

Work~Connections

Employee-Centered Illness and Injury Program

University of Michigan

TOLL-FREE 1-877-869-5266 (UMWKCON)

Fax (734) 936-1913

Please follow directions on how to submit Work~Connection forms.

Health Care Provider Report To be completed by treating health care provider.		
Name of Patient _____		Social Security Number _____
Primary Diagnosis Diagnosis _____ ICD9 _____ Treatment Plan and Present Complications _____		Medications and Dosage _____
Secondary Diagnosis Diagnosis _____ IC09 _____ Treatment Plan and Present Complications _____		
Additional Diagnoses _____		
Name of Consulting Physician, If Referred _____	Specialty _____	Date of Visit _____
Date Patient First Unable to Work _____	Date of Last Office Visit _____	Date of Next Office Visit _____
Surgical Procedure _____	Date Performed/Scheduled _____	CPT Procedure Code _____
Name of Hospital _____	Date of Admission _____	Date of Discharge _____
Reason for Hospitalization _____		
For Pregnancy Related Disability (Please describe any complications) _____		
EDC _____	Delivery Date _____	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
Return to Work Plan. Please specify restrictions as needed.		
<input type="checkbox"/> Return to work Unrestricted on Effective Date _____ <input type="checkbox"/> Return to work Restricted on Effective Date _____ Expiration Date _____ Target Date for Full Recovery _____ Has the Employee Reached Maximum Medical Improvement (MMI)? <input type="checkbox"/> Yes <input type="checkbox"/> No Target Date for MMI _____	LIFTING LIMIT OF _____ POUNDS <input type="checkbox"/> Limit work above chest/shoulder level with R <input type="checkbox"/> L <input type="checkbox"/> UPPER EXTREMITY <input type="checkbox"/> None <input type="checkbox"/> Limited to _____ <input type="checkbox"/> Forceful or Repetitive Grasping with R <input type="checkbox"/> L <input type="checkbox"/> HAND <input type="checkbox"/> None <input type="checkbox"/> Limited to _____ <input type="checkbox"/> Bending or Twisting at Waist <input type="checkbox"/> Kneeling Squatting <input type="checkbox"/> None <input type="checkbox"/> Limited to _____ <input type="checkbox"/> None <input type="checkbox"/> Limited to _____ <input type="checkbox"/> Walking <input type="checkbox"/> Sit or Stand at Will _____ <input type="checkbox"/> None <input type="checkbox"/> Limited to _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Limit Hours of Work to _____	
Health Care Provider Information		
Health Care Provider Name (please print) _____		Specialty _____
Health Care Provider's Address _____	Telephone Number _____	Fax Number _____
Health Care Provider's Signature _____		Date Signed _____