MEDICAL STATUS FORM

Employer Contact Information (Optional)

City of Great Falls
Angela Swingley 406-455-8446
aswingley@greatfallsmt.net

Employee Info

Employee's Name (Last, First) _____ Date of Birth (mm/dd/yyyy) _____ Provider Timestamp _____

Claim Number _____ Date of Injury (mm/dd/yyyy) _____ Provider Contact Information _____

Released for Work?

- ☐ Employee Released to Full Duty — Date _____ To _____
- ☐ Employee Released to Modified Duty (See Work Abilities) — Date _____ To _____
- ☐ Employee May Work Limited Hours: Hours Per Day — Date _____ To _____
- ☐ Employee May Work Part-time: — Date _____ To _____
- ☐ Employee Not Released to Work — Date _____ To _____
- ☐ Capacity Duration (Estimate Days): ☐ 1-10 ☐ 11-20 ☐ 21-30 ☐ 30+ ☐ Permanent

Modified Work Abilities

Blank Space = Not Restricted (NR)				Continuous	Frequent	Occasional	Never
Hand/Wrist	L	R	B				
Grasping	L	R	B				
Pushing/Pulling	L	R	B				
Fine Manipulation	L	R	B				
Reaching	L	R	B				
Bending							
Climbing							
Lifting 01-10 lbs.							
Lifting 11-20 lbs.							
Lifting 21-25 lbs.							
Lifting 26-50 lbs.							
Lifting 51-70 lbs.							

Number of Hours Employee May: Sit Stand Walk

List Other Restrictions:

Signatures

Employee Signature	Date
Provider Signature	Date

☐ Copy of Medical Status Form to Employee

Date of Next Visit

Treatment Plan

Employee Progress:	As Expected/Better Than Expected Slower Than Expected
Current Rehab:	PT OT Home Exercise Other:
Surgery:	Not Indicated Possible Planned
Comments:	

- ☐ Treatment Concluded by Provider:
- ☐ Max. Medical Improvement (MMI):
- Care Transferred To:
- Consultation Needed With:

Study Pending:

Medications:

Opioids Prescribed for: Acute Pain Chronic Pain

Diagnosis: