

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																																																																																																																											
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)? <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.					Other Restrictions / Instructions:																																																																																																																						
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Required: Plans Worker progress: <input type="checkbox"/> As expected / better than expected <input type="checkbox"/> Slower than expected (<i>address in chart notes</i>) Current rehab: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Home exercise <input type="checkbox"/> Other (e.g., Activity Coaching) _____ Surgery: <input type="checkbox"/> Not Indicated <input type="checkbox"/> Possible <input type="checkbox"/> Planned Date: ____/____/____ <input type="checkbox"/> Completed Date: ____/____/____ <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 <input type="checkbox"/> Care transferred to: _____ <input type="checkbox"/> Consultation needed with: _____ <input type="checkbox"/> Study pending: _____																																																																																																																												
					Reg: Sign <input type="checkbox"/> Copy of APF given to worker <input type="checkbox"/> Discussed three key messages on back of form with patient Signature: _____ _____/____/____ () _____ <input type="checkbox"/> Doctor <input type="checkbox"/> ARNP <input type="checkbox"/> 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.