

RESTRICTIONS / RELEASE FORM



Northern Illinois Medical Center
Emergency Department
4201 Medical Center Drive
McHenry, Illinois 60050
(815) 344-5000



Memorial Medical Center
3701 Doty Rd.
Woodstock, Illinois 60098
(815) 334-3900

PATIENT NAME

Paul Dulberg

DATE

6/28/2011

PHYSICIAN SIGNATURE

[Signature]



1117900323
 DULBERG, PAUL R
 M 41Y 03/19/1970
 06/28/2011 B 0000109381

☐ May return to ☐ work ☐ school ☐ gym without restriction.

☒ May not return to ☒ work ☐ school ☐ gym for 2 day(s).

☐ May return to school with the following restrictions:

☐ Gym/Sports restrictions are _____ for _____ day(s).

☐ Must take prescription medication for _____ day(s).

☐ May return to work with the following restrictions:

☐ No lifting greater than _____ lbs. for _____ day(s).

☐ Machinery/Driving restriction while on medication that can cause drowsiness.

☐ No continuous ☐ standing ☐ sitting for _____ day(s).

☐ Must keep _____ elevated for _____ day(s).

☐ Sedentary work only for _____ day(s).

☐ Must use crutches for _____ day(s).

☐ No overhead work for _____ day(s).

☐ No bending or twisting for _____ day(s).

☐ Must wear immobilizer for _____ day(s).

☐ No climbing on ladder or stairs for _____ day(s).

☐ Other _____

☐ See your physician in _____ days for reevaluation.

☐ LIMITED WORK WITH
☐ NO WORK WITH

<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Hand	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Arm
<input type="checkbox"/> Foot	<input type="checkbox"/> Foot
<input type="checkbox"/> Leg	<input type="checkbox"/> Leg

For _____ Days

All patients are referred to their personal physicians or a doctor on the staff of this hospital. Release from restriction must be obtained from that doctor and not the Emergency Department.

I (or responsible person) have/has received and understand(s) the instructions to follow as noted above.

Patient signature (or responsible person):

Paul Dulberg

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DATE 09/14/2012

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