



PROVIDER'S REPORT OF PHYSICAL ABILITY

This form shall be reimbursed if completed at initial visit or for a change in work status or activity restrictions, per WCA Health Care Provider Fee Schedule p. 22. Helpful guidelines on back

1 - GENERAL INFORMATION

Worker Name (Last, First)		Date of Injury	Visit date	Facility Address and Phone
SSN-last 4 digits XXX-XX-	Date of Birth	Primary Treating Provider Name		

Visit Type: ☐ Initial ☐ Follow-up - For follow-ups, is there a change in your recommendation since last visit? ☐ YES ☐ NO

Diagnosis: _____

In my opinion, this diagnosis is: ☐ Work-related ☐ Not work-related

Maximum Medical Improvement (MMI) indications (Check one and indicate date) :

☐ Worker reached MMI on _____ (date). ☐ Not at MMI but anticipated on _____ (date).

2 - WORK STATUS

After evaluation, I recommend this worker be (check only one option) :

☐ **OPTION 1 – Released to regular work** Status from (start date): _____ to (end date): _____

Released to hours and tasks routinely performed on the job held at the time of injury. SKIP TO SECTION 4 FOLLOW-UP

☐ **OPTION 2 – Not released to ANY work at all** Status from (start date): _____ to (end date): _____

The worker is not capable of performing ANY work activities at this time. SKIP TO SECTION 4 FOLLOW-UP

☐ **OPTION 3 – Released to modified duty** Status from (start date): _____ to (end date): _____

Released to work, subject to the following restrictions in Section 3 ACTIVITY RESTRICTIONS (Unmarked items indicate no restriction)

3 - ACTIVITY RESTRICTIONS

Lift / Carry / Push / Pull Restrictions (if any)

Maximum cumulative hours/day	>	0	2	4	6	8	Other
Lift from the floor	☐ Left ☐ Right	lbs.	lbs.	lbs.	lbs.	lbs.	
Lift from waist height	☐ Left ☐ Right	lbs.	lbs.	lbs.	lbs.	lbs.	
Carry	☐ Left ☐ Right	lbs.	lbs.	lbs.	lbs.	lbs.	
Push	☐ Left ☐ Right	lbs.	lbs.	lbs.	lbs.	lbs.	
Pull	☐ Left ☐ Right	lbs.	lbs.	lbs.	lbs.	lbs.	

Posture / Motion Restrictions (if any)

Maximum cumulative hours/day	→	0	2	4	6	8	Other
Stand		☐	☐	☐	☐	☐	
Walk		☐	☐	☐	☐	☐	
Sit		☐	☐	☐	☐	☐	
Bend / Stoop		☐	☐	☐	☐	☐	
Twist		☐	☐	☐	☐	☐	
Kneel / Squat		☐	☐	☐	☐	☐	
Climb (stairs/ladder)		☐	☐	☐	☐	☐	
Drive		☐	☐	☐	☐	☐	
Grasp / Squeeze	☐ Left ☐ Right	☐	☐	☐	☐	☐	
Wrist (flex/extension)	☐ Left ☐ Right	☐	☐	☐	☐	☐	
Fine manipulation	☐ Left ☐ Right	☐	☐	☐	☐	☐	
Reach above shoulder	☐ Left ☐ Right	☐	☐	☐	☐	☐	
Reach below shoulder	☐ Left ☐ Right	☐	☐	☐	☐	☐	
Other:		☐	☐	☐	☐	☐	

Miscellaneous Restrictions (if any)

☐ Max hours per day of work: _____

☐ Sit/stretch breaks of _____ (# of times) per _____

Medication Restrictions (if any)

☐ Meds restrict ability to work safely (explain restrictions below)

Psychological Restrictions (if any)

☐ Psychological restrictions evident (explain restrictions below)

OTHER RESTRICTIONS / MODIFICATIONS (be specific) :

4 - FOLLOW-UP

Expected follow-up services (check all that apply and indicate dates, if known) :

- ☐ Next evaluation by treating provider on _____ (date) at _____ (time)
- ☐ Referral to / Consult with _____ (provider name and specialty)
- ☐ Physical / Occupational therapy / Chiropractic / Osteopathic Rehabilitation / Reconditioning _____ x/week for _____ weeks
- ☐ Other treatment / Follow-up _____
- ☐ Worker fully discharged from care. This is the last scheduled visit for this problem.

Clear Form

Provider Signature: _____ Date this form completed: _____

WCA PROVIDER'S REPORT OF PHYSICAL ABILITY (back page)

HELPFUL GUIDELINES / DEFINITIONS FOR HEALTH CARE PROVIDER (HCP) COMPLETING THIS FORM

BASIC INFORMATION:

- **For questions on this form:** Email the WCA Medical Cost Containment Bureau at **WCA-MCC@wca.nm.gov** or call 505-795-5752.
- **Purpose of this form:** Because a prolonged workplace absence is detrimental to a worker's well-being, the WCA asks that you facilitate the recovering worker's safe, efficient return-to-work by providing interested parties a clear, quantitative description of current claim-related physical restrictions. In this way, you help employers identify suitable work and assign safe work activities.
- **When / who fills this form out:** Based on a reasonable medical probability, you as the primary treating HCP are encouraged to fill this form out at each appointment, however **you can only be reimbursed if the form is completed at the initial assessment or if there is a change in work status or activity restrictions**, as indicated in the WCA Health Care Provider fee Schedule and Billing Instructions (HCP Fee Schedule).
- **After you fill this report out:** Provide a copy to the worker immediately after each office visit.
- **Note-** This form is not intended to substitute a Functional Capacity Evaluation (FCE).

DEFINITIONS OF PHYSICAL CAPACITY LEVELS (for reference only):

Sedentary - Ability to lift up to 10 lbs. occasionally or 5 lbs. frequently with sitting, walking/standing necessary to carry out duties

Light - Ability to lift up to 20 lbs. occasionally or 10 lbs. frequently, significant standing/walking or sitting with pushing/pulling of arm/leg

Medium - Ability to lift up to 50 lbs. occasionally or up to 25 lbs. frequently

Heavy - Ability to lift up to 50 lbs. occasionally or up to 50 lbs. frequently

HELPFUL GUIDELINES:

1 - GENERAL INFORMATION Fill out worker's name, last 4 digits of SSN, date of birth, date of injury, visit date, your clinic or facility name and address, your name as the primary treating HCP and your phone number

- Visit Type: Indicate if this is an initial or follow-up visit for this worker regarding this workers' compensation injury/illness
- For Follow-ups only: Check either YES or NO to indicate if you are making ANY change in recommendation since the last visit
- Diagnosis: Indicate diagnosis. Underneath, check if, in your opinion the diagnosis is work-related or not work-related. Check only one box
- Maximum medical improvement (MMI) –Check only one box. Indicate the date if the worker has reached MMI at the current visit or at a prior visit. If worker is not at MMI yet, write the date you anticipate the worker might reach MMI

2 - WORK STATUS Check the appropriate option box to indicate if the medical condition(s) resulting from this workers' compensation injury/illness will allow for this worker to return-to-work in some capacity. For each option, indicate the start and anticipated end date of your current work status recommendation. If it is permanent, you can write that in. Note: DO NOT check more than one box.

- Option 1 - Check this box to release the worker to regular work with no restrictions. Do not fill out Section 3 ACTIVITY RESTRICTIONS. Skip to Section 4 FOLLOW-UP and sign/date
- Option 2 - Check this box if you recommend NO work at all be performed at this time. Do not fill out Section 3 ACTIVITY RESTRICTIONS. Skip to Section 4 FOLLOW-UP and sign/date
- Option 3 - Check this box if you feel the worker can return to work in a modified duty capacity with restrictions. Fill out Section 3 ACTIVITY RESTRICTIONS to indicate all the applicable restrictions as well as Section 4 FOLLOW-UP and sign/date

3 - ACTIVITY RESTRICTIONS Fill this section out only if you checked "Option 3 – Released to modified duty" in Section 2 WORK STATUS

- These restrictions are based on the HCP's best understanding of the employee's essential job functions
 - If a particular restriction does not apply, leave it blank. All unmarked items are considered no restrictions
 - **Note to worker :** These restrictions should be followed outside of work as well as at work
- Lift / Carry / Push / Pull Restrictions:** For each activity listed that you are restricting -
 - Check "Left" or "Right" if limitation is to just one side. For bilateral restrictions, check both "Left" AND "Right"
 - Under the maximum cumulative hours/day allowed, write the maximum number of pounds the worker can handle
 - Under "Other," indicate further instructions beyond the maximum cumulative hours/day allowed, if appropriate– Note re lifting restrictions: If you are restricting lifting from the floor, indicate If lifting from waist height is also restricted
 - Posture / Motion Restrictions:** For each activity listed that you are restricting -
 - Where applicable, check "Left" or "Right" if limitation is to just one side. For bilateral restrictions, check both "Left" AND "Right"
 - Under the maximum cumulative hours/day allowed, write the maximum number of pounds the worker can handle
 - Under "Other," indicate further instructions beyond the maximum cumulative hours/day allowed, if appropriate
 - Miscellaneous Restrictions:** Check all restrictions that may apply and write in applicable specifics
 - Medication Restrictions:** Check if medication(s) restrict work ability. Explain restrictions under "Other restrictions/modifications"
 - Psychological Restrictions:** Check if psychological factors restrict work ability. Explain under "Other restrictions/modifications"
 - Other Restrictions / Modifications:** If your recommendations are not indicated anywhere else on this form, write in

4 - FOLLOW-UP Fill this section out at each appointment to indicate ongoing treatment / follow-up services / referrals you are recommending. Check all that apply and indicate dates, if known

- Next evaluation: Provide the date of the next scheduled appointment the worker has with you as the treating provider
- Referral to / Consult with: If you are referring the worker to a specialist or other HCP, write in the HCP name and specialty
- Physical / Occupational Therapy: Circle appropriate treatment and indicate how many times per week worker should attend
- Other Treatment / Follow-up: Check if applicable. Write in any other treatment and/or follow-up you are recommending
- Worker fully discharged: Check only if you are discharging the worker from any further care for this particular condition