**Patient Name: (First)**_____ **(Last)**_____ **Date of Birth**_____

## Patient Form instructions: You are responsible for completing this section of the form

If you have an injury or illness that is impacting your daily work or your job outlook, the following forms are intended to help guide you through this process to advocate for needs and identify what type of daily work would be suitable with your medical condition. The information can be used in working with Workforce advocates for opportunities to enhance your employment. To begin, start with the following questions to help identify areas of need and limitations so the provider can assist in meeting work goals.

1. *What type of work are you looking for, or trying to return to? (Circle One: manual labor-light / medium / heavy / seated work) Briefly describe*: _____
2. *What physical or mental limitations are you experiencing and what are you currently unable to do at work? (Ex: musculoskeletal, depression, etc.)* _____

_____

3. *Please briefly describe your condition:* _____

**You are responsible for taking the steps to get the form completed:**

- If you access this form online, or you are handed this form, and you:
  - have no upcoming appointment with your provider, please contact their office to ask about their forms completion policy. They may require a separate appointment.
  - have an upcoming appointment, ask your provider's office if this form can be done at the same time.

## Healthcare Provider Form Instructions:

- Use questions 1-3 above to guide your recommendations and assessment to help the patient meet their workforce goals.
- Your patient will use this form to advocate for themselves with their local WorkForce Center, their employer, or simply used to help them understand what job might be best for them considering their health limitations.

Your patient is seeking assistance with their employment and has indicated their health is impacting their everyday work. Please find two forms attached and determine with your patient which is appropriate for their condition: **PHYSICAL** OR **MENTAL**.

### PHYSICAL HEALTH FORM:

Functional Restrictions – Examples of restrictions that would limit the amount or type of work your patient can perform:

- Patient can only functionally sit for 6 hours a workday = frequent
- Patient can stand/walk the other 2 hours of the workday = occasional

Reasonable Accommodations – Examples of recommendation(s) to help with body positioning during work hours:

- ergonomic chair
- standing desk
- ergonomic keyboard
- ergonomic mouse
- a flexible schedule
- an alteration of what is feasible in a standard workday

### MENTAL HEALTH FORM:

Functional Restrictions – Examples of restrictions that would limit the amount or type of work your patient can perform:

- Patient can give a presentation up to 1 hour/day = seldom
- Patient can interact directly with customer/client up to 6 hours/day = frequent

Reasonable Accommodations – Examples of recommendation(s) to help with body positioning during work hours:

- utilizing a communication board to prevent disruptions during a workday.
- allowing to focus on one task at a time
- a flexible schedule
- a transition in job duties

***Please sign and date the form after completion and return to the patient.***

Healthcare Provider Employment Resource

*"Work is a Health Outcome"*

# Physical Health Restrictions Form - Completed by Provider

**Patient Name:** _____ **Date of Birth** _____

**Date of Injury/Illness:** _____ **Date of Surgery (if applicable):** _____

**Please circle the following:** Employed? YES or NO Seeking Employment? YES or NO

**Provider (optional):** You may attach your own preferred form, but we request you still sign and date the bottom.

☐ In lieu of this form, I am attaching my standard WORK STATUS form.

| Patient Can: | Never | Seldom<br>*Up to 10%*<br>*0 - 1 hours* | Occasional<br>*11 - 33%*<br>*1 - 3 hours* | Frequent<br>*34 - 66%*<br>*3 - 6 hours* | Constant<br>*67 - 100%*<br>*Not restricted* |
|---|---|---|---|---|---|
| Sit | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stand / Walk | ☐ | ☐ | ☐ | ☐ | ☐ |
| Climb (Ladder / Stairs) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Twist | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bend / Stoop | ☐ | ☐ | ☐ | ☐ | ☐ |
| Squat / Kneel | ☐ | ☐ | ☐ | ☐ | ☐ |
| Crawl | ☐ | ☐ | ☐ | ☐ | ☐ |

Other applicable restrictions (lifting, etc.): -

_____

_____

_____

**Please select degree of restriction:**

☐ The patient's injury/condition **SIGNIFICANTLY** impairs their employment.
*Example: a person with a serious back injury who works on their feet most of the day, and lifts items that weigh 20 lbs or more throughout their shift.*

☐ The patient's injury/condition **MILD to MODERATELY** impairs their employment.
*Example: a person with Major Depressive Disorder in a role with basic assigned duties with low complexity, and symptoms that are being managed.*

*Reasonable Accommodation Section (Examples: assistive equipment, a flexible schedule, etc.)*

Is follow up needed for this patient? YES or NO **If yes, date of follow up:** _____

**Provider Printed Name:** _____ **Date:** _____

**Provider Signature:** _____

Healthcare Provider Employment Resource

*"Work is a Health Outcome"*

# Mental Health Restrictions Form - Completed by Provider

**Patient Name:** _____ **Date of Birth**_____

**Approximate Date of Mental Health Diagnosis (if known):** _____

**Please circle the following:** Employed? YES or NO Seeking Employment? YES or NO

**Provider (optional):** You may attach your own preferred form, but we request you still sign and date the bottom.

☐ In lieu of this form, I am attaching my standard WORK STATUS form.

| Patient Can: | Never | Seldom<br>Up to 10%<br>0 - 1 hours | Occasional<br>11 - 33%<br>1 - 3 hours | Frequent<br>34 - 66%<br>3 - 6 hours | Constant<br>67 - 100%<br>Not restricted |
|---|---|---|---|---|---|
| Work in a distracting environment | ☐ | ☐ | ☐ | ☐ | ☐ |
| Attend an In-Person Meeting | ☐ | ☐ | ☐ | ☐ | ☐ |
| Give a Presentation | ☐ | ☐ | ☐ | ☐ | ☐ |
| Interact with Customers / Clients | ☐ | ☐ | ☐ | ☐ | ☐ |
| Operate Machinery (if medicated) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Please select degree of restriction:**

☐ The patient's injury/condition **SIGNIFICANTLY** impairs their employment.

*Example: a person with Major Depressive Disorder in a role that requires high-level decision making, who may be impaired due to difficulty concentrating, poor sleep, or severe fatigue.*

☐ The patient's injury/condition **MILD to MODERATELY** impairs their employment.

*Example: a person with a serious back injury who works seated most of the day, and primarily works at a computer or with the hands directly in front of them throughout their shift.*

*Reasonable Accommodation Section (Examples: assistive equipment, a flexible schedule, etc.)*

Is follow up needed for this patient? YES or NO **If yes, date of follow up:** _____

**Provider Printed Name:** _____ **Date:** _____

**Provider Signature:** _____