HEADWATERS Health Care Centre

ATTENDING PRACTITIONER STATEMENT/FUNTIONAL ABILITIES FORM CONFIDENTIAL

Return completed forms to:
Occupational Health and Safety
100 Rolling Hills Drive
Orangeville, ON L9W 4X9
Phone: 519-941-2410 ext. 2801
Confidential FAX: 519-941-2342

Employee Name:	**DOB:**
Department/Position:	**Manager:**
Last Day Worked:	**First Day Missed:**

I hereby authorize my Health Care Provider, to release information requested by Headwaters Healthcare Centre Occupational Health Safety and Safety Department with respect to this injury/illness; return to work; and/or my claim for disability benefits. I acknowledge my obligation to ensure the completion of this form and its prompt return to OHS.
I understand that *ALL sections must be completed in order for this application to be processed and that* omission of information, including signatures, may result in disruption of short term disability benefits and/or return to work.

EMPLOYEE'S SIGNATURE: ________________________________ **DATE** (dd/mm/yy)**:**____________________________

TO HEALTH CARE PROVIDER: *Please complete the most appropriate abilities form (physical or cognitive or both) attached.*
Fully complete the sections below based on your objective assessment.
Omission of information may result in disruption of benefits or delay in return to work.
Headwaters Healthcare Centre is committed to facilitating transitional/modified return to work. Providing this information will assist Occupational Health and Safety in planning for the employee's successful return to pre-disability condition.

This section to be Completed by Health Care Practitioner for Current Medical Condition/Absence

Please complete sections in their entirety

Type of disability (check all that apply): □ Illness □ Injury □ Communicable Disease
□ Work Related Illness/Injury (WSIB) □ WSIB Health Professional's Report (Form 8) submitted?
□ Surgery □ Motor Vehicle Accident □ Non OHIP Procedure
Nature of disability: ______________________________________ Hospitalized? □ No □ Yes, from _______ to _______

Date of illness/injury onset __________________________ Date of first assessment _____________________________

Date of exam this report based on _____________________ Date of next reassessment ______________________________

Return to Work Planning: Patients employer has variety of modified duties; RTW process does NOT require 100% fitness to be at work. Most restrictions / limitations can be accommodated prior to FULL recovery as part of recovery and work hardening.
****To be considered completed in full ALL questions must be answered ****
Based on your current assessment and accepted recovery times for your patient's condition please advise:
If can participate in transitional return to work program now (goal of return to full duties/hours within 8 weeks? - YES □ NO □
If can return to regular hours now? – YES □ NO □ OR Reduced hours now? – YES □ NO □
If can perform **sedentary** (clerical, self-paced) duties now? – YES □ NO □;
Light duties – YES □ NO □ Medium duties – YES □ NO □ Heavy duties YES □ NO □
(Refer to definitions of light, medium, heavy provided on physical abilities form)
If answered no to all of above is patient considered totally disabled from being able to work in **ANY** capacity? YES □ NO □
If totally disabled answer the following:
Signs/symptoms____
Treatment Plan/dates:____
Referrals:____
Advise date may be considered able to participate in a transitional return to work program? _____________________
Advise date may be considered **fully** recovered? ______________________________

MUST HAVE OFFICE STAMP AND SIGNATURE TO BE CONSIDERED VALID

Health Care Provider's NAME, ADDRESS, SPECIALITY (Please print and stamp):	**Health Care Provider's SIGNATURE:**	**DATE:**

HEADWATERS Health Care Centre

ATTENDING PRACTITIONER STATEMENT/FUNTIONAL ABILITIES FORM PHYSICAL ABILITIES

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EMPLOYEE'S NAME (Please Print): ____

PLEASE COMPLETE THE FOLLOWING TO IDENTIFY ANY/ALL ABILITIES RELATED TO PHYSICAL FUNCTION USING NATIONAL OCCUPATIONAL CLASSIFICATION (NOC) DEFINITIONS (Provided below)

Weight Handled	Frequency
Limited: Handle loads up to 5 kg **Light:** Handle loads from 5 kg but less than 10 kg **Medium:** Handle loads from 10 – 20 kg **Heavy:** Handle loads over 20 kg	**Intermittent:** <30min/day **Occasional:** <1hr/day or 1 repetition/30 minutes **Frequent:** 1 – 3 hrs/day or 1 repetition/2 minutes **Constant:** >3hrs/day or 1 repetition/30 seconds

WALKING:	STANDING:	SITTING:	LIFTING – Weight	LIFTING – Frequency	LIMITED ABILITY TO LIFT:
☐Full Abilities ☐Up to 100 Metres ☐100 to 200 Metres ☐Ability to change position	☐Full Abilities ☐Up to 15 Min. ☐15 to 30 Min. ☐Ability to change position	☐Full Abilities ☐Up to 30 Min. ☐30 -60 Min. ☐Ability to change position	☐Full Abilities ☐Limited ☐Light ☐Medium ☐Heavy ☐None	☐Full Abilities ☐Intermittent ☐Occasional ☐Frequent ☐Constant	☐Full Abilities ☐Floor to Waist ☐Waist to Shoulder ☐Above Shoulder

CARRYING – Weight	CARRYING – Frequency	PUSHING/PULLING – Weight	PUSHING/PULLING – Frequency	REACHING	STAIR CLIMBING:
☐Full Abilities ☐Limited ☐Light ☐Medium ☐Heavy ☐None	☐Full Abilities ☐Intermittent ☐Occasional ☐Frequent ☐Constant	☐Full Abilities ☐Limited ☐Light ☐Medium ☐Heavy ☐None	☐Full Abilities ☐Intermittent ☐Occasional ☐Frequent ☐Constant	☐Full Abilities ☐Below Waist ☐At Waist ☐At Shoulder ☐Above Shoulder ☐Forward	☐Full Abilities ☐Up to 5 Steps ☐5 to 10 Steps ☐None

LADDER CLIMBING:	CROUCHING/KNEELING:	HAND LIMITATIONS:	TRAVEL TO WORK:
☐Full Abilities ☐1 to 3 Steps ☐4 to 6 Steps ☐None	☐Full Abilities ☐Occasional ☐Frequent ☐None	☐Full Abilities ☐Hold Objects ☐Grip ☐Type ☐Write	Ability to use Public Transit: ☐Yes ☐No Ability to Drive a Car: ☐Yes ☐No

BENDING/TWISTING REPETITIVE MOVEMENT:	CHEMICAL EXPOSURE TO: / ENVIRONMENTAL EXPOSURE TO:	OPERATE EQUIPMENT/MOTORIZED VEHICLE	
☐Full Abilities ☐Avoid ☐Occasional ☐Limited (please specify)	**CHEMICAL EXPOSURE TO:** **ENVIRONMENTAL EXPOSURE TO:**	☐ Full Abilities ☐ Limited – Explain:	
		DURATION OF LIMITATIONS: ☐3 to 7 Days ☐8 to 14 Days ☐14 to 30 Days ☐> 30 Days (Explain below)	**RECOMMENDED WORK HOURS:** ☐Regular ☐Reduced Describe below:

Under active treatment ☐ Yes ☐ No
Referral to specialist ☐ Yes ☐ No **Date**______________
Complete recovery expected ☐ Yes ☐ No

Have you discussed return to work goals ☐ Yes ☐ No
If yes, please comment below
Compliant with treatment ☐ Yes ☐ No

Additional l Comments

HEADWATERS Health Care Centre

ATTENDING PRACTITIONER STATEMENT/FUNTIONAL ABILITIES FORM

COGNITIVE ABILITIES

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EMPLOYEE'S NAME (please print):____

TO BE COMPLETED IF LIMITATIONS/RESTRICTIONS ARE IMPACTING PSYCHOLOGICAL/ PSYCHOSOCIAL OR COGNITIVE ABILITIES/FUNCTIONS:
(Please check corresponding answer. If has restrictions/limitations please specify level of impairment)

Ability to self-supervise	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to supervise others	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to meet deadlines under pressure	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to follow instructions	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to attend to detail (Attention/Concentration)	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to perform multiple tasks	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to manage stressful situations	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to recall (Short-term Memory)	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability for decision making, organizing & planning	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to tolerate emotional/confrontational situations	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to work co-operatively with others	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to communicate verbally/ written /comprehension	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to exercise judgement in safety sensitive situations (Critical Thinking)	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to tolerate environmentally distracting stimuli (Noise, Temperature, Lighting)	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to work with the public	☐ No Restrictions	Restrictions: ☐ mild ☐ moderate ☐ severe
Ability to work alone	☐ Yes ☐ No	
Ability to perform calculations (Reconstitution)	☐ Yes ☐ No	
DURATION OF LIMITATIONS: ☐3 to 7 Days ☐8 to 14 Days ☐14 to 30 Days ☐> 30 Days (Explain below)	TRAVEL TO AND FROM WORK: Ability to use public transit Ability to drive a car	☐ Yes ☐ No ☐ Yes ☐ No
Under active treatment	☐ Yes ☐ No	
Referral to specialist	☐ Yes ☐ No If yes, dates of appointment ________________	
Complete recovery expected	☐ Yes ☐ No	
Have you discussed return to work goals	☐ Yes ☐ No If yes, please comment below	
Compliant with treatment	☐ Yes ☐ No	

Additional Comments: