PATIENT STATUS REPORT (PSR)

*** (Note to Employee: Return this form to your supervisor immediately after your appointment) ***

EMPLOYEE / INJURY INFORMATION

Name: _____ Today's Date: _____ Time In/Out: ____/____

Diagnosis: _____ Date of Injury: _____

Work Related?: ☐ Yes ☐ No ☐ Undetermined Medical Status?: ☐ Same ☐ Improved ☐ Worse ☐ MMI

PRESCRIPTION MEDICATIONS

Is this employee taking prescription medications that would affect the employee's ability to drive a state vehicle, commercial vehicle, or other equipment? ☐ Yes ☐ No

Please explain:

If this appointment is for a Workers' Compensation injury, please list all medications that have been prescribed to this employee?

WORK STATUS

☐ Cannot return to work. Explain: _____

☐ Return to work **without** restrictions. Date can return: _____ (includes Saturdays, Sundays, Holidays)

☐ Return to work **with** restrictions. Date can return: _____ (includes Saturdays, Sundays, Holidays)

Number of hours per day: _____

Restriction Status: ☐ Temporary ☐ Permanent

WORK RESTRICTIONS

Restricted Activity (Check if restricted)	Cannot 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%	Explain:
☐ Lift/Carry _____#	☐	☐	☐	☐	
☐ Push/Pull _____#	☐	☐	☐	☐	
☐ Reach above Shoulder	☐	☐	☐	☐	
☐ Stand/Walk	☐	☐	☐	☐	
☐ Stand/Walk on Uneven Ground	☐	☐	☐	☐	
☐ Sit	☐	☐	☐	☐	
☐ Data Entry/Typing	☐	☐	☐	☒	
☐ Simple Grasping	☐	☐	☐	☐	
☐ Bend/Twist	☐	☐	☐	☐	
☐ Squat/Kneel	☐	☐	☐	☐	
☐ Climb	☐	☐	☐	☐	
☐ Jack Hammer	☐	☐	☐	☐	
☐ Pneumatic Tools	☐	☐	☐	☐	
☐ Operate Foot Controls	☐	☐	☐	☐	
☐ Pull Self into Heavy Equipment	☐	☐	☐	☐	
☐ Operate Car/Pickup/Heavy Equipment	☐	☐	☐	☐	

MEDICAL PROVIDER INFORMATION

Medical Office Name: _____ Phone No.: _____

Medical Provider's Name: _____

Medical Provider's Signature: _____ Date of Signature: _____

Date/Time of Next Appointment: _____

Referral Requested To: _____ Date/Time of Referred Appointment: _____