Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

MODIFIED DUTY FORM

TO BE COMPLETED BY HEALTHCARE PROVIDER <u>ONLY</u> if there has been a change in patient's abilities. WRHA will pay up to **<u>$25.00</u>** for the **<u>COMPLETED</u>** form. Completed forms can be faxed to **WRHA OESH CONFIDENTIAL FAX LINE <u>204-831-2918</u>**

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

RETURN TO WORK:

Start Date: _____/_____/_____
dd mm yyyy

☐ **Full Functional Abilities** ☐ **Reduced Functional Abilities**

Estimated Duration: _____

Recommended Gradual Hours ***(if applicable)***

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** (up to 33% of the day) **F – Frequent** (between 34-66% of the day) **C – Constant** (between 67-100% of the day)	Sitting	☐	☐	☐	☐	Neck ROM *(specify)*	☐	☐	☐	☐
	Standing	☐	☐	☐	☐	Shoulder/Reaching ☐ R ☐ L At Shoulder Level	☐	☐	☐	☐
	Walking	☐	☐	☐	☐	Below Shoulder Level	☐	☐	☐	☐
	Kneeling	☐	☐	☐	☐	Above Shoulder Level	☐	☐	☐	☐
	Deep Squat/Crouch	☐	☐	☐	☐	Low Back Bending/Twisting	☐	☐	☐	☐
	Stairs/Climbing	☐	☐	☐	☐	Hand Dexterity/Fine Motor	☐	☐	☐	☐
	Other:	☐	☐	☐	☐	Gripping ☐ R ☐ L ☐ Power ☐ Pinch	☐	☐	☐	☐

Strength / Exertion *(check all that apply)*	**0 - 10lbs**				**10 – 20lbs**				**20 – 50lbs**			
	N	**O**	**F**	**C**	**N**	**O**	**F**	**C**	**N**	**O**	**F**	**C**
LIFTING: Floor to Waist	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LIFTING: Waist to Shoulder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LIFTING: Above Shoulder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CARRYING	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
PUSH/PULL FORCE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional recommendations regarding functional abilities:

Healthcare Provider Information:

Name:	**Clinic Information:**
Signature:	**Date:**