

**Nebraska City  
Medical Clinic**

1700 14th Avenue  
Nebraska City, NE 68410  
PH 402.873.4242  
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TIME IN \_\_\_\_\_ Clinic Site Identification \_\_\_\_\_ Today's Date \_\_\_\_\_ TIME OUT \_\_\_\_\_

New  Follow up

**PLEASE RETURN THE WHITE COPY TO YOUR EMPLOYER**

HAS EMPLOYER BEEN NOTIFIED?  YES  NO

**PATIENT**

Name: \_\_\_\_\_  
Home address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Phone # \_\_\_\_\_  
Social Security # \_\_\_\_\_

**COMPANY**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone # \_\_\_\_\_  
Supervisor: \_\_\_\_\_

Emer. Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_  
Primary Care Physician's Name: \_\_\_\_\_

Date of initial injury: \_\_\_\_\_  
Brief description of patient complaint/symptoms: \_\_\_\_\_

**BELOW TO BE COMPLETED BY ATTENDING PHYSICIAN**

CHECK IF DONE: Office Visit  Sutures  X-ray  Cast

Brief description of Diagnosis/Condition: \_\_\_\_\_

**WAS THIS A BLOODBORNE EXPOSURE? YES  NO  IF YES, IS SOURCE KNOWN? YES  NO**

**INDICATE WHAT STEPS WERE FOLLOWED:**

POST EXPOSURE PROPHYLAXIS GIVEN? YES  NO

COUNSELING PROVIDED? YES  NO

HEPATITIS B VACCINATION (ENGERIX) SERIES STARTED? YES  NO

COMPANY NOTIFIED OF TREATMENT PERFORMED? YES  NO

**ANY FURTHER DOCUMENTATION PLEASE USE COMMENT AREA BELOW**

**RECOMMENDATION**

THE ABOVE PATIENT IS TO:

- I. Return to work ON: \_\_\_\_\_ with NO restrictions necessary.
- II. Returning to work ON: \_\_\_\_\_ and capable of performing the degree of work checked below:  
**(THIS IS ONLY IF THE CURRENT COMPANY HAS THIS WORK AVAILABLE.)**

- \_\_\_\_\_ **Sedentary Work** (Lifting 10 lbs. maximum & occasionally lifting and/or carrying such articles as files, ledgers & small tools.)
- \_\_\_\_\_ **Light Work** (Lifting 30 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs.)
- \_\_\_\_\_ **Light Medium Work** (Lifting 30 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)
- \_\_\_\_\_ **Medium Work** (Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)
- \_\_\_\_\_ **Light Heavy Work** (Lifting 75 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 40 lbs.)
- \_\_\_\_\_ **Heavy Work** (Lifting 100 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 50 lbs.)

IN AN 8-HOUR WORKDAY, PATIENT MAY:

Stand/Walk: \_\_\_\_\_ None \_\_\_\_\_ 1-4 Hrs. \_\_\_\_\_ 4-6 Hrs. \_\_\_\_\_ 6-8 Hrs.  
Sit: \_\_\_\_\_ 1-3 Hrs. \_\_\_\_\_ 3-5 Hrs. \_\_\_\_\_ 5-8 Hrs.  
Drive: \_\_\_\_\_ 1-3 Hrs. \_\_\_\_\_ 3-5 Hrs. \_\_\_\_\_ 5-8 Hrs.

PATIENT MAY USE HAND(S) FOR REPETITIVE: \_\_\_\_\_ Single grasping \_\_\_\_\_ Pushing & Pulling \_\_\_\_\_ Fine Manipulation  
PATIENT MAY USE FOOT/FEET FOR REPETITIVE MOVEMENT AS IN OPERATING FOOT CONTROLS: \_\_\_\_\_ Yes \_\_\_\_\_ No

PATIENT IS ABLE TO: (✓ Areas)	1-33% (Occasionally)	34-66% (Frequently)	67-100% (Constant)
Bend			
Squat			
Climb			
Twist			
Reach			

**THE ABOVE RESTRICTIONS ARE IN EFFECT UNTIL: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ OR UNTIL PATIENT IS RE-EVALUATED ON \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_.**

- III. THE ABOVE PATIENT IS NOT TO RETURN TO WORK UNTIL FURTHER NOTICE. NEXT EVALUATION IS ON: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_.
- IV. REFERRED TO ANOTHER PHYSICIAN OR THERAPY? \_\_\_\_\_ YES \_\_\_\_\_ NO When/Who: \_\_\_\_\_
- V. COMMENTS: \_\_\_\_\_

ATTENDING PHYSICIANS SIGNATURE: \_\_\_\_\_