STOKES & ASSOCIATES
VOCATIONAL REHABILITATION | LIFE CARE PLANNING

PHYSICIAN'S CONSULTATION FORM

Patient/Examinee Name:

1. What is the date of injury? _____
2. What was the date of the last Examination? _____
3. What is the diagnosis? _____
4. Have diagnostic tests been performed? _____ Yes _____No

If so, please identify what tests have been performed, the date, and the findings?

_____

5. What is the prognosis? _____
6. What is the current medical status? _____
7. Has the patient reached maximum medical improvement?

_____ Yes _____No Date? _____

8. If no, what is the expected date of maximum medical improvement?

_____

9. Is the patient taking medication that impacts his/her ability to work?

_____ Yes _____No

Please explain any limitations:

_____

10. Can the patient be released to his/her previous job or regular work?

_____ Yes _____No

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11. Can the patient return to temporary light work duty? (Explain limitations or restrictions) _____

12. Can the patient work based on The Department of Labor Definitions of Physical Demands? Select the maximum strength demand.

_____Sedentary _____Light _____Medium _____Heavy _____Very Heavy

13. Please give an opinion of work restrictions or complete a physical capacity work restriction form. If you do not have a work restriction or physical capacities form, one can be provided to you.

_____

14. If the patient/examinee is not capable of working in any capacity currently, when do you anticipate releasing for work?

_____

15. Are breaks required during the workday? _____ Yes _____No

Frequency _____

Duration _____

16. Can the patient operate a motor vehicle? _____ Yes _____No

_____ _____

Signature Print Name Date