



**Emergency Management,
Building & Safety**
510 Broadway
Baraboo, WI 53913

CHIROPRACTOR'S WORK RECOMMENDATION REPORT

I hereby authorize the release of information requested on this form to Sauk County Emergency Management and/or my insurance carrier. The release of information is effective until further notice in writing.

EMPLOYEE'S NAME: _____ EMPLOYEE'S SIGNATURE: _____ DATE: _____

DIAGNOSIS SPECIFIC DIAGNOSIS OF CONDITION: _____

DATE OF FIRST TREATMENT: _____ DATE OF LAST TREATMENT: _____

X-RAY TAKEN YES NO — WHY NOT? _____

IS THIS CONDITION WORK RELATED? YES NO EXPLANATION: _____

30-DAY TREATMENT PLAN OUTLINE OF THE TREATMENT PLAN: _____

NUMBER AND SCHEDULE OF FUTURE ADJUSTMENTS: _____

EXERCISE INSTRUCTIONS: _____

IDENTIFY ALL PREVIOUS TREATMENTS FOR SIMILAR PROBLEMS: _____

NEXT EVALUATION (DATE/TIME): _____ NEXT X-RAY SCHEDULED FOR: _____

WORK STATUS

CHIROPRACTOR: We want our employees gainfully employed and if necessary, will attempt to place them in a position which accommodates your instructions. If a copy of the employee's job description would be helpful in determining your treatment plan, please indicate by checking the box below. Employees will be required to follow these instructions both at work and at home.

Job Description Requested

- EMPLOYEE MAY RETURN TO WORK ON _____ WITH NO RESTRICTIONS.
- EMPLOYEE MAY RETURN TO WORK ON _____ WITH RESTRICTIONS (SEE BELOW).
- EMPLOYEE MAY NOT RETURN TO WORK UNTIL _____ REASON: _____

SPECIFIC RESTRICTIONS

- | | | | | | |
|-------------------|-----------------------------------|------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| LIFTING/CARRYING: | <input type="checkbox"/> 1-5 lbs. | <input type="checkbox"/> 6-10 lbs. | <input type="checkbox"/> 11-25 lbs. | <input type="checkbox"/> 26-50 lbs. | <input type="checkbox"/> 51-75 lbs. |
| WALKING/STANDING: | <input type="checkbox"/> 0-2 hrs. | <input type="checkbox"/> 2-4 hrs. | <input type="checkbox"/> 4-6 hrs. | <input type="checkbox"/> 6-8 hrs. | |
| SITTING: | <input type="checkbox"/> 0-2 hrs. | <input type="checkbox"/> 2-4 hrs. | <input type="checkbox"/> 4-6 hrs. | <input type="checkbox"/> 6-8 hrs. | |
-
- | | | | |
|--|--|---|--|
| <input type="checkbox"/> NO PUSHING/PULLING | <input type="checkbox"/> NO BENDING (BACK) | <input type="checkbox"/> NO ELBOW MOTION | <input type="checkbox"/> NO SLIPPERY/UNEVEN SURFACES |
| <input type="checkbox"/> NO SQUATTING/CROUCHING | <input type="checkbox"/> NO BENDING (NECK) | <input type="checkbox"/> NO WRIST MOTION | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> NO REACHING ABOVE SHOULDERS | <input type="checkbox"/> NO HANDLING BULKY ITEMS | <input type="checkbox"/> NO GRASPING/GRIPPING | |

REQUIREMENTS:

- RIGHT HAND WORK ONLY
- LEFT HAND WORK ONLY
- MUST WEAR PROTECTIVE SPLINT
- SITTING WORK ONLY
- OTHER _____

ADDITIONAL COMMENTS: _____

IF AND WHEN ANY CHANGES OCCUR IN THE EMPLOYEE'S CONDITION CONTRARY TO THE ABOVE REPORT, PLEASE CONTACT CARL GRUBER AT (608) 355-4400

FACILITY NAME: _____ CHIROPRACTOR'S NAME: _____ (PLEASE PRINT)

CHIROPRACTOR'S SIGNATURE: _____ DATE: _____ PHONE: _____