Functional Abilities Form

(Taken from the Conference Board of Canada)

Instructions

Health Professionals, please use this Form when requested by an employer or worker. The purpose of this form is to identify a patient's overall functional abilities and work restrictions that will assist his/her return to suitable work. Please promptly complete and return this form to the worker or employer to assist the workplace parties in planning an early and safe return to work.

Employee Authorization	
By signing below, I authorize any health professional who treats me to provide me and my employer the following information about my functional abilities.	
Signature:	Date:
Employee Information	
Last Name:	First Name:
Address:	Telephone Number:
Position:	Work Hours:
The following information to be completed by the health professional	
Date of Last Examination:	Date of Next Appointment:
Nature of Illness/Area of Injury (provide description but not diagnosis):	Does the worker have a diagnosed medical condition? ☐ Yes ☐ No
Rehabilitation Treatment Required (describe):	Is the worker capable of returning to work immediately without restrictions? ☐ Yes ☐ No - Please fill out the section below
Abilities and/or Restrictions	
Please indicate Abilities that apply – include additional details below:	

Walking: ☐ Full Abilities ☐ Up to 100 meters ☐ 100 - 200 meters ☐ Other (please specify)	Standing: ☐ Full Abilities ☐ Up to 15 minutes ☐ 15 - 30 minutes ☐ Other (please specify)	Sitting: ☐ Full Abilities ☐ Up to 30 minutes ☐ 30 minutes - 1 hour ☐ Other (please specify)	Lifting from Floor to Waist: ☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms ☐ Other (please specify)
Lifting from Waist to Shoulder: ☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms ☐ Other (please specify)	Stair Climbing: ☐ Full Abilities ☐ Up to 5 steps ☐ 5 – 10 steps ☐ Other (please specify)	Ladder Climbing: ☐ Full Abilities ☐ 1 – 3 steps ☐ 4 – 6 steps ☐ Other (please specify)	Able to use Public Transit: ☐ Yes ☐ No Able to Drive a Car: ☐ Yes ☐ No
Supervision Required: ☐ No supervision required ☐ Limited supervision required ☐ Frequent supervision required ☐ Constant supervision required	Supervision of Others: ☐ No restrictions on ability to supervise others ☐ Can supervise a small group of up to __ people ☐ Unable to supervise	Tolerance of Deadlines: ☐ No restriction on deadlines ☐ Can deal with strict deadlines ☐ Can deal with recurring deadlines ☐ Can deal with occasional deadline pressure ☐ Cannot deal with deadline pressure	Attention to Detail: ☐ Able to concentrate intensely on detailed work ☐ Can concentrate on detail with occasional breaks of non-detail work ☐ Concentration on detail limited ☐ Concentration on detail severely limited
Task Responsibility and Independence: ☐ No restrictions on task responsibility or independence ☐ Require allowance to leave work and access a quiet area as needed ☐ Must work with a partner or be restricted to job shadowing ☐ Unable to take primary	Performance of Multiple Tasks: ☐ Fully able to handle multiple tasks without difficulty ☐ Can handle multiple tasks but may require additional time ☐ Can handle more than one task, but a limited number only ☐ Can deal with only one task at a time	Tolerance to External Stimulus: ☐ Fully able to cope with multiple stimuli without negative effect ☐ Can cope with distracting stimuli for a portion of the day ☐ Can cope with a small degree of distraction ☐ Needs quiet, non-distracting work environment	Ability to Work Cooperatively with Others: ☐ Can work with others cooperatively ☐ Can tolerate others within vicinity ☐ Only tolerates working alone

responsibility for completing tasks			
Ability to Cope with Confrontational Situations: ☐ Able to deal with confrontational situations ☐ Moderate ability to cope with confrontational situations ☐ Unable to cope with confrontational situations	Memory: ☐ Has no restriction on memory ability ☐ Has basic memory ability (i.e., can recall information that is applied to work tasks on a regular basis without rigid time constraints) ☐ Has poor ability to remember information and apply to work tasks	Cognitive Demands: ☐ Capable of analytical thinking ☐ Capable of making sound judgment ☐ Able to take initiative ☐ Able to problem solve and make decisions ☐ Able to attain precise limits/standards	Tolerance of Emotional Circumstances: ☐ Able to tolerate frequent exposure (e.g., daily) to emotionally stressful circumstances or emotionally distressed individuals ☐ Able to tolerate occasional exposure (e.g., weekly) to emotionally stressful circumstances or emotionally distressed individuals ☐ Able to tolerate infrequent exposure (e.g., monthly) to emotionally stressful circumstances or emotionally distressed individuals ☐ Unable to work effectively in emotionally stressful circumstances or with emotionally distressed individuals

Please indicate Restrictions that apply – Include additional details below

☐ Bending/twisting Repetitive Movement of (please specify):	☐ Work at or Above Shoulder Activity:	☐ Chemical Exposure to:	☐ Environmental Exposure to: (e.g., heat, cold, noise, scents)	☐ Exposure to Vibration: ☐ Whole body ☐ Hand/Arm

☐ Limited Pushing/Pulling with: ☐ Left arm ☐ Right arm ☐ Other (please specify)	☐ Limited use of Hand(s): ☐ Left Right ☐ Gripping ☐ Pinching ☐ Other (specify)	☐ Potential Side Effects from Medications (please specify):	☐ Operating Motorized Equipment (e.g., forklift)

Is there objective medical evidence to support the restrictions and limitations noted above?

☐ Yes
☐ No Explain:

Is there objective medical evidence to support the worker's diagnosis?

☐ Yes
☐ No Explain:

If there is rehabilitative treatment required, has the employee been participating in the prescribed treatment plan?

☐ Yes
☐ No Explain:

Additional Comments on Abilities and/or Restrictions:

Is employee able to Return to Work

☐ Yes
☐ No - Explain why not and expected return date:

Recommended Hours:	☐ Regular Full Time	☐ Modified Hours	☐ Graduated Hours	Expected Return Date:

Prognosis for return to full duties:

Health Professional Please Complete Section Below

Health Professional's Name (Please Print):	Type of Health Profession:
Full Address:	Health Professional's Signature:
Healthcare Stamp:	Contact Information: