Activity Prescription Form Completeness Standards 3/08

State Fund Claims: Dept. of Labor and Industries - Claims Section
PO Box 44291, Olympia WA 98504-4291

Self-Insured Claims: Contact the Self Insured Employer (SIE)/Third Party Administrator (TPA)*

INSURER ACTIVITY PRESCRIPTION FORM (APF)
***WITH INSTRUCTIONS* for training purposes.**
Reminder: Send chart notes and reports to L&I, or to SIE/TPA as usual

Billing Code: 1073M (Guidance on back)

General Info

Worker's Name: | Visit Date: | Claim Number:

Health-care Provider's I

All sections should be complete. A clinic sticker may be used if ALL information is provided (claim #, ICD-9, etc.)

Released for work? *Check one*

☐ Worker is **released** to the job of injury without restrictions on (date): ____/____/____ *Skip to "Plans" section below*

☐ Worker **may perform m** d duties or limited hours), if available, from (date): ____/____/_ ___ for _____hours/day

Estimate physical capacities e Key Objective Findings to the right.

☐ Worker **not released to** e): ____/____/____ to ____/____/____

☐ **Prognosis poor for** he job of injury at any date

☐ May need assistanc

Estimate physical capacities below and complete the Key Objective Findings to the right.

One section must be completed with dates or date span.

Key Objective Finding(s)
Required for time-loss payment decisions

Required, if anything other than full release. to JOI

Doctor's Estimate of Physical Capacities

☐ **Temporary Restrictions** ☐ **Permanent / Indefinite Restrictions**

Worker can: (Related to work injury.) Blank space		Seldom	Occasional	Frequent	Constant
Sit					
Stand / Walk					
Climb (ladder / sta					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach					
Work above shoul					
Keyboard					
Wrist (flexion/exte					
Grasp (forceful)					
Fine manipulation					
Operate foot controls	**L**, **R**, **B**				

At least one box completed or restriction written at right, IF worker on modified duty or off work.

The number of restrictions indicated is up to the professional discretion of the provider. Only the provider, examining the patient, will be able to determine the appropriate restriction. Remember, those left blank are not restricted, so one restriction may be appropriate.

Restrictions are applicable 24 hours per day, not just at work.

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	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs

Other Restrictions / Instructions:

Approved Absence Dates: *required for Boeing (SI employer)*

Employer Notified of restrictions? ☐Yes ☐No
Date notified: ___/___/___
Modified duty: ☐ Available ☐ Not available
Notes:

***Not required**, but advisable best practice*

Note to Claim Manager:

***Not required**. Provider will complete to draw CM's attention to issue (i.e." r. shoulder should be added to claim")*

Plans

Worker progress: ☐ As expected/better than expected. *Circle one*
☐ Slower than expected. *Address in chart notes*

Current rel

At least one box checked or note made.

Surgery: ☐ Indicated / planned ☐ Not indicated
Comments:

☐ Next scheduled visit is: ____/____/____
☐ None, treatment concluded, Max. Medical Improvement (MMI)
A bly
V
I
☐ C
☐ Study pending:_____
☐ Consultation scheduled with:_____

At least one box checked or note made.

Sign

Signature: _ _ ( )____-_____ Date: _____/_____/_____
Phone number

Signature & date required

☐ Copy of APF given to worker (To show it to employer) ☐ Talking points (on back) discussed with worker

Activity Prescription Form (APF) Instructions

To ensure payment, please include all required information as detailed below:

General Info Section: All fields in the "General Info" section **MUST** be completed. Patient identification (peel and stick) labels may be used, as long as all the requested information is provided. ICD-9 codes or written diagnoses may be used.

"Released for Work?" Section: One box **MUST** be completed to indicate work status; dates or a time span must be included.

Key Objective Findings: If the worker is not returned to full duty, objective medical findings (OMF) **MUST** be documented. OMF are verifiable on exam. Examples are: x-rays, swelling, muscle atrophy, decreased ROM. They do not include subjective complaints such as pain, tenderness or fatigue.

Estimate of Capacities Section: Restrictions are applicable 24 hours a day, not just at work, so restrictions **MUST** be provided even when the patient is off work. In addition, including current restrictions may enable employers to identify appropriate light/modified duty jobs.

- A provider phone call to the employer is not required but is an advisable best practice. It may be billed for in addition to this form (with proper supporting documentation).
- The note to claim manager is not required. It is intended to assist you in drawing the claim manager's attention to an issue, i.e. "right shoulder strain should be included on claim."
- Approved absence dates in the "Other Restrictions/Instructions" section is an optional field that is only required for Boeing employees.

Plans Section: Your plan **MUST** be documented. Please include your assessment of progress, any rehabilitation, and if treatment is continuing or concluded. This information is critical for claim management decisions.

Sign Section: Your signature, along with the date MUST be provided.

Please note: This form's purpose is to give the claim manager timely information for time-loss payment and treatment authorizations. Writing "See chart notes" on an APF is not acceptable because chart notes are not standardized and typically arrive in the claim file later than the APF. To be complete, all relevant information must be stated on this form.

Additional Resources for Claim Managers:

Web address: www.ActivityRx.Lni.wa.gov