY: _____

TESTING RESULTS: _____

FUTURE PLAN: _____

Return Appointment: _____ _____ _____

Physician Signature **Date**

PPI Rating: YES NO

____ Send a copy with the patient ____ Fax form with progress notes to claim adjuster ____ Fax form only to employer contact