

APPENDIX B – ABILITIES FORM

Employee Group:	Requested By:
WSIB Claim: <input type="checkbox"/> Yes <input type="checkbox"/> No	WSIB Claim Number:

To the Employee: The purpose for this form is to provide the Board with information to assess whether you are able to perform the essential duties of your position, and understand your restrictions and/or limitations to assess workplace accommodation if necessary.

Employee's Consent: I authorize the Health Professional involved with my treatment to provide to my employer this form when complete. This form contains information about any medical limitations/restrictions affecting my ability to return to work or perform my assigned duties.

Employee Name: (Please print)	Employee Signature:
Employee ID:	Telephone No:
Employee Address:	Work Location:

1. Health Care Professional: The following information should be completed by the Health Care Professional

Please check one:

☐ Patient is capable of returning to work with no restrictions.

☐ Patient is capable of returning to work with restrictions. Complete section 2 (A & B) & 3

☐ I have reviewed sections 2 (A & B) and have determined that the Patient is totally disabled and is unable to return to work at this time. Complete sections 3 and 4. Should the absence continue, updated medical information will next be requested after the date of the follow up appointment indicated in section 4.

First Day of Absence: _____	General Nature of Illness (please do not include diagnosis): _____
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Date of Assessment: dd mm yyyy
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2A: Health Care Professional to complete. Please outline your patient's abilities and/or restrictions based on your objective medical findings.

PHYSICAL (if applicable)											
Walking: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other (please specify):	Standing: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other (please specify):	Sitting: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes - 1 hour <input type="checkbox"/> Other (please specify):	Lifting from floor to waist: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify):								
Lifting from Waist to Shoulder: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify):	Stair Climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 6 - 12 steps <input type="checkbox"/> Other (please specify):	Use of hand(s): <table border="0"> <tr> <td>Left Hand</td> <td>Right Hand</td> </tr> <tr> <td><input type="checkbox"/> Gripping</td> <td><input type="checkbox"/> Gripping</td> </tr> <tr> <td><input type="checkbox"/> Pinching</td> <td><input type="checkbox"/> Pinching</td> </tr> <tr> <td><input type="checkbox"/> Other (please specify):</td> <td><input type="checkbox"/> Other (please specify):</td> </tr> </table>		Left Hand	Right Hand	<input type="checkbox"/> Gripping	<input type="checkbox"/> Gripping	<input type="checkbox"/> Pinching	<input type="checkbox"/> Pinching	<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Other (please specify):
Left Hand	Right Hand										
<input type="checkbox"/> Gripping	<input type="checkbox"/> Gripping										
<input type="checkbox"/> Pinching	<input type="checkbox"/> Pinching										
<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Other (please specify):										

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<input type="checkbox"/> Bending/twisting repetitive movement of (please specify):	<input type="checkbox"/> Work at or above shoulder activity:	<input type="checkbox"/> Chemical exposure to:	Travel to Work: Ability to use public transit <input type="checkbox"/> Yes <input type="checkbox"/> No Ability to drive car <input type="checkbox"/> Yes <input type="checkbox"/> No
2B: COGNITIVE (please complete all that is applicable)			
Attention and Concentration: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Following Directions: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Decision- Making/Supervision: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Multi-Tasking: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:
Ability to Organize: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Memory: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Social Interaction: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Communication: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:
Please identify the assessment tool(s) used to determine the above abilities (Examples: Lifting tests, grip strength tests, Anxiety Inventories, Self-Reporting, etc.			
Additional comments on Limitations (not able to do) and/or Restrictions (should/must not do) for all medical conditions:			
3: Health Care Professional to complete.			
From the date of this assessment, the above will apply for approximately: <input type="checkbox"/> 6-10 days <input type="checkbox"/> 11- 15 days <input type="checkbox"/> 16- 25 days <input type="checkbox"/> 26 + days		Have you discussed return to work with your patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Recommendations for work hours and start date (if applicable): <input type="checkbox"/> Regular full time hours <input type="checkbox"/> Modified hours <input type="checkbox"/> Graduated hours		Start Date: dd mm yyyy	
Is patient on an active treatment plan?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has a referral to another Health Care Professional been made? <input type="checkbox"/> Yes (optional - please specify): _____ <input type="checkbox"/> No			
If a referral has been made, will you continue to be the patient's primary Health Care Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4: Recommended date of next appointment to review Abilities and/or Restrictions: dd mm yyyy			

Completing Health Care Professional Name: (Please Print)	
Date:	
Telephone Number:	
Fax Number:	
Signature:	