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)
(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

RESET

Index: **APF**

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.