

State Fund Claim:

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



Activity Prescription Form (APF)

Billing Code: 1073M (Guidance on back)

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

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	<input type="checkbox"/> 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)																																																																																																																						
	<input type="checkbox"/> Worker may perform modified duty , if available, from (date): ____/____/____ to* ____/____/____ (*estimated date) <input type="checkbox"/> If released to modified duty, may work more than normal schedule <input type="checkbox"/> Worker may work limited hours : ____ hours/day from (date): ____/____/____ to* ____/____/____ (*estimated date) <input type="checkbox"/> Worker is working modified duty or limited hours			Required: Measurable Objective Finding(s) (e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)																																																																																																																			
	<input type="checkbox"/> Worker not released to any work from (date): ____/____/____ to* ____/____/____ (*estimated date) <input type="checkbox"/> Poor prognosis for return to work at the job of injury at any date																																																																																																																						
How long do the worker's current capacities apply (estimate)? <input type="checkbox"/> 1-10 days <input type="checkbox"/> 11-20 days <input type="checkbox"/> 21-30 days <input type="checkbox"/> 30+ days <input type="checkbox"/> permanent Capacities apply all day, every day of the week, at home as well as at work.																																																																																																																							
Required: Estimate what the worker can do at work and at home unless released to JOI	Other Restrictions / Instructions:																																																																																																																						
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Worker can: (Related to work injury) A blank space = Not restricted</th> <th style="width:10%;">Never</th> <th style="width:10%;">Seldom 1-10% 0-1 hour</th> <th style="width:10%;">Occasional 11-33% 1-3 hours</th> <th style="width:10%;">Frequent 34-66% 3-6 hours</th> <th style="width:10%;">Constant 67-100% (Not restricted)</th> </tr> </thead> <tbody> <tr><td>Sit</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Stand / Walk</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Perform work from ladder</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Climb ladder</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Climb stairs</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Twist</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Bend / Stoop</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Squat / Kneel</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Crawl</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Reach Left, Right, Both</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Work above shoulders L, R, B</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Keyboard L, R, B</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Wrist (flexion/extension) L, R, B</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Grasp (forceful) L, R, B</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Fine manipulation L, R, B</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Operate foot controls L, R, B</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Vibratory tasks; high impact L, R, B</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Vibratory tasks; low impact L, R, B</td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>					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					
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Employer Notified of Capacities? <input type="checkbox"/> Yes <input type="checkbox"/> No Modified duty available? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of contact: ____/____/____ Name of contact: _____ Notes: _____																																																																																																																							
Note to Claim Manager:																																																																																																																							
<input type="checkbox"/> May need assistance returning to work New diagnosis: _____ Opioids prescribed for: <input type="checkbox"/> Acute pain or <input type="checkbox"/> Chronic pain																																																																																																																							
Required: Plans	Worker progress: <input type="checkbox"/> As expected / better than expected <input type="checkbox"/> Slower than expected (<i>address in chart notes</i>)		<input type="checkbox"/> Next scheduled visit in: ____ days ____ weeks or Date: ____/____/____ <input type="checkbox"/> Treatment concluded, Max. Medical Improvement (MMI) Any permanent partial impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possibly If you are qualified, please rate impairment for your patient <input type="checkbox"/> Will rate <input type="checkbox"/> Will refer <input type="checkbox"/> Request IME																																																																																																																				
	Current rehab: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Home exercise <input type="checkbox"/> Other (e.g., Activity Coaching) _____		<input type="checkbox"/> Care transferred to: _____ <input type="checkbox"/> Consultation needed with: _____ <input type="checkbox"/> Study pending: _____																																																																																																																				
Req: Sign	Surgery: <input type="checkbox"/> Not Indicated <input type="checkbox"/> Possible <input type="checkbox"/> Planned Date: ____/____/____ <input type="checkbox"/> Completed Date: ____/____/____																																																																																																																						
	<input type="checkbox"/> Copy of APF given to worker <input type="checkbox"/> Discussed three key messages on back of form with patient		Signature: _____ /____/____ () _____ - _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <input type="checkbox"/> Doctor <input type="checkbox"/> ARNP <input type="checkbox"/> PA-C Date Phone </div>																																																																																																																				

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.