Health Care Practitioner's Statement (HCPS)

Occupational Health Department St. Joseph's Health Centre Guelph (SJHCG)

PHYSICAL FUNCTIONS FORM – ADDITIONAL FORM ON REVERSE

EMPLOYEE AUTHORIZATION: I authorize my physician/practitioner to complete this form for the CONFIDENTIAL ATTENTION of the Occupational Health Department at SJHCG only. I agree to the release of information between my healthcare practitioner and Occupational Health as it pertains to this injury/illness, to address a disability decision and to process return to work/accommodation.

PLEASE NOTE: FORMS MUST BE FULLY COMPLETED AND LEGIBLE OR PROCESSING DELAYS MAY OCCUR

______________________ ______________________ ______________________
Employee Name (print) Employee Signature Date of Birth (d/m/y)

______________ ______________ ______________@______________ ______________
Employee's Position/Title Cell/Home # Email Employee's Manager (print)

1. TOTALLY/SUBSTANTIALLY DISABILITY:
Unable to perform the regular duties of own job as performed immediately before becoming disabled. Please specify objective medical information that supports total/substantial disability, including responses to questions below. We offer a supportive accommodation/return to work program to assist employees back to work.

Nature of illness/injury: ______________________ Next appointment: ______________________

Totally disabled from (date):______________ to (date): ______________ Estimated return to work date: ______________________

Current/planned treatment: ____

Prognosis: __________________ Next Specialist visit: ___________________ Surgery (date & type): ___________________

2. PARTIAL DISABILITY:
Able to perform modified duties, meaning: own job or suitable duties of another job; include information/details in Functional Abilities, Section 3, below.

May return to work performing modified duties: ________________________ Estimated date to resume full duties: ______________________

NOTE: Long term/permanent restrictions may require a HCPS to be completed by a Specialist

3. PHYSICAL CAPABILITIES (Please note – if "other" is selected, please specify details):

Walking □ Full abilities □ Up to 100 metres □ 101 to 200 metres □ Other:	**Standing** □ Full abilities □ Up to 15 minutes □ 16 to 30 minutes □ Other:	**Lifting floor to waist** □ Full abilities □ Less than 5 kg □ 6 – 10 kg □ 11 – 23 kg □ Other:	**Lifting waist to shoulder** □ Full abilities □ Less than 5 kg □ 6 – 10 kg □ 11 – 23 kg □ Other:
Sitting □ Full abilities □ Up to 30 minutes □ 31 to 60 minutes □ Other:	**Stair climbing** □ Full abilities □ 1 – 10 steps □ 11+ steps □ None	**Ladder climbing** □ Full abilities □ 1 to 3 steps □ 4 to 6 steps □ None	**Push/pull** □ Left □ Right □ Full abilities □ Less than 5 kg □ 6 – 10 kg □ 11 – 23 kg □ Other:
Bending/twisting/repetitive movement restrictions (specify)	**Above shoulder activity restrictions (specify)**	**Below shoulder activity restrictions (specify)**	**Hand/Fine Motor** □ Left □ Right □ Grip/grasp □ Pinch □ Keyboard □ Other:
Impact of medication on function □ Yes □ No	**Ability to operate machinery/motorized equipment** □ Yes □ No	**Reassessment date** □ 3 – 7 days □ 8 – 14 days □ 14 + days □ Other:	

Hours of work: ☐4hrs ☐6hrs ☐8hrs ☐12hrs Frequency/Days per week: ________________ ☐ WSIB/Work-related condition

______________________ ______________________ ______________
Practitioner's Signature & Credentials **Practitioner's Name (Printed)** **Date**

PLEASE RETURN FORM IN CONFIDENCE TO:
St. Joseph's Health Centre Guelph
Occupational Health Department
100 Westmount Road, Guelph, ON N1H 5H8
Phone: 519 824-6000 Ext. 4363 Fax: 519 767-3444

Health Care Practitioner's Statement (HCPS)

Occupational Health Department St. Joseph's Health Centre Guelph (SJHCG)

NON-PHYSICAL / PSYCHOLOGICAL AND / OR COGNITIVE FUNCTIONS – Additional form on reverse

EMPLOYEE AUTHORIZATION: I authorize my physician/practitioner to complete this form for the CONFIDENTIAL ATTENTION of the Occupational Health Department at SJHCG only. I agree to the release of information between my healthcare practitioner and Occupational Health as it pertains to this injury/illness, to address a disability decision and to process return to work/accommodation.

PLEASE NOTE: FORMS MUST BE FULLY COMPLETED AND LEGIBLE OR PROCESSING DELAYS MAY OCCUR

______________________________ ______________________________ ______________
Employee Name (print) Employee Signature Date of Birth (d/m/y)

______________ ______________ ______________@______________ ______________
Employee's Position/Title Cell/Home # Email Employee's Manager (print)

1. TOTAL/SUBSTANTIAL DISABILITY:
Unable to perform the regular duties of own job as performed immediately before becoming disabled. Please specify objective medical information that supports total / substantial disability, including responses to questions below. We offer a supportive accommodation / return to work program to assist employees back to work.

Nature of condition/illness: ______________________________ Next appointment: ______________________________

Totally disabled from (date):______________ to (date): ______________ Estimated return to work date: ______________________

Current/planned treatment: ____ Prognosis: ______________

2. PARTIAL DISABILITY:
Able to perform modified duties, meaning: duties of own job or suitable duties of another job (Note: cognitive/functional capabilities must be indicated below to ensure that duties are appropriately modified).

May return to work performing modified duties: ____________________ Estimated date to resume full duties: ________________

Current/Planned Treatment: ____

NOTE: Long term/permanent restrictions may require a HCPS to be completed by a Specialist

3. COGNITIVE CAPABILITIES:

Able to follow a schedule and maintain attendance/punctuality: □ Yes, full abilities □ No, not consistently (provide detail)	**Deadlines:** □ Can handle deadlines (full abilities) □ Can handle occasional deadlines □ Cannot manage deadlines	**Able to perform work that is (check all that apply):** □ Monotonous □ Repetitive, short cycle work □ Varied, with basic tasks □ Varied, with moderately complex tasks
Emotional / Social □ Has no restrictions **Can work (check all that apply):** □ In isolation □ As part of a team □ In relationship building situations □ Supervising others □ Influencing others □ Resolving conflict □ In emotional /confrontational situations □ In crisis or emergency situations □ With the public/patients	**Cognitive Demands** □ Has no restrictions **Can handle (check all that apply):** □ Attention to detail □ Limited attention to detail □ Following specific instructions □ Self-supervision / autonomy □ Attainment of precise standards □ Planning and time management □ Problem solving / decision making □ Initiating action and being adaptable	**Mental Demands** □ Has no restrictions **Can handle (check all that apply):** □ Sustained concentration and focus □ Partial concentration and focus □ Retention of information □ New learning □ Multi-tasking □ Analytical thinking □ Sound judgment □ Effective written communication

Hours of work: ☐4hrs ☐6hrs ☐8hrs ☐12hrs Frequency/Days per week: ______________ ☐ WSIB/Work-related condition

______________________________ ______________________________ ______________
Practitioner's Signature & Credentials **Practitioner's Name (Printed)** **Date**

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