SAVE THE BRAIN

RETURN TO WORK FOLLOWING CONCUSSION

This form must be filled out by a licensed healthcare provider.

Employee Name____ Date____________________

Date of Injury_________________ Healthcare Provider__________________________________

	Attendance
	No work for ____ day(s)
	Attendance at work _____ days per week
	Attendance at work _____ hours per day
	Partial work days as tolerated by the employee Starting: ___________
	Full work days as tolerated by the employee Starting __________
	Visual Stimulus
	Allow employee to wear sunglasses/hat at work
	No computer use
	Limited computer, TV screen, bright screen use Time limit ________ hours
	Reduce brightness on monitor/screen
	Change office seating to a quiet location
	Workload/Multi-Tasking
	Light duty
	Additional time to complete tasks
	No more than one task a day

	Breaks
	Allow the employee to take a break if symptoms increase
	Take _____ minute rest every _______ hour(s)
	Allow employee to go home if symptoms do not subside
	Audible Stimulus
	Lunch in a quiet place
	Allow to wear earplugs as needed
	Physical Exertion
	No physical exertion, lifting, climbing
	No driving
	Walking and driving ________ minutes/hour(s)
	Light lifting, climbing
	Additional Recommendations/Restrictions

The patient will be reassessed for revision of the recommendations in ____________ weeks. This patient has been diagnosed with a concussion (brain injury) and is currently under our care. Flexibility and additional supports are needed during recovery. The above are recommendations for workload adjustments to be individualized for the employee.

I, ______________________________, give permission for __________________________________ to share the above information with my employer.

Patient Signature____ Date________________________

Provider Information:

Name______________________________________ Address____

Office Phone _________________________________ Fax ____

Provider Signature____ Date_________________________

Save the Brain Concussion Clinic (406) 758-7035

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