

*REPORT OF WORK ABILITY

CorVel Corporation, 3001 NE Broadway St #610, Minneapolis MN 55413
Telephone (866)399-8541 or (612)436-2542 ~ Fax (612)436-2499

1. PATIENT INFORMATION		
Last Name	First	Middle Initial
Social Security Number	Date of Injury/Illness	
Job Title/Description	Home Phone	
Employer	Supervisor or Contact	Employer Phone
Work Comp Insurer	Claim Number	

2. AUTHORIZATION TO RELEASE INFORMATION	
I hereby authorize my medical provider to release or exchange information acquired in the course of my examination or treatment for the following medical condition to my employer or employer representative.	
Patient Signature: _____	Date: _____

3. TREATING PROVIDER'S EVALUATION-COMplete IN FULL FOR EACH VISIT	
Treatment Date _____ / _____ / _____	For: <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Follow-up Appointment
	Nature of Visit: <input type="checkbox"/> Work Related <input type="checkbox"/> Not Work Related <input type="checkbox"/> Unknown
Describe Circumstances of the Injury/Illness	
Diagnosis (include ICD-9 code)	
Treatment	
Medication (when ordering a medication, MN Rules require the words "Work Comp" or "W.C." be included on the prescription)	
Maximum Medical Improvement Reached (see instructions on the reverse side) <input type="checkbox"/> Yes <input type="checkbox"/> No Date of MMI: _____	
Disability Permanency Rating (PPD) if applicable	
Referral/Consult	
Next Appointment Date: _____ Time: _____ Doctor: _____	

4. RETURN TO WORK																																																												
<input type="checkbox"/> May return to work with no restrictions: <input type="checkbox"/> Immediately, or <input type="checkbox"/> Beginning _____																																																												
<input type="checkbox"/> Injury will result in loss of time from work: from _____ through _____																																																												
<input type="checkbox"/> May return to work with the following restrictions: from _____ through _____ (note: schedule appointment)																																																												
Patient's capabilities:																																																												
Patient is able to lift up to: _____ lbs.																																																												
Patient is able to use Hands: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both																																																												
Hand / Wrist / Elbow / Shoulder restrictions: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both _____																																																												
In an 8 hour day patient may (in hours):																																																												
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>none</th> <th>1-2</th> <th>2-4</th> <th>4-6</th> <th>6-8</th> <th>none</th> <th>1-2</th> <th>2-4</th> <th>4-6</th> <th>6-8</th> </tr> </thead> <tbody> <tr> <td style="text-align: right;">Stand and Walk</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td style="text-align: right;">Sit</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Bend and Squat</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td style="text-align: right;">Drive</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Carry and Level Lift</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td style="text-align: right;">Push / Pull</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Bend and Lift</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </tbody> </table>		none	1-2	2-4	4-6	6-8	none	1-2	2-4	4-6	6-8	Stand and Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bend and Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carry and Level Lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Push / Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bend and Lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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Other Restrictions: _____																																																												
Estimated Return to Full Duty is: _____ / _____ / _____ (If unable to return on full duty date, patient should return to clinic)																																																												

5. TREATING PROVIDER	
Provider Name (please print)	Clinic Name
Provider Signature	Clinic Address

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INSTRUCTIONS:

This form is to be completed by the treating provider for the initial evaluation and for all follow-up visits and treatment relating to a work injury or illness. This information is required under Minnesota Workers' Compensation Rules, 5221. A "treating provider" may be a medical physician, an osteopath, a chiropractor, a podiatrist or a dentist.

1. PATIENT INFORMATION:

Patient information is to be completed by the medical secretary or nurse, in conjunction with the injured / ill employee or with the employer / supervisor.

Complete all requested information. In particular, be sure to complete information identifying the patient and injury: patient name and social security number, date of injury / illness, and employer.

2. AUTHORIZATION TO RELEASE INFORMATION

Obtain the patient's signature authorizing the release or exchange of medical records and information relating to the medical condition to the employer or employer representative. The patient's release is recommended, although not required for MN workers' compensation.

3. TREATING PROVIDER'S EVALUATION – COMPLETE IN FULL FOR EACH VISIT

Completed by the treating provider at the time of the visit. This section includes specific information based on the provider's most recent evaluation of the employee's signs, symptoms, physical and clinical findings, and functional status.

CorVel notification is required for referrals / consultations. Other services may require prior authorization or coordination with the CorVel managed care plan. Consult the CorVel provider policy and procedures manual for sections describing:

- CorVel Provider Education – for procedures used in working with the managed care plan.
- Workers' Compensation Medical Treatment Parameters – established by the Department of Labor and Industry.

Follow-up appointments should be assigned as medically necessary. In particular, follow-up appointments should be assigned:

- When the physician is unable to assess a full-duty date.
- When an employee has been seen by an Emergency Room contracting physician and the employee is unable to return to work within three (3) days. A follow-up visit is to be advised within three calendar days when it appears the disability will extend beyond the three day period.
- You must complete formal MMI information on the Health Care Report Form as required by the MN Department of Labor and Industry. Health Care Provider Report Forms are available from the MN Department of Labor & Industry.

4. RETURN TO WORK

Completed by the treating provider at the time of the visit. This section includes specific information regarding return to work instructions for the employee.

The return to work date shall be the earliest possible medically appropriate date, regardless of holidays, weekends, or regularly scheduled workdays.

Return to full duty shall be the date the employee can return to his or her normal duty job functions without restrictions.

Return to work with restrictions shall specifically indicate medical restrictions to be followed by the employee and employer.

A duration of these restrictions shall be assigned. Open-ended durations of disability or restriction may not be given.

5. TREATING PROVIDER

Completed by the treating provider at the time of the visit.

NOTICE TO EMPLOYEE

You must promptly provide a copy of this report to your employer or workers' compensation insurer, and to any assigned qualified rehabilitation consultant.