Carleton University

MEDICAL INFORMATION AND FUNCTIONAL ABILITIES FORM
In support of a safe return to work **CONFIDENTIAL**

To our Employee: *Please ask your attending physician/ 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.*

A -Completed by the Employee

Name:_____ Employee ID Number:_____
Last day worked:_____ Job title:_____

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:_____

B -Completed by Physician or Health Practitioner

Please complete all relevant sections and provide as much detail as possible. ***Missing information will require the employer to follow-up.***

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? ☐No ☐Yes (specify date if Yes)_____

Is the illness or injury being treated work-related? ☐No ☐Yes

Is the employee able of returning to work immediately without limitations? ☐Yes ☐No If YES skip to section F

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

If yes, please detail expected duration of the restrictions: _____
Also complete applicable sections C, D, E, F, G

Please reference any job description, physical demands analysis or job summary that has have been provided in determining any restrictions.

C -Musculoskeletal functional information

Please identify and detail limitations/ restrictions (use ***Additional Comments*** *section on last page if required). Provide details of restrictions where applicable (%, kg, degree, repetition, not applicable, etc.)*

Neck:	
Shoulder:	
Elbow:	
Wrist/Hand:	
Finger:	
Back:	
Hip:	
Knee:	
Ankle/Foot:	

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 to 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
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: _____

Musculoskeletal Comments (please use **Additional Comments** section on last page if required):
_____
_____
_____
_____

D -Behavioural and Cognitive functional information

*Please identify and detail limitations/ restrictions (use **Additional Comments** section on last page if required):*

Communication **Details:**

☐Full Abilities _____

☐Limitations/Restrictions _____

_____

_____

Memory **Details:**

☐Full Abilities _____

☐Limitations/Restrictions _____

_____

_____

Cognitive demands **Details:**

☐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

Behavioural and Cognitive Comments (please use **Additional Comments** section on last page if required):

_____

_____

_____

_____

E -Return to Work

Have you discussed return to work with your patient? ☐Yes

☐No (provide reason)_____

To commence a Return to Work:

Estimated duration of functional limitations: ☐days ☐2-4 weeks ☐4-6 weeks ☐6-8 weeks ☐8-10 weeks

☐ > 10 weeks

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

Details:_____

Recommended Start Date: _____

F -Physician Information

Health Physician's Name: _____ Specialty/Health Profession:_____
Address: _____ Telephone:_____
Date: _____ Health Physician's Signature:

G -Additional Information

Please return:

Via email to: MedicalLeave@cunet.carleton.ca

Or the employee can submit the completed document securely through the Carleton network at: Medical Absence - Human Resources (HR) - Service project (carleton.ca)