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| --- | --- |
| Clinic Name  |       |
| Address  |       |
| Phone number |       |

 | **Work Rehabilitation****Care Conference** |
| Worker Name:      | Date of Injury:      | Claim Number(s):      |
| Conference Date:      | Program Type: [ ]  WR - Conditioning [ ]  WR - Hardening |
| Attending/Referring Provider:       | Next AP appointment Date: [ ]  Unknown       |
| Job Goal:       | Physical Demand Level of Job Goal:       |
| Vocational Provider:       | Modified Work Options: : [ ] Full-Duty [ ] Modified Duty [ ]  Not Working [ ]  Other |
| Date of WR Evaluation:      | Approved # of Weeks:      | Current week #:       | Attendance:   /   Scheduled Visits# Cancellations:    # No Show:     |
|  |
| **Team Discussion** |
| **Functional Progress Achieved to Date:** *(i.e. positional tolerances, material handling, body mechanics, pacing, and work simulation)* | **Functional Goal** |
| *Example: Occasional lifting floor to waist 10 pounds* | *Occasional lifting floor to waist 40 pounds* |
|       |       |
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| **Identify and outline the plan to meet return to work goals and address any barriers:** (*What is the focus for the next two weeks and who will address specific tasks*) |
|       |

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| **Change in Plan of Care:**   |
|       |

Next Care Conference Date:       Time:

Anticipated Discharge Date is Planned for:

**Attendees** OT:       PT:       COTA:       PTA/ATC:

AP:       [ ]  Phone [ ]  In-clinic [ ]  Not available VRC:       [ ] Phone [ ] In-clinic [ ]  Not available

L&I Representative:

Conference Start/End Time       to