**RETURN TO WORK/STAY AT WORK**

**PHYSICIAN & COUNSELLOR PLANNING FORM**

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| **Background** | [Organization] is committed to the health and safety of its employees. As part of our commitment, our Return to Work/Stay at Work Program seeks to focus on the abilities of our employees, while recognizing any physical and/or cognitive limitations. Where appropriate, we will offer modified work that assists recovery and can be performed safely and effectively without placing your patient or other employees at undue risk. | |
| **Purpose** | We will use the information provided on this form to help us substantiate the requested medical leave, facilitate a safe and effective modified work arrangement at the appropriate time, clarify restrictions and limitations and/or ensure the [Organization] complies with legal and regulatory standards.  **The purpose of this form is NOT to inquire into illnesses/injuries or restrictions/limitations that are unrelated to this employee’s current illness and/or injury.** | |
| Employee (Patient) Name: | | Position: |
| Brief Description of Job Requirements:  [INSERT BRIEF DESCRIPTION OF JOB REQUIREMENTS] | | |
| **Patient Consent** | I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have authorized \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, my Health Care Provider, to complete this medical questionnaire.  Privacy Notification: Your personal health information is collected under the authority of section 26(c) of the *Freedom of Information and Protection of Privacy Act* (FIPPA). This information will be used for the purposes of enabling the [Organization] to assess your ability to return to work or consider a request for workplace accommodation. Questions about the collection of this information may be directed to [HR CONTACT].  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PATIENT SIGNATURE DATE | |

**CLINICAL INFORMATION**

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| **Area of Injury:** | **Nature of the medical condition:** |
| **Further improvement expected by:** | **Full recovery expected by:** |
| **Date of first consultation regarding this condition:** | |
| **Participation in and response to treatment to date:** | |
| **Under the care of a specialist? If yes, start date and frequency of visits:** | |
| **Is your patient currently able to return to work?** | |
| **YES, at full duties** – *If able to return to full duties, please skip to the* ***RECOMMENDED WORK HOURS/SCHEDULE*** *section of this form.* | |
| **YES, with modified duties** – *If able to return to modified duties, please indicate the limitations and restrictions on the following page(s).* | |
| **NO** – *If currently unable to return to work, please indicate the expected date they will be able to return to work.*  *My patient is able to return to work by (insert date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *with*  □ Full Duties or □ Modified Duties *(please indicate the limitations and restrictions in sections below)*  *and*  □ Full hours or □ Modified schedule *(please complete RECOMMENDED WORK HOURS/SCHEDULE)* | |

**PSYCHOLOGICAL/COGNITIVE RESTRICTIONS AND LIMITATIONS**

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| **LIMITATIONS** are defined as areas of function that may be impacted by a health condition but are not expected to be unsafe or cause aggravation of the condition. For example, an employee may have difficulty concentrating on writing reports; they can still write reports, but they may take more time to do so than is typical.  **RESTRICTIONS** are defined as activities that should not be performed by an employee because it is unsafe and/or will cause aggravation of the health condition. For example, an employee may experience side effects due to medication or have a health condition that make it unsafe for them to operate machinery or drive vehicles. | | | |
| **Areas of difficulty: please check areas in which the employee is experiencing difficulty** | **Limitation** | **Restriction** | **Severity of impairment: MILD, MODERATE, SEVERE** |
| **CONCENTRATION, PERSISTENCE AND PACE** | | | |
| □ concentration/attention |  |  |  |
| □ short-term memory |  |  |  |
| □ attention to detail |  |  |  |
| □ learning new material |  |  |  |
| □ working at a normal pace |  |  |  |
| □ stamina/endurance |  |  |  |
| **SOCIAL FUNCTIONING** | | | |
| □ regulating emotions |  |  |  |
| □ working collaboratively/cooperatively |  |  |  |
| □ managing specific social situations (meetings, public speaking, teaching, etc.) |  |  |  |
| □ receiving supervision |  |  |  |
| □ providing supervision |  |  |  |
| □ maintaining boundaries |  |  |  |
| **RESILIENCE TO CHANGE, STRESS AND COMPLEX SITUATIONS** | | | |
| □ managing emotional/confrontational situations |  |  |  |
| □ tolerance of distracting stimuli |  |  |  |
| □ adaptability/flexibility |  |  |  |
| □ deadlines/time pressures |  |  |  |
| □ multi-tasking |  |  |  |
| □ decision-making |  |  |  |
| □ problem solving/analyzing |  |  |  |
| □ responsibility/accountability |  |  |  |
| □ organizing/planning |  |  |  |
| **ACTIVITIES OF DAILY LIVING** | | | |
| □ self-care and hygiene |  |  |  |
| □ sleep |  |  |  |
| □ verbal communication |  |  |  |

**DURATION OF PSYCHOLOGICAL/COGNITIVE LIMITATIONS AND RESTRICTIONS**

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| How long do you anticipate these identified limitations/restrictions will be in effect? |

**PHYSICAL RESTRICTIONS AND LIMITATIONS**

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| Please check the appropriate injury box(es) below to indicate the medical and/or safety considerations we should implement in order to develop an appropriate offer of modified/light duties as your patient returns to work. |

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| **LOW BACK**  **Ensure the worker can:**   * Self-pace and/or take micro breaks * Change position between walking, standing and sitting   **Limit:**   * Walking on uneven ground * Lifting and carrying light or medium loads, depending on frequency and postures   **Avoid:**   * Jarring * Repetitive bending * Long periods of static standing or sitting * Extreme bending of the back * Twisting of the back | **SHOULDER**  **Ensure the worker can**:   * Self-pace and/or take micro breaks   **Limit:**   * Climbing ladders * Activities using arm above shoulder level, including reaching down * Activities that require lifting and carrying light or medium loads   **Avoid:**   * Holding the arm outstretched for periods especially while holding weights and applying force * Lifting and carrying with arm above shoulder level | **KNEE**  **Ensure the worker can:**   * Self-pace and/or take micro breaks * Occasionally elevate the knee * Frequently change position between walking, standing and sitting   **Limit:**   * Walking on uneven ground   **Avoid:**   * Long periods of standing or walking * Deep squatting, kneeling or crouching * Pivoting the knee * Activities requiring bracing, balancing or running * Stair use or running |
| **ANKLE**  **Ensure the worker can:**   * Self-pace and/or take micro breaks * Occasionally elevate the ankle   **Limit:**   * Stair use   **Avoid:**   * Long periods of standing or walking * Walking on uneven ground * Climbing ladders * Deep squatting and crouching * Activities requiring bracing, balancing or running | **ELBOW/FOREARM**  **Ensure the worker can:**   * Self-pace and/or take micro breaks   **Limit:**   * Repetitive or sustained gripping, especially where high forces are required * Repetitive elbow bending * Total time spent keyboarding/driving * Use of impact tools (including power tools and hammers)   **Avoid:**   * Hanging weights * Forearm rotations * Pressure on the elbow | **WRIST/HAND**  **Ensure the worker can:**   * Self-pace and/or take micro breaks   **Limit:**   * Repetitive or sustained gripping, especially where high forces are required * Lifting and carrying light to medium loads * Total time spent keyboarding/driving   **Avoid:**   * Extreme postures of the wrist, especially with force |
| **NECK**  **Ensure the worker can:**   * Self-pace and/or take micro breaks   **Limit:**   * Activities with arms above shoulder level, including reaching down * Activities with lifting and carrying light or medium loads * Hanging weights * Ladder climbing | **Avoid:**   * Lifting and carrying with arms above shoulder level * Extremes of looking up, down or over the shoulder, especially if sustained for more than a few seconds | **Strength categories for handling loads, as per the National Occupational Classification:**  **Limited**: Handling loads up to 5 kg  **Light**: Handling loads 5 kg - 10 kg  **Medium**: Handling loads 10 - 20 kg  **Heavy**: Handling loads more than 20 kg |

**ADDITIONAL PHYSICAL CONSIDERATIONS (OPTIONAL)**

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| Please specify any additional considerations we should make when planning modified work duties. | |
| Walking \_\_\_\_\_\_\_ minutes at a time | Lifting/carrying weight exceeding \_\_\_\_\_\_\_ kg |
| Sitting \_\_\_\_\_\_\_ minutes at a time | Pushing/pulling weight exceeding \_\_\_\_\_\_\_ kg |
| Standing \_\_\_\_\_\_\_ minutes at a time | |
| Vision impaired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Speech impaired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Hearing impaired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Typing/writing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Screen time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Mousing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Overall body fatigue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**DURATION OF PHYSICAL LIMITATIONS AND RESTRICTIONS**

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| How long do you anticipate these identified limitations/restrictions will be in effect? |

**RECOMMENDED WORK HOURS/SCHEDULE**

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| Please check one of the below options, indicating patient’s ability to work full-time hours or modified hours. | |
| **Able to return to full-time hours** | **Able to return to modified hours**  Gradual Return to Work Schedule:  Week 1: \_\_\_\_\_\_\_ hrs/day \_\_\_\_\_\_\_ days/week  Week 2: \_\_\_\_\_\_\_ hrs/day \_\_\_\_\_\_\_ days/week  Week 3: \_\_\_\_\_\_\_ hrs/day \_\_\_\_\_\_\_ days/week  Week 4: \_\_\_\_\_\_\_ hrs/day \_\_\_\_\_\_\_ days/week  Week 5: \_\_\_\_\_\_\_ hrs/day \_\_\_\_\_\_\_ days/week  Week 6: \_\_\_\_\_\_\_ hrs/day \_\_\_\_\_\_\_ days/week |

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| Clinician Name: | Clinician Signature: | Date: |

I appreciate that you are very busy and thank you in advance for your assistance with this request. Please fax the completed form to [HR DEPARTMENT FAX NUMBER].

Sincerely,

[Name]

[Organization]

P: XXX

F: XXX

E-mail: XXX