ACTIVITY PERSCRIPTION FORM (APF)

General Info

Worker's Name:	Patient ID:	Visit Date:	Claim Number:
Healthcare Provider's Name (please print):		Date of Injury:	Diagnosis:

Required: Work status

☐ Worker is **released** to the job of injury (JOI) without restrictions (related to the work injury) as of (date): ____/____/____
(If selected, skip to "Plans" section below)

☐ Worker **may perform modified duty**, if available, from (date):
____/____/____ to* ____/____/____ (*estimated date)

☐ If released to modified duty, may work more than normal schedule

☐ Worker **may work limited hours**: _____ hours/day from (date):
____/____/____ to* ____/____/____ (*estimated date)

☐ Worker **is working** modified duty or limited hours

☐ Worker **not released to any work** from (date): ____/____/____ **to*** __/____/____
(*estimated date)

☐ **Poor prognosis for return to work** at the job of injury at any date

Required: Measurable Objective Finding(s)
(e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)

Required: Estimate what the worker can do at work and at home unless released to JOI

How long do the worker's current capacities apply (estimate)?
☐ 1-10 days ☐ 11-20 days ☐ 21-30 days ☐ 30+ days ☐ permanent
Capacities apply all day, every day of the week, at home as well as at work.

Worker can: (Related to work injury) A blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% (Not restricted)
Sit					
Stand / Walk					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist (flexion/extension) L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					
Vibratory tasks; high impact L, R, B					
Vibratory tasks; low impact L, R, B					

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift L, R, B	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs
Carry L, R, B	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs
Push / Pull L, R, B	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐ Yes ☐ No
Modified duty available? ☐ Yes ☐ No
Date of contact: ____/____/____
Name of contact: _____
Notes:

Note to Claim Manager:

☐ May need assistance returning to work
New diagnosis: _____
Opioids prescribed for: ☐ Acute pain or ☐ Chronic pain

Required: Plans

Worker progress: ☐ As expected / better than expected ☐ Slower than expected (*address in chart notes*)

Current rehab: ☐ PT ☐ OT ☐ Home exercise ☐ Other (e.g., Activity Coaching) _____

Surgery: ☐ Not Indicated ☐ Possible ☐ Planned Date: ____/____/____ ☐ Completed Date: ____/____/____

☐ Next scheduled visit in: ___days ___weeks or Date: ___/___/___
☐ Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? ☐ Yes ☐ No ☐ Possibly
If you are qualified, please rate impairment for your patient
☐ Will rate ☐ Will refer ☐ Request IME
☐ Care transferred to: _____
☐ Consultation needed with: _____
☐ Study pending: _____

Reg: Sign

☐ Copy of APF given to worker ☐ Discussed three key messages on back of form with patient

Signature: _____ ____/____/____ ( ) ____-____
☐ Doctor ☐ ARNP ☐ PA-C Date Phone

Please fax completed form to Penser North America at 509-420-7289