OrthopedicSpecialists

*Matthew D. Collard, D.O.*
*Workers' Compensation*
*Arthroscopy/Sports Medicine*
*Extremity Trauma*
*Joint Replacement Surgery*

*2325 Dougherty Ferry Rd, Ste. 100*
*St. Louis, MO 63122*
*(314) 909-1359 Fax (314) 909-1370*
*www.stlorthospecialists.com*

# PATIENT STATUS REPORT

Patient Name: _____ DOB: _____

DIAGNOSIS: _____

_____

_____

COMPENSATION CARRIER: _____

Is this a work related injury? ☐ Yes ☐ No FAX: _____

Is patient working? ☐ Yes ☐ No

Estimated date of return to work with full duty: _____

Estimate date of return to work with limitations: _____

☐ Work ☐ Cannot work

## WORK LIMITATIONS

- ☐ None
- ☐ No use of injured hand / upper extremity L / R
- ☐ Limited use of injured upper extremity L / R
- ☐ Weight bearing lower extremity L / R
- ☐ Non weight bearing lower extremity L / R
- ☐ Partial weight bearing lower extremity L / R
- ☐ Clerical work only upper extremity L / R

## FUNCTIONAL RESTRICTIONS

- ☐ Limited / No lifting
- ☐ Limited / No pushing
- ☐ Limited / No pulling
- ☐ Limited / No grasping
- ☐ Limited / No repetitive movement
- ☐ Limited / No twisting
- ☐ Limited / No overhead activities
- ☐ Limited / No climbing
- ☐ Limited / No bending
- ☐ Limited / No pivoting
- ☐ Limited / No squatting
- ☐ Limited / No standing
- ☐ Limited/ No ambulating

## WEIGHT RESTRICTIONS

- ☐ 0 to 5 lbs.
- ☐ 0 to 10 lbs.
- ☐ 0 to 20 lbs.
- ☐ 0 to 50 lbs.

## TESTING

- ☐ EMG/NCS
- ☐ MRI
- ☐ CT SCAN
- ☐ BONE SCAN
- ☐ OTHER

TREATMENT PLAN: ☐ THERAPY ☐ SPLINT ☐ MEDICATION ☐ INJECTION

_____

_____

SURGERY: ☐ Yes ☐ No SURGERY RECOMMENDED: _____

_____

_____

PRESENT CONDITION: ☐ Stable ☐ Improving ☐ Unchanged ☐ Worsening

FOLLOW UP: _____ APPOINTMENT: _____ TIME: _____

DATE: _____ PHYSICIAN NAME: _____