DMEC
Disability Management Employer Coalition

ACTIVITY/PRESCRIPTION FORM (AFP)

GENERAL INFORMATION

EMPLOYEE'S NAME: _____ DATE OF VISIT: ___/___/___ CLAIM #: _____

HEALTHCARE PROVIDER'S NAME: _____ DATE OF INJURY: ___/___/___ DIAGNOSIS: _____

REQUIRED RELEASE FOR WORK

KEY OBJECTIVE FINDINGS: _____

☐ Worker is released to return to work WITHOUT restrictions on ___/___/___.
☐ Worker may perform modified duty, if available, from ___/___/___ to ___/___/___.
☐ Worker may work limited hours of _____ hours per day, from ___/___/___ to ___/___/___.
☐ Worker is NOT returned to work any duties from ___/___/___ to ___/___/___.
☐ Worker's prognosis is poor for return to work at any date in the foreseeable future.

REQUIRED IDENTIFICATION OF WORKER'S CAPABILITIES

CAPACITY DURATION (DAYS): ☐ 1-10 ☐ 11-20 ☐ 20-30 ☐ 30+ ☐ PERMANENT

Worker CAN *(blank space = no restriction)*	**Never**	**Seldom** *(1-10%)*	**Occasional** *(11-33%)*	**Frequently** *(34-66%)*	**Regularly** *(67-100%)*
Sit					
Stand/Walk					
Climb (ladder/stairs)					
Twist					
Bend/Stoop					
Squat/Kneel					
Crawl					
Reach (left, right, or both)					
Work above shoulders (left, right, or both)					
Keyboard (left, right, or both)					
Wrist (flexion/extension) (left, right, or both)					
Grasp forcefully (left, right, or both)					
Fine manipulation (left, right, or both)					
Operate foot controls (left, right, or both)					
Vibratory tasks: (high impact)					
Vibratory tasks: (low impact)					

Lifting/Pushing		**Never**	**Seldom** *(1-10%)*	**Occasional** *(11-33%)*	**Frequently** *(34-66%)*	**Regularly** *(67-100%)*
Example		*50 lbs.*	*20 lbs.*	*10 lbs.*	*0 lbs.*	*0 lbs.*
Lift	(left, right or both)	lbs.	lbs.	lbs.	lbs.	lbs.
Carry	(left, right or both)	lbs.	lbs.	lbs.	lbs.	lbs.
Push/Pull	(left, right or both)	lbs.	lbs.	lbs.	lbs.	lbs.

OPIOIDS PRESCRIBED FOR ☐ Acute Pain ☐ Chronic Pain ☐ No Rx

OTHER RX/RESTRICTIONS/INSTRUCTIONS: _____

EMPLOYER NOTIFIED OF CAPACITIES? ☐ Yes ☐ No Contact Date ___/___/___

NAME OF CONTACT/ADDITIONAL NOTES _____

REQUIRED PLANS

WORKER'S PROGRESS: ☐ As Expected ☐ Slower than Expected *(Provide Additional Comments on Back)*

REHABILITATION: ☐ PT ☐ OT ☐ Home Exercise ☐ Other _____

SURGERY: ☐ N/A ☐ Possible ☐ Planned *(Date/Comments)* _____

NEXT VISIT: (DAYS/WEEKS/SPECIFIC DATE) _____

CARE TRANSFERRED TO: _____ CONSULTATION NEEDED: _____

STUDY PENDING: _____

TREATMENT ENDED: ☐ Yes ☐ No ☐ Possible ☐ Permanent Impairment

SIGNATURE (REQUIRED): _____ PHONE: (____) ____ - _____

DATE OF SIGNATURE: ___/___/___ ☐ Doctor ☐ ARNP ☐ PA-C

COPY OF APF GIVEN TO WORKER: ☐ Yes ☐ No ADDITIONAL NOTES ON BACK OF FORM: ☐ Yes ☐ No