FORESIGHT

Physical Capacities Evaluation

Patient's Name: Job Title:

Diagnosis: Date of Services: Time in: Time out:

Doctor: *This form will be used to make some determinations regarding your patient's ability to perform work-related activities. Please complete the following items based upon your clinical evaluation, the objective medical evidence and diagnostic test results.*
Please provide this form to employee to return to employer.

In a typical 8-hour day, the patient can (check full capacity for each activity, numbers indicate hours):

(PLEASE CHECK # OF HOURS, i.e., 1, 2, 3, etc)

Activity	0	1	2	3	4	5	6	7	8	9	10	11	Special Instructions
Sit:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stand:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Walk:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Drive Vehicles (Bus/Utility):	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Operate Machinery (Rail):	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Total hours patient can work	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

The patient can perform these physical demands (please check all that applies)

	Never 0 hours	Rarely 1-3 hours	Occasionally 3-6 hours	Frequently 6-8 hours	Continuously 8+ hours
☐ Lift ___lbs (indicate maximum # of lbs)	☐	☐	☐	☐	☐
☐ Climb stairs	☐	☐	☐	☐	☐
☐ Climb ladders	☐	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐
☐ Kneel	☐	☐	☐	☐	☐
☐ Squat	☐	☐	☐	☐	☐
☐ Crawl	☐	☐	☐	☐	☐
☐ Flex or extend neck	☐	☐	☐	☐	☐
☐ Simple grasping	☐	☐	☐	☐	☐
☐ Fine Manipulation	☐	☐	☐	☐	☐
☐ Keyboarding	☐	☐	☐	☐	☐
☐ Can return to full duty – no restrictions	☐	☐	☐	☐	☐

These restrictions are TEMPORARY and will be reassessed on: _____
MM/DD/YYYY

Patient is able to return to full duty within 180 days:

☐ Yes ☐ No

Treatment Facility (please check):

☐ Occ Med ☐ Emergency Room ☐ Urgent Care

Was patient referred to a specialist?

☐ Yes ☐ No Next office visit date: _____
MM/DD/YYYY

Print Doctor's Name: Doctor's Signature:

I understand that by signing this form, I am agreeing to furnish a copy to my work location

Telephone Number: Employee's Signature: