

MEDICAL STATUS FORM

Employer Contact Information (Optional)

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?	<input type="checkbox"/> Employee Released to Full Duty	Date _____	To _____
	<input type="checkbox"/> Employee Released to Modified Duty (See Work Abilities)	Date _____	To _____
	<input type="checkbox"/> Employee May Work Limited Hours: _____ hours per day	Date _____	To _____
	<input type="checkbox"/> Employee May Work Part-time: _____	Date _____	To _____
	<input type="checkbox"/> Employee Not Released to Work	Date _____	To _____
	<input type="checkbox"/> Capacity Duration (estimate days):		
	<input type="checkbox"/> 1-10	<input type="checkbox"/> 11-20	<input type="checkbox"/> 21-30
	<input type="checkbox"/> 30+	<input type="checkbox"/> permanent	

Modified Work Abilities	Blank Space = Not Restricted (NR)	Continuous	Frequent	Occasional	Never	
	Hand/Wrist <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>				
	Grasping <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>				
	Pushing/Pulling <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>				
	Fine Manipulation <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>				
	Reaching <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>				
	Bending	<input type="checkbox"/>				
	Climbing	<input type="checkbox"/>				
	Lifting 01-10 lbs.	<input type="checkbox"/>				
	Lifting 11-20 lbs.	<input type="checkbox"/>				
	Lifting 21-25 lbs.	<input type="checkbox"/>				
	Lifting 26-50 lbs.	<input type="checkbox"/>				
Lifting 51-70 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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 _____

Medical Status Form Instructions

The purpose of the Medical Status Form is to:

- 1) facilitate communication between a worker with a work-related injury or occupational disease, the employer, and the health care provider for Stay at Work/Return to Work; and
- 2) provide necessary medical status to the insurer.

The Medical Status Form is a statutory requirement. MCA 39-71-1036 says, "The department shall create a medical status form to be provided to a health care provider providing treatment for a compensable injury or occupational disease." An insurer may request additional information not contained in the form from the health care provider. The treating physician (or a designee) is now required to complete the form following every office visit with the worker.

This three-part form is designed to transmit the correct and essential information to the appropriate parties, easily and accurately.

Employer Contact Information: Enter the name, address, phone number and facsimile number of the Employer. (Optional)

Employee Info: Enter Patient/Employee Name, Date of Birth, Claim Number and Date of Injury.

Provider Time Stamp: Health Care Provider may enter timestamp if necessary.

Provider Contact Information: Enter the name, address, phone number and facsimile number for the Provider.

Released for Work? The Medical Status Form will allow for more than one option to be selected. Check all the applicable boxes and enter the effective date, which in most cases is the date of current office visit. The "To___" box in most cases is the follow-up visit date and can be considered the "Anticipated MMI date" by the payer. See below for steps for each option.

Patient/Employee Released to Full Duty: If selected, enter the effective date, and skip to Signature and Treatment Plan.

Patient/Employee Released to Modified Duty: If selected, enter the effective date, answer the Capacity Duration (estimate days) and continue to the next section (Modified Work Abilities).

Patient/Employee Released to Limited Hours: If selected, enter the number of hours per day, enter the effective date, answer the Capacity Duration (estimate days) and skip to the questions at the bottom of the next section (Modified Work Abilities).

Patient/Employee Released to Work Part-time: If selected, enter days of the week, enter the effective date, answer the Capacity Duration (estimate days) and skip to the questions at the bottom of the next section (Modified Work Abilities).

Patient/Employee Not Released to Work: If selected, enter the effective date, answer the Capacity Duration (estimate days) and "To___" date. Skip to Signature and Treatment Plan.

Capacity Duration (estimate days) is the provider's estimation of how long the current work restrictions will last. Are the work restrictions permanent? The capacity duration can also be used to estimate "Anticipated MMI Date" by the payer.

Modified Work Abilities: This section must be completed if Patient/Employee Released to Modified Duty was checked in the previous section. All categories should be completed if there are restrictions. If there is no restriction; BLANK SPACE means this area is normal and not restricted.

Work Abilities (Continuous/ Frequent/ Occasional/ Never): Check the appropriate box for each activity. If there is limitation to use just one side or hand check the appropriate "L" for left, "R" for right or "B" for bilateral box.

Number of Hours (Sit/Stand/Walk): Enter the maximum number of hours for each activity the patient/employee is limited to per day if these hours of limitations exceed normal break and lunch periods and are not accommodated by normal breaks and lunch periods in an 8 hour day.

List Other Restrictions: Is the patient/employee involved in treatment and/or medication related to the work-related injury/occupational disease that might affect their ability to work safely in any capacity? --A response is required. Enter in free text area of **List Other Restrictions**. **Will the patient/employee be required to use any devices or braces? --A response is required.** Enter in free text area of **List Other Restrictions**. **Additional comments specific to patient/employee's work abilities --A response is required.** Use the **List Other Restrictions** area to indicate any unaddressed limitations, such as driving restrictions.

Signatures: *The signature of the patient/employee is for the sole purpose of acknowledging receipt of the information on the form.* Provider Signature to complete and date as indicated. Check box if copy of form is given to employee. Date of Next (scheduled) Visit.

The information above is automatically transferred to the Page Two (yellow copy of triplicate form) and Page Three (pink copy triplicate form) of the form. Page Three (pink copy) is for employer ONLY. The bottom section on Page One (white copy) and Page Two (yellow copy) contains confidential information for the medical provider, insurer, and patient/employee only and is NOT given to the employer without the patient/employee's authorization.

Employee Progress: When slower than expected is checked this communicates to payer that more intervention or assistance may need to be undertaken to improve employee's progress.

Current Rehab: select appropriate category if applies.

Surgery: select one.

Comments: free text area to communicate further information regarding treatment plan or special circumstances or need for aggressive interventions to the payer; or Stay At Work/Return to Work.

Treatment concluded by this provider: select if this provider has no further treatments or interventions to offer the Employee. Enter effective date.

Max Medical Improvement (MMI): select if the Employee has reached MMI. Enter effective date.

Care Transferred to: complete if transferred indicating name of provider and specialty.

Consultation needed with: complete if necessary and indicate specialty and/or name of provider.

Study Pending: complete if there are diagnostic studies ordered and awaiting results.

Medications: complete for all medications whether OTC or prescribed for the work injury.

Opioids Prescribed for: indicate if Employee is receiving opioids and whether they are for acute (less than 30 days) pain or for chronic (greater than 30 days) pain.

Diagnosis: Enter the work injury/work disease diagnosed condition(s).