ABILITY TO WORK REPORT – ONEIDA COUNTY CSA

Patient Name: Date of Birth: SSN:

PLEASE SELECT **ONE** OF THE FOLLOWING OPTIONS:

1. _____ Patient is PERMANENTLY & TOTALLY DISABLED as of _____ (date).

OR

2. _____ Patient is TEMPORARILY & TOTALLY DISABLED as of _____ (date) through _____ (date) **AND**

   a) On _____ (date), patient will be reevaluated.

   OR

   b) Patient has been referred to _____ for further treatment/opinion.
   Name/Address/City/State/Phone: _____
   _____
   _____

OR

3. _____ Patient is (Choose one: PERMANENTLY or TEMPORARILY) PARTIALLY DISABLED and has the following work restrictions as of _____ (date), as follows/attached:
   _____
   _____
   _____
   will be reevaluated on _____ (date) OR
   will be released to return to work without restrictions on _____ (date).

1. State the medical problem(s) which cause the inability, including diagnosis and date of injury/illness:

2. Has the patient kept all appointments during the last six months? If not, list the missed appointments.

3. What is the date of the next appointment that the patient has with you?

4. What is the prognosis regarding the ability to work for the patient if she/he follows your recommendation? (Please include list of recommendations)

5. What is the prognosis regarding the ability to work for the patient if she/he does not follow your recommendation?

6. What possible treatments (such as medications/surgery) would be likely to improve the patient's ability to work? Of these, which have already been tried?

7. Name any treatments the patient has refused to try.

Medical Provider's Signature (No Stamps): _____ Date:_____

Medical Provider's Printed or Stamped:
Name:_____
Address:_____
City: _____
State: _____
Phone: _____

Please return to:
Oneida County Dept. of Social Services
Child Support Agency
P. O. Box 400
Rhinelander, WI 54501
FAX: 715-362-7910