

CITY OF MADISON MEDICAL STATUS REPORT

This form is to assist **The City of Madison** place injured workers into suitable work within the limitations prescribed by the Medical Provider
LIGHT DUTY WORK IN THE CITY OF MADISON IS AVAILABLE FOR MOST CONDITIONS.
IT IS ASSIGNED WITH WORK RESTRICTIONS BELOW.

Worker's Compensation Administrator – WMMIC (608) 852-8645 • FAX: (608) 852-8647
 WMMIC Billing Address: 4781 Hayes Road, Suite 201, Madison, WI 53704

Today's Date: _____

Next physician's appointment:
 Date: _____ Time: _____

Next therapy appointment:
 Date: _____ Time: _____

PATIENT'S NAME:	AGENCY/WORK UNIT:
CLINIC OR HOSPITAL NAME:	
DATE OF INJURY/ILLNESS:	

Diagnosis/Description of Illness/Injury: _____

The patient whose name appears in the boxed area was seen for:

- Treatment of Initial Injury/Illness
- Follow-Up Care for a Previously Reported Injury/Illness
- Independent Evaluation/Consultation

The patient is:

- Discharged from Care
- Able to Return to Full Work on (Date) _____ Is Working
- Unable to Work From _____ Through _____

Because of:

- Able to Return to Limited Work (Identify Specific Work Limitations/Physical Restrictions Below)
 From _____ Through _____

Medication Restrictions:

- | | |
|--|--|
| Prescribed medication | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Advised to take over the counter pain medication | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Approved to operate equipment/vehicles while taking medication | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Work Limitations:

- | | | |
|--|---|---|
| <input type="checkbox"/> Restricted Lifting | MAXIMUM WEIGHT IN POUNDS
<input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> 50 | |
| <input type="checkbox"/> Pushing, Pulling | MAXIMUM WEIGHT IN POUNDS
<input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> 50 | |
| <input type="checkbox"/> Restricted Bending | MAXIMUM NO TIMES PER HOUR
<input type="checkbox"/> 0-2 <input type="checkbox"/> 2-6 <input type="checkbox"/> 6-10 <input type="checkbox"/> 10-20 | DEGREE OF BEND
<input type="checkbox"/> 10-20 <input type="checkbox"/> 20-45 <input type="checkbox"/> Full |
| <input type="checkbox"/> To Keep Wound Clean & Dry | <input type="checkbox"/> Right Hand Work Only | <input type="checkbox"/> No Repetitive Motions |
| <input type="checkbox"/> No Climbing or Overhead Work | <input type="checkbox"/> Left Hand Work Only | <input type="checkbox"/> 1. Hand Grasp |
| <input type="checkbox"/> No Operation of Vehicles/Moving Equipment | <input type="checkbox"/> Sitting Job Only | <input type="checkbox"/> 2. Wrist Motion |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> 3. Elbow Flexion |
| | | <input type="checkbox"/> 4. Foot Controls |

Explain Restrictions: _____

PROVIDER'S PRINTED NAME

PROVIDER'S SIGNATURE