Work Conditioning Questionnaire
FOR WEB BASED SUBMISSIONS

Patient Name: _____ **Claim ID** # (7 digits): _____

If you HAVE NOT treated the patient, please DO NOT complete this form.*

* **Instead, please provide documentation of readiness to participate in work conditioning**
(e.g., physical capacities evaluation, therapy discharge summary, ordering provider office note, etc).

- **Attach as a document to your on-line submission *(preferred)***
  or **fax to Qualis Health at 877-665-0383** (please include reference number on cover sheet)

FORM INSTRUCTIONS - ALL of these questions are MANDATORY.

Failure to answer **any** questions will cause delays; all information is required to process this request.

For the following: **AP** = Attending Provider **PT** = Physical Therapy
OT = Occupational Therapy **WC** = Work Conditioning

1. Has the AP released the injured worker (IW) to participate in a total body strengthening/ endurance program?
   ☐ Yes ☐ No - If no, describe limitations: _____
2. Date of WC evaluation: _____
3. Number of completed visits since initial WC evaluation: _____
4. Number of cancelled or no show visits from initial WC evaluation: _____
5. What is IW's current work status?
   Select all that apply.
   ☐ Full duty ☐ Full time ☐ Not working
   ☐ Modified duty ☐ Part time
6. Identified barrier(s) to achieving work goals.
   Select all that apply.
   ☐ None ☐ Attendance ☐ Assistive Device
   ☐ Co-morbidities ☐ Multiple injuries ☐ Medically directed restrictions
   ☐ Self limiting ☐ HEP compliance ☐ De-conditioned
   ☐ Transportation ☐ Pain > 4/10 ☐ Other
7. Is the worker scheduled for or receiving treatments/procedures by other providers?
   Select all that apply.
   ☐ None ☐ Massage Therapy ☐ Physical therapy by different clinic
   ☐ Chiropractic ☐ Surgery ☐ Occupational therapy by different clinic

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8. Describe patients progress towards current goals, lbs **and/or** positional tolerances
(Fill in all that apply: **S** = seldom, **O** = occasional, **F** = frequent, **C** = constant)

Task	Goal	Initial eval	Week 1	Week 2	Week 3	Week 4
Lift floor to waist						
Lift waist shoulder						
Lift overhead						
Carry						
Push/Pull						
Sitting						
Standing						
Kneeling						
Reach						
Grasp						
Fine Manipulation						
Keyboard						
Other						

9. Current rehab potential to achieve functional goals in order to return to work:

☐ Good ☐ Fair ☐ Poor

10. What is the return to work goal for this worker?

☐ Job of injury ☐ Modified job ☐ Transferrable skills job

☐ Retraining goal ☐ Increased return to work options

11. Describe return to work goal. Include the job title if known.

_____

12. What is the physical demands goal?

☐ Sedentary ☐ Light ☐ Light-medium

☐ Medium ☐ Medium-heavy ☐ Heavy

13. At the conclusion of these visits are additional services anticipated?

☐ Work Conditioning ☐ Work Hardening ☐ Pain Program