MARKHAM STOUFFVILLE HOSPITAL CORPORATION

☐ Markham Site ☐ Uxbridge Site

Functional Abilities Form (FAF)

Fax Number: 905-472-7626

Section A: To be completed by the employee

Claim number (if available) _____ ☐ Initial form ☐ Follow-up form

Employee Last name _____ First name _____

Home address _____ Postal Code _____

Date of accident/onset of illness _____ Area of affected (if applicable) _____

Job at time of accident/illness _____ Last day & shift worked _____

Department/Unit _____ Manager _____ Telephone _____

Employee Status ☐ Full-time ☐ Part-time ☐ Casual

Physical Demands Analysis enclosed ☐ Yes ☐ No Job description enclosed ☐ Yes ☐ No

Section B: Employee Consent (to be completed by the employee)

I authorize the health professional involved with my treatment to provide me, my employer, the Hospital's benefit/insurance provider and/or the Workplace Safety and Insurance Board (if applicable) this completed form containing information about my ability to return to work.

Signature ……Date ……...

Section C: To be completed by the treating health professional and returned to the employee

Examination Date……..... Next Appointment Date (if applicable) …. ….....……

Date of accident/onset of illness/surgery …… Area affected (if applicable) ……..……

☐ Injury / Illness Non Work Related ☐ Injury / Illness Work Related

Estimated recovery time …….. Dominate Hand ☐ Right ☐ Left

Is complete recovery expected ☐Yes ☐ No, please specify……

Have you discussed return to work with your patient? ☐ Yes ☐ No

Is further testing scheduled or required:……..... If yes dates …. ….....……

Ability to return to work (check only one):

☐ Able to return to work immediately without restrictions

☐ Able to return to modified duties; Start date: …….. Duration of limitations ……..weeks

☐ Date expected to resume full duties …….. or …….. Weeks

☐ Unable to participate in any work, including modified duties for ……days or ……..weeks

If transitional duties are required, please check any specific medical restrictions necessary.

LIFTING (floor to waist)	☐ Full abilities	☐ Up to 5 kg	☐ 5 – 10 kg	☐ Other (please specify) _____
LIFTING (waist to shoulder)	☐ Full abilities	☐ Up to 5 kg	☐ 5 – 10 kg	☐ Other (please specify) _____
LIFTING (at or above shoulder)	☐ Full abilities	☐ Up to 5 kg	☐ 5 – 10 kg	☐ Other (please specify) _____
CARRYING	☐ Full abilities	☐ Up to 5 kg	☐ 5 – 10 kg	☐ Other (please specify) _____
PUSHING/PULLING	☐ Full abilities	☐ up to 7 kg	☐ up to 14 kg	☐ up to 25 kg ☐ Other(please specify) _____
HAND FUNCTION	☐ Avoid repetitive hand motion	☐ No strong gripping		☐ Avoid gripping
REACHING	☐ No prolonged overhead reaching	☐ No overhead reaching		☐ Avoid any reaching
SITTING	☐ Full abilities	☐ less than 30 min	☐ less than 1 hr	☐ Other (please specify) _____

STANDING	□ Full abilities	□ Up to 15 minutes	□ 15 – 30 minutes	□ Other (please specify) _____
WALKING Continuously	□ Full abilities	□ Up to 15 minutes	□ 15 – 30 minutes	□ 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 to 6 steps	□ Other (please specify) _____
BENDING	□ No prolonged bending	□ Occasional bending only		□ Avoid bending
CROUCHING/KNEELING	□ Full abilities	□ Less than 30 minutes	□ less than 1 hour	□ Other (please specify) _____
CPR	□ Can perform fully	□ Can initiate and maintain for 2 minutes		□ Unable to perform
RESTRAINING PATIENT	□Can restrain	□ No restraining		

OPERATE MOTORIZED EQUIPMENT: □ Yes please specify _____ □ No

EXPOSURE TO VIBRATION: □ Yes please specify _____ □ No

TRAVEL TO WORK:

Ability to use public transit □ Yes please specify _____ □ No

Ability to drive a car □ Yes please specify _____ □ No

Please note any limitations/restrictions as they pertain to the following areas and provide details:

- ❑ Attention/Concentration: _____
- ❑ Memory: _____
- ❑ Decision making/Judgement: _____
- ❑ Organization/Planning: _____
- ❑ Ability to cope with multiple tasks: _____
- ❑ Working with others/Social Interaction/Communication: _____
- ❑ Self-supervision: _____
- ❑ Supervision of others: _____
- ❑ Deadline pressures: _____
- ❑ Exposure to confrontation: _____
- ❑ Responding to emergencies: _____
- ❑ Other: _____

Are there any other environmental sensitivities (e.g. chemical, latex,)? *Please describe* _____
_____

If the employee is on medication how will it affect his/her performance at workplace & potential side effects? _____
_____

What medical condition prevents this employee from attending work on a regular basis? _____
_____

What treatment plans are in place to help this employee improve his/her medical condition and is he/she following the treatment? ___
_____

Are there any outstanding medical treatments/tests and when they scheduled: _____
_____

Has the patient been referred for consultative care? □ No □ Yes please specify _____

Specialist name: _____ Date of appointment: _____

If the ability management staff recommends this employee for functional abilities testing, are there any contraindications to the testing process: □ Yes □ No

Comments/Specific Limitations: Please describe any additional related medical restrictions pertaining to – effects of medication, driving vehicles or operating equipment, physical exertion, vibration, work environment, work hours.

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(Please Print) Health professional's name and title ……

Address ……Postal code ……

Telephone ……Signature……Date ……