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 **L**eft, **R**ight, **B**oth					
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

Discuss your patient's role in their recovery
Research has shown that returning to activity (including lighter work) speeds recovery and reduces the risk of becoming disabled from most work-injuries. In addition to providing good clinical care, it is important to set expectations for a good recovery and assure patients understand the importance of doing their part. Take just a couple minutes during an initial office visit to explain the following (check each one as you complete it):

Key Messages

1. **"You must help in your own recovery…"**
   - Only you can ensure your own successful recovery.
   - It's your job (and my expectation) that you follow activity recommendations (both at home and at work).
2. **"Activity helps recovery…"**
   - Bodies heal best with activity that you can safely do, and need to do, to recover.
   - Incrementally increase the activity you do a little bit, each day.
   - Some discomfort is normal when returning to activities after an injury. This is not harmful, and is different from pain that indicates a setback.
3. **"Early and safe return to work makes sense…"**
   - Return to work is one of the goals of treatment.
   - The longer you are off work, the harder it is to get back to your original job and wages.
   - Even a short time off work takes money out of your pocket because time loss payments do not pay your full wage.

To be paid for this form, providers must:

1. Submit this form:
   - With reports of accident when there are work related physical restrictions, or
   - When documenting a change in your patient's medical status or capacities.
2. Complete all relevant sections of the form.
3. Send chart notes and reports as required.

Important notes

- A provider may submit up to 6 APFs per worker within the first 60 days of the initial visit date and then up to 4 times per 60 days thereafter.
- Use this form to communicate expectations of the patient to be physically active during recovery, work status, activity restrictions, and treatment plans.
- This form will also certify time-loss compensation, if appropriate.
- Occupational and physical therapists, office staff, and others will not be paid for working on this form.

To learn how to complete this form, go to www.Lni.wa.gov/activityRX.

About impairment ratings

We encourage you, the qualified attending health-care provider, to rate your patient's permanent impairment. If this claim is ready to close, please examine the worker and send a rating report.

Qualified attending health-care providers include doctors currently licensed in medicine and surgery (including osteopathic and podiatric) or dentistry, and chiropractors who are department-approved examiners.

Thank you for treating this injured worker