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WORKSTRATEGIES[®]

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Patient Name: _____ **Date:** _____

Diagnosis: _____

Evaluation and Testing

_____ **Functional Capacity Evaluation:** This test is approx. 4-5 hours and is designed to assess function (work related, general, ADL). This test is used to determine the readiness for return to work and to determine appropriateness and present functional abilities for transitional work or work conditioning.

Requested specific assessments (check all that apply):

_____ Ability to return to usual and customary job duties.

_____ Determine current functional capacity.

_____ Assess patient's current degree of effort.

_____ Make recommendations for transitional/modified duty.

_____ Assess for Appropriateness for Work Conditioning.

_____ Add additional job simulation activities of up to 2 hrs (7 hr total test time).

_____ Specific Restrictions for Testing _____

_____ **Ergonomic / Job Analysis:** Office / Industrial on-site assessment of job tasks, tools, work station layout, followed by a written report that identifies potential workplace risk factors and proposes solutions. A follow up visit is done to ensure appropriate modifications have been made.

Return to Work Services

_____ **Work Conditioning-** (Daily from 4-8 hours per day) Usually appropriate for individuals whose injuries have occurred within last 6 months. Does not include vocational and psychological services. Single discipline approach.

Other Services

_____ **Impairment ROM/Impairment Rating** – Impairment measurements or calculate impairment rating with report. Physician can designate us to perform components of impairment rating such as ROM, MMT or sensory to calculate entire or whole person percentage on their behalf.

Physician Signature

Services requested and authorized

Phone number: _____ Fax Number _____

_____ **Please include the following information if readily available** _____

INSURANCE INFORMATION

INSURANCE NAME: _____ CLAIM #: _____
ADJUSTER / CASE MANAGER: _____ PHONE: () _____

EMPLOYER INFORMATION

EMPLOYER: _____ JOB TITLE _____

EMPLOYER CONTACT: _____ PHONE: () _____