Tips for completing the Activity Prescription Form

Instructions for health care providers

Washington State Department of Labor & Industries

Work Status:

Complete at least one part of the Work Status section. Fill in dates, hours per day, and/or date ranges as needed.

Make sure there are no time gaps or overlaps in any of the date ranges you indicate in the Work Status and Plans sections.

Capacities and other Restrictions:

Indicate the patient's current capacities and/or restrictions. They must apply to your patient at all times, all day, every day of the week, even if you are not releasing your patient to any work. It will help the employer begin identifying light duty jobs your patient can do safely during recovery.

If none of the listed capacities apply, list restrictions.

Example: *May not drive due to medication.*

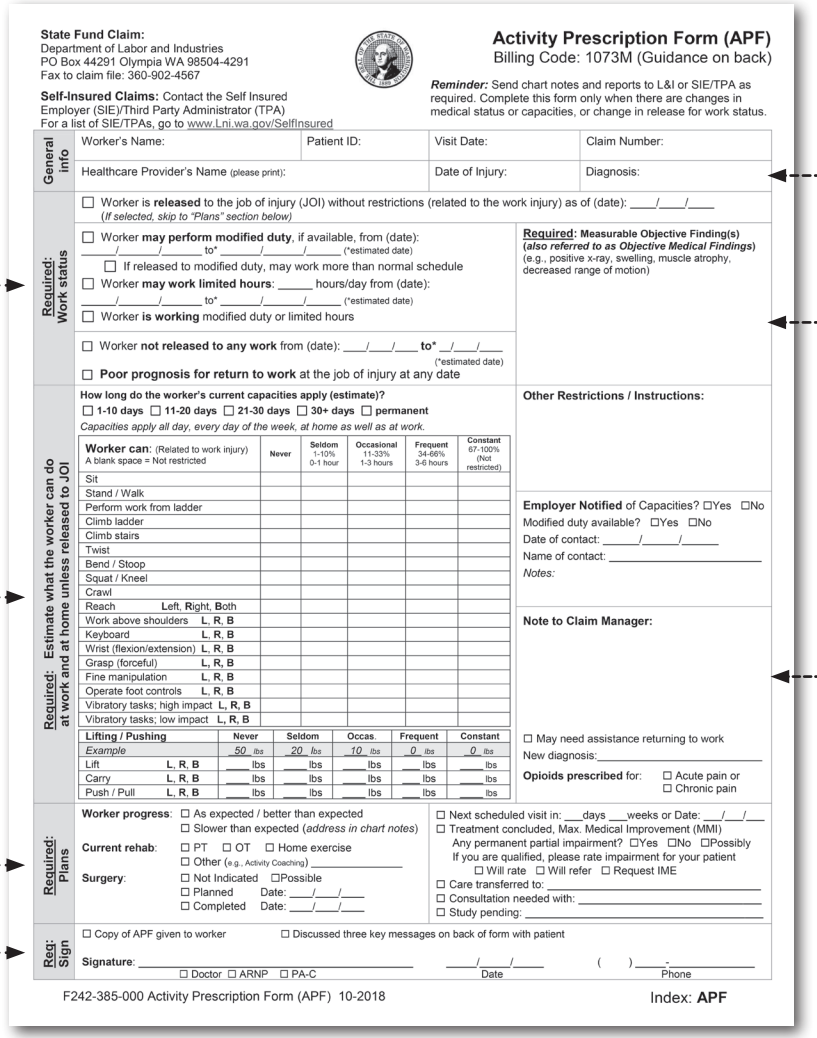
Plans:

Please check all that apply in both columns.

Schedule your patient's next visit to take place within any date range you indicated in the Work Status section above (unless you are releasing the patient to full duty).

Sign:

Sign, date, and check your provider type.



State Fund Claim:
Department of Labor and Industries
PO Box 44291 Olympia WA 98504-4291
Fax to claim file: 360-902-4567

Self-Insured Claims: Contact the Self Insured Employer (SIE)/Third Party Administrator (TPA)
For a list of SIE/TPAs, go to www.Lni.wa.gov/SelfInsured

Activity Prescription Form (APF)
Billing Code: 1073M (Guidance on back)

Reminder: Send chart notes and reports to L&I or SIE/TPA as required. Complete this form only when there are changes in medical status or capacities, or change in release for work status.

General info: Worker's Name: | Patient ID: | Visit Date: | Claim Number:
Healthcare Provider's Name (please print): | Date of Injury: | Diagnosis:

Required: Work status
☐ Worker is **released** to the job of injury (JOI) without restrictions (related to the work injury) as of (date): ___/___/___ *(If selected, skip to "Plans" section below)*
☐ Worker **may perform modified duty**, if available, from (date): ___/___/___ to* ___/___/___ (*estimated date)
☐ If released to modified duty, may work more than normal schedule
☐ Worker **may work limited hours**: _____ hours/day from (date): ___/___/___ to* ___/___/___ (*estimated date)
☐ Worker **is working** modified duty or limited hours
☐ Worker **not released to any work** from (date): ___/___/___ **to*** __/___/___ (*estimated date)
☐ **Poor prognosis for return to work** at the job of injury at any date

Required: Measurable Objective Finding(s) ***(also referred to as Objective Medical Findings)*** (e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)

Required: Estimate what the worker can do at work and at home unless released to JOI

How long do the worker's current capacities apply (estimate)?
☐ **1-10 days** ☐ **11-20 days** ☐ **21-30 days** ☐ **30+ days** ☐ **permanent**
Capacities apply all day, every day of the week, at home as well as at work.

Worker can: (Related to work injury) A blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% (Not restricted)
Sit					
Stand / Walk					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist (flexion/extension) L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					
Vibratory tasks; high impact L, R, B					
Vibratory tasks; low impact L, R, B					

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift L, R, B	___ lbs	___ lbs	___ lbs	___ lbs	___ lbs
Carry L, R, B	___ lbs	___ lbs	___ lbs	___ lbs	___ lbs
Push / Pull L, R, B	___ lbs	___ lbs	___ lbs	___ lbs	___ lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐Yes ☐No
Modified duty available? ☐Yes ☐No
Date of contact: ___/___/___
Name of contact: _____
Notes:

Note to Claim Manager:

☐ May need assistance returning to work
New diagnosis:_____
Opioids prescribed for: ☐ Acute pain or ☐ Chronic pain

Required: Plans
Worker progress: ☐ As expected / better than expected ☐ Slower than expected *(address in chart notes)*
Current rehab: ☐ PT ☐ OT ☐ Home exercise ☐ Other (e.g., Activity Coaching) _____
Surgery: ☐ Not Indicated ☐Possible ☐ Planned Date: ___/___/___ ☐ Completed Date: ___/___/___

☐ Next scheduled visit in: ___days ___weeks or Date: ___/___/___
☐ Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? ☐Yes ☐No ☐Possibly
If you are qualified, please rate impairment for your patient
☐ Will rate ☐ Will refer ☐ Request IME
☐ Care transferred to: _____
☐ Consultation needed with: _____
☐ Study pending: _____

Reg: Sign
☐ Copy of APF given to worker ☐ Discussed three key messages on back of form with patient
Signature: _____ ___/___/___ ( )___-___
☐ Doctor ☐ ARNP ☐ PA-C Date Phone

F242-385-000 Activity Prescription Form (APF) 10-2018 Index: **APF**

Complete this form online by going to **www.Lni.wa.gov/ActivityRX**.

Diagnosis:

Provide the reason for today's visit or primary diagnosis (ICD code(s) or written description).

Measurable Objective Findings:

(also referred to as Objective Medical Findings)

Examples of findings we CAN accept:

- *X-rays*
- *Swelling*
- *Muscle atrophy*
- *Increased/decreased range of motion.* (Chart note must include ROM measurements).

Examples of findings we CANNOT accept:

- *Pain*
- *Tenderness*
- *See chart notes*

Note to Claim Manager:

You may use this box to communicate important information the form does not require.

Example: *I am the new Attending Provider (AP) or Pending surgical authorization.*

Upon request, foreign language support and formats for persons with disabilities are available. Call 1-800-547-8367. TDD users, call 711. L&I is an equal opportunity employer.

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