

**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 204-787-1172**

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

<b>RETURN TO WORK:</b>  <b>Start Date:</b> ____/____/____ <small>dd mm yyyy</small>  <input type="checkbox"/> <b>Full Functional Abilities</b> <input type="checkbox"/> <b>Reduced Functional Abilities</b>  <b>Estimated Duration:</b> _____	<b>Recommended Gradual Hours (if applicable)</b>																	
	<table border="1"> <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
<b>*FREQUENCY</b> <b>N – Never</b> <b>O – Occasional</b> <small>(up to 33% of the day)</small> <b>F – Frequent</b> <small>(between 34-66% of the day)</small> <b>C – Constant</b> <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:	
<b>Name:</b>	<b>Clinic Information:</b>
<b>Signature:</b>	<b>Date:</b>