

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY if there has been a change in patient's abilities. WRHA will pay up to **\$25.00** for the **COMPLETED** form. Completed forms can be faxed to **WRHA OESH CONFIDENTIAL FAX LINE 204-940-2570**

Employee Name:	Position:	Site:
Authorization of Employee: <i>I authorize the release of this information to the Winnipeg Regional Health Authority Occupational and Environmental Safety & Health Department.</i>		General Nature of illness/injury: <i>(specific diagnosis should not be included)</i>
_____ <i>Employee Signature</i>		_____ <i>Date</i>

RETURN TO WORK:	Recommended Gradual Hours (if applicable)																		
Start Date: ____/____/____ dd mm yyyy <input type="checkbox"/> Full Functional Abilities <input type="checkbox"/> Reduced Functional Abilities Estimated Duration: _____	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Graduated</th> <th>Hours / Day</th> <th>Days / Week</th> </tr> </thead> <tbody> <tr><td>week 1</td><td></td><td></td></tr> <tr><td>week 2</td><td></td><td></td></tr> <tr><td>week 3</td><td></td><td></td></tr> <tr><td>week 4</td><td></td><td></td></tr> <tr><td>week 5</td><td></td><td></td></tr> </tbody> </table>	Graduated	Hours / Day	Days / Week	week 1			week 2			week 3			week 4			week 5		
Graduated	Hours / Day	Days / Week																	
week 1																			
week 2																			
week 3																			
week 4																			
week 5																			

FUNCTIONAL ABILITIES

(Please be specific and check all that apply)

KEY	Mobility/Posture	N	O	F	C	Mobility/Posture	N	O	F	C
*FREQUENCY N – Never O – Occasional <small>(up to 33% of the day)</small> F – Frequent <small>(between 34-66% of the day)</small> C – Constant <small>(between 67-100% of the day)</small>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck ROM <i>(specify)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder/Reaching <input type="checkbox"/> R <input type="checkbox"/> L At Shoulder Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Below Shoulder Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Above Shoulder Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Deep Squat/Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Bending/Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stairs/Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hand Dexterity/Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gripping <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Power <input type="checkbox"/> Pinch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Strength / Exertion <i>(check all that apply)</i>	0 - 10lbs				10 – 20lbs				20 – 50lbs			
	N	O	F	C	N	O	F	C	N	O	F	C
LIFTING: Floor to Waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LIFTING: Waist to Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LIFTING: Above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARRYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PUSH/PULL FORCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional recommendations regarding functional abilities:

Healthcare Provider Information:	
Name:	Clinic Information:
Signature:	Date: