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MEDICAL INFORMATION AND FUNCTIONAL ABILITIES FORM

Carleton University is dedicated to ensuring the safe and healthy return to work of our employees. We ask that this form be completed in its entirety so that the University has the necessary information to plan for a successful return to work for this employee.

To our Employee: At Carleton University, we recognize and respect the importance of privacy. Personal information that we collect is kept confidential. Please ask your attending physician or health practitioner to complete the bottom portion of this form. Failure to provide consent for the release of the functional abilities information can result in loss of benefits.

Employee Information (to be completed by the employee):

Name: Employee ID Number:

Last day worked:

Employee Authorization: I authorize any Health Professional involved with my treatment to provide my employer with this form when completed, containing information including any medical limitations/restrictions related to my ability to return to work or perform my assigned duties.

Employee Signature: Date:

To the attending Physician or Health Practitioner: Please complete and return this form to the employee.

Approximate date of commencement of illness: _____

Most recent examination date: _____

Date of next appointment for review of capabilities: _____

Prognosis for recovery: _____

Has this employee been referred to a specialist? If yes, what date? _____

Is the illness or injury being treated work-related? _____

Is the employee capable of returning to work immediately without limitations? ◯ Yes ◯ No

Is the employee capable of returning to work with restrictions? ◯ Yes ◯ No

If yes, please detail expected duration of the restrictions: _____

Musculoskeletal

Please check restrictions if any, and provide comments where applicable (%, kg, degree, repetition, not applicable, etc.)

Body part/area	Comments
◯ Neck	
◯ Shoulder	
◯ Elbow	
◯ Wrist/Hand	
◯ Finger	
◯ Back	
◯ Hip	
◯ Knee	
◯ Ankle/Foot	

Functional Walking:
◯ Full abilities ◯ Up to 100 meters ◯ 100-200 meters ◯ Other: _____
Standing:
◯ Full abilities ◯ Up to 15 minutes ◯ 15-30 minutes ◯ Other: _____
Sitting:
◯ Full abilities ◯ Up to 30 minutes – 1 hour ◯ Other: _____
Lifting from floor to waist:
◯ Full abilities ◯ Up to 5 kilograms ◯ 5-10 kilograms ◯ Other: _____
Lifting from waist to shoulder:
◯ Full abilities ◯ Up to 5 kilograms ◯ 5-10 kilograms ◯ Other: _____
Stair climbing:
◯ Full abilities ◯ Up to 5 steps ◯ 5-10 steps ◯ Other: _____
Ladder climbing:
◯ Full abilities ◯ 1-3 steps ◯ 4-6 steps ◯ Other: _____

Travel to Work: Ability to use public transit ◯ Yes ◯ No
Ability to drive a car ◯ Yes ◯ No
Additional Comments: _____

Difficulty in: ◯ Bending/twisting repetitive movement of: _____
◯ Working at or above shoulder activity: _____

Limited pushing/pulling with:
◯ Not applicable ◯ Left arm ◯ Right arm ◯ Other: _____

Limited use of hand(s) or wrist(s):
◯ Not applicable
Typing/keyboard use: ◯ Left ◯ Right
Writing: ◯ Left ◯ Right
Gripping: ◯ Left ◯ Right
Pinching: ◯ Left ◯ Right
Other: _____ ◯ Left ◯ Right

Difficulty in:
◯ Not applicable
◯ Operating motorized equipment: _____ ◯ Operating machinery: _____
◯ Working at heights: _____ ◯ Situation Sensitivity: _____
◯ Chemical Exposure to: _____ ◯ Environmental conditions: _____
◯ Exposure to vibration: _____

Potential side effects from medications: _____

Additional Comments: _____

_____

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Behavioural and Cognitive

Please identify limitations/ restrictions if any and provide comments where applicable.

Communication:
◯ Full Abilities
◯ Limitations/Restrictions

Memory:
◯ Full Abilities
◯ Limitations/Restrictions

Cognitive demands:
◯ Full abilities
◯ Limitations/Restrictions

Are you aware of any work related issues that may have a negative effect on the employee's present medical condition?
◯ Yes
◯ No

Additional Comments: _____

_____

_____

Return to Work

Have you discussed return to work with your patient? ◯ Yes ◯ No

Estimated duration of limitations: ◯ ___ days ◯ 2-4 weeks ◯ 4-6 weeks
◯ 6-8 weeks ◯ 8-10 weeks ◯ > 10 weeks ◯ Permanent

Recommended hours of work: ◯ Full-time hours ◯ Graduated and/or Modified hours: _____

Recommended Start Date: _____

This employee will need to attend appointments at the following intervals: _____

_____

Health Physician's Name: _____

Specialty/Health Profession: _____

Address: _____

Telephone: _____

Date: _____ Health Physician's Signature: _____

Please return to:

Lori East, Benefits Officer - Human Resources
Carleton University, Room 507 Robertson Hall
1125 Colonel By Drive, Ottawa, Ontario K1S 5B6
Tel: 613-520-2600 ext. 8654
Fax: 613-520-4464