Functional Capability Forms

Many workplaces have developed their own unique Functional Capability Forms for workers to bring to their healthcare providers. The form provides an avenue for healthcare professionals to outline the worker's abilities and prognosis. This can provide the employer with information to clarify the workers functional capabilities and assist in the development of a RTW plan.

Healthcare providers typically request a fee to complete Functional Capability Forms. If your company has developed this type of form it is important that you also budget to pay for the completion of these forms and communicate the process to the worker. If an employer is requesting completion of a form then it is the employer's responsibility to pay the healthcare provider for completion of the form

Failure to address this issue may become a barrier to having the form completed and returned.

Functional Abilities Form

Name: _____ _____
First name initial last name day month year

The following information should be completed by the Health Professional:

Date of examination on which the report is based: ____ / ____ / ____ Area of Injury: _____

Is the worker capable of returning to work immediately without restrictions? ☐ Yes ☐ No *(if no, please complete next section)*

Estimate abilities unless specified:

Walking	**Standing**	**Sitting**	**Stair Climbing**	**Traveling to Work:**	
☐ Full abilities	☐ Full abilities	☐ Full abilities	☐ None	Public Transit	Drive a Car
☐ Up to 100 metres	☐ Up to 15 minutes	☐ Up to 30 minutes	☐ 2-3 steps only	☐ Yes	☐ Yes
☐ 100-200 metres	☐ 15-30 minutes	☐ 30 minutes - 1 hr	☐ short flight	☐ No	☐ No
☐ Other *(please specify)*	☐ Other *(please specify)*	☐ Other *(please specify)*	☐ Own pace		

Lifting Floor to Waist	**Lifting Waist to Shoulder**	**Lifting/Reaching Above Shoulder**	**Limited Ability to:**	**Limited Ability to:**
☐ Full abilities	☐ < 5 kg	☐ < 5 kg	☐ Hold Objects	☐ Bend
☐ Up to 5 kg	☐ 5-9 kg	☐ 5-9 kg	☐ Grip	☐ Squat
☐ 5-10 kg	☐ 10-25 kg	☐ 10-25 kg	☐ Type/Keyboard	☐ Kneel
☐ Other *(please specify)*	☐ Other *(please specify)*	☐ Other *(please specify)*	☐ Write	☐ Twist
			☐ Other *(please specify)*	☐ Other *(please specify)*

Limitations/Restrictions:

☐ Chemical Exposure to:	☐ Environmental exposure to: *(ex. Heat, cold, noise or scents)*	☐ Potential side effect from medications that could impact RTW. *(please specify)*

Additional Comments on Abilities and/or Restrictions:

Estimated duration of limitations: _____ Complete recovery expected? _____

Date of next review or appointment: _____

Recommended work hours: ☐ Full time hours ☐ Reduced hours

Graduated Return Proposal

	Hours/day	Days/week
Week 1		
Week 2		
Week 3		
Week 4		

Healthcare Provider's Name: _____ **Phone number:** (_____) _____ - _____
Print

_____ _____
Healthcare Provider's Signature Date

Return to Work Medical Release – Accordance with WCB and MMA Guidelines

Doctor: Our employee _____, required medical assessment due to illness/injury that may prevent him/her from returning to regular duties. It is our policy, together with the WCB (Workers Compensation Board) and while following the MMA (Manitoba Medical Association) Position Statement, to help employees return to meaningful employment through a Modified/Alternate Work Program. The return to work is subject medical authorization and the availability of suitable tasks within the medical restrictions.

A. Please indicate the nature of the location of the problem: (specify left or right where applicable)

_____
_____
_____

B. Employee may return to normal duties:

☐ Yes date of return: dd / mm / yyyy
☐ No date of next visit: dd / mm / yyyy If no, please complete Section C

C. We have modified/alternate duties for employees in light of restrictions:

(Please indicate any limitations by marking an (x) in all applicable boxes, indicating left or right)

Activity	Occasionally (33% or less of working day)	Unable (with right)	Unable (with left)	Length of time
Lift/carry __moderate __ light				
Walk				
Stand				
Sit				
Bend/turn				
Push/pull (cart) __ moderate __ light				
Climb __stairs/steps/ladders				
Reach __ above shoulder __ below shoulder				
Use hands for: __ writing/typing __ simple grasping				

DOCTOR – If you have any recommendations or questions on the Modified Duty Program or for a list of Modified Duties including video documentation contact _____.

Today's Date: dd / mm / yyyy Modified Duties Until: dd / mm / yyyy

Physician's Name and Address _____

Signature of Physician_____

Patient:	Date of examination:
Work related injury/illness: [ ] yes [ ] no	Physician [ ] Physio [ ] Chiropractor [ ]
Name:	Other Medical Practitioner:
Address: Signature:	

Invoices may be submitted to the individual's company for work-related injuries only at a rate of $_____/completed form.

Subject to the capabilities listed below, our Company can accommodate light/modified/alternate duties. Completion of this form will enable us to facilitate this individual's earliest return to work. Please return this form completed with the individual after your examination or fax it directly to the individual's company listed below, immediately following the examination.

A. This person is ***Capable*** of: Not applicable, see comments

1. Balance	Yes / no	12. Lifting up to 25 lbs.	Yes / no
2. Crawling	Yes / no	13. Lifting up to 50 lbs	Yes / no
3. Crouching	Yes / no	14. Pushing up to ____ lbs	Yes / no
4. Climbing ladders	Yes / no	15. Pulling up to ____ lbs	Yes / no
5. Climbing stairs	Yes / no	16. Reaching	Yes / no
6. Kneeling	Yes / no	17. Raising right arm above shoulder	Yes / no
7. Stooping / Bending	Yes / no	18. Raising left arm above shoulder	Yes / no
8. Walking _____%	Yes / no	19. Tactile sensation – indicate extremities	Yes / no
9. Walking _____%	Yes / no	20. Use of both hands – see section B	Yes / no
10. sitting _____%	Yes / no	21. Operating heavy equipment (forklift, crane)	Yes / no
11. Lifting up to 10 lbs.	Yes / no	22. Operating motor vehicle/transport vehicle	Yes / no

B. This person is ***Limited*** to:

1. Use of right hand, partial use of left	
2. use of left hand, partial use of right	
3. Use of right hand only	
4. Use of left hand only	

This person ***should not*** be exposed to:

1. Heat/cold	
2. Vibration/excessive Noise	
3. High places	
4. Mechanical hazards/moving machinery	
5. Chemical Exposure/allergies	

Is the individual involved with medication that might affect his/her ability to work? [ ] yes [ ] no

Based on the above capabilities, is the individual capable of performing light or modified duties effective immediately? [ ] yes [ ] no Duration of light or modified duties? _____

If no, when will the individual be able to return to work?
Modified duties: _____ Regular duties: _____

Are all the limitations considered permanent? [ ] yes [ ] no
Is the individual capable of working his/her regular work day with modified duties? [ ] yes [ ] no
Comments:

AUTHORIZATION TO RELEASE INFORMATION
I am aware that alternate/modified duties are available in my workplace, and hereby authorize my attending physician/physio/chiropractor _____(name) to release my functional (work) abilities to my employer. I understand that all information discussed and reports will be held in the strictest confidence. Employee Signature _ _____ Date __ _____

AUTHORIZATION TO RELEASE INFORMATION

I understand that modified or alternate duties are available at the RHA to assist with my return to work. I authorize my healthcare provider to release information to the RHA concerning my functional capabilities and/or limitations and restrictions.

Print Employee Name | Employee Signature | Date

HEALTHCARE PROVIDER:

To assist in the early and successful rehabilitation of injured, ill, or disabled employees, the RHA has implemented a modified return to work program. We are committed to working together with our employees, their medical providers, and insurance companies (as applicable) to arrange suitable return to work programs and assist employees in the transition of returning to work.

As such, we are prepared to offer a suitable modified work assignment for our employee. In order to determine what duties are appropriate for this employee, the RHA is requesting that your complete this form and return it to the employee or fax it directly to the Disability Manager's confidential fax number: 123-1234. It is important that the employer have information on the employee's most current abilities and restrictions to ensure a successful return to work plan. Thank you in advance for your co-operation.

NATURE OF DISABILITY/ILLNESS: _____

On the basis of my examination dated: ___ dd__/__mm__/____yyyy_____ this patient:

[ ] May return to work with no restrictions [ ] May return to work with modified duties based on the limitations listed below.

Restrictions are to apply from: __dd____/__mm__/__yyyy____ to dd__/____mm__/__yyyy

Will be reassessed at **NEXT SCHEDULED APPOINTMENT DATE OF** ___dd__/__mm__/____yyyy

ESTIMATED DATE OF RETURN TO REGULAR DUTIES: ___dd__/__mm__/___yyyy

General Restrictions – Please put a check in the appropriate box.

Activity Level	Not at all	1-3 hr shift	4-6 hr shift	6-8 hr shift	8-10 hr shift	12-12 hrs shift
a) remain sedentary						
b) remain sedentary with alternate sitting and standing/frequent position changes						
c) can stand/walk move freely						

Types of Activities Allowed	No Restrictions on this activity	Frequently	Occasionally	Should not do this activity at all
Push/pull				
Bend				
Twist				
Squat				
Climb				
Reach overhead				
Reach below shoulder height				
Type/keyboarding				

Weight Restrictions	**From Waist Level**	**From Floor**	**Overhead**
Light weight (0-20lbs)			
Moderate weight (20-35lbs)			
Heavy Weight (35-50lbs)			**N/A**
Push, pull or drag – i.e. carts, stretchers (50-100lbs)		**N/A**	**N/A**

Restrictions (if required): a) days per week _____ b) time of day _____

Other restrictions (please be specific regarding task restrictions e.g.: no patient handling, no emergency codes): _____

Additional comments or other physical/psychological factors to be considered for a successful RTW:_____

Signature _____ Phone _____ Date _____

Physician's Modified Work Information Sheet

To be completed by attending physician and returned to ACB Company prior to the start of the next shift.

Doctor:	Date:
RE:	Injury/Illness Date
ID#:	Work Locations:

ACB Company is committed to a modified/alternate duties program to accommodate the timely return to productive, beneficial work that facilitates recovery. In order for the return to wok to be successful, it is important that the accommodation fits the appropriate restriction(s) and limitation(s) that the employee should be observing. To assist us in identifying suitable duties, please indicate your patients work capabilities and any other comments you may have. ABC Company has the ability to provide duties that accommodate almost all restrictions.

Check one	**LEVEL:**	**WEIGHT LIFTED**	**FREQUENCY OF LIFT**	**WALK/CARRY**
	A. sedentary	10 lbs. or less	Infrequent	Limited
	B. Light	20 lbs. or 10 lbs. or less	Infrequent Frequent	2.5 mph (light pace) 10 lbs. or less
	C. Medium **(regular duties)**	50 lbs. 25 lbs. or less	Infrequent Frequent	3.5 mph (medium pace) 25 lbs. or less

Affected body part:

Additional comments, recommendations or restrictions:

Recommended duration of restrictions and anticipated return to regular duties:

Can extra hours be worked within these restrictions?

Physicians name (please print): _____

Signature: _____

ABC Company - Work Capabilities Form

To all employees:

Please return this completed report directly to your supervisor within 24 hours of your injury or illness, and prior to the start of your next scheduled work shift. If you are unable to continue to work, please speak to your supervisor in person at least once per week with an update on your capabilities.

Attending Physician

The health and safety of our employees is of the utmost importance to us. As such we ask that you take the time to complete this report to assist in the safe return to work of our injured employee.

Any charges incurred for form completion must initially be paid by the employee, which later upon receiving a receipt of payment we will reimburse them.

Employee Authorization to Release Information

I understand that modified or alternate duties are available at ABC Company to assist my return to work. I authorize my signed doctor to release information to ABC Company concerning my functional capabilities and/or limitations and restrictions.

Employee Name _____ Employee Signature _____ Date _____

Modified duties are, and/or will be made available, specifically based on your assessment.

Date of Visit: _____

Dr. _____

Signature: _____

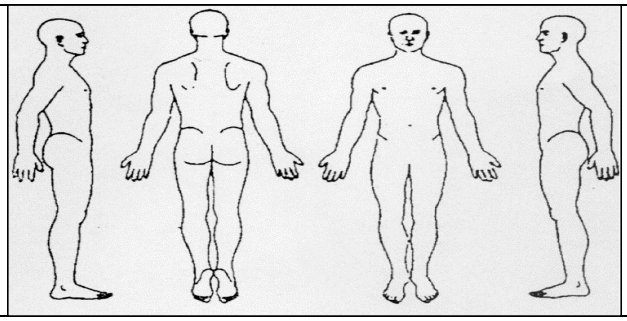
Phone Number: _____

Fax Number: _____

Clinic/Hospital: _____

Next Appointment: _____

Body Part affected by the Injury/Illness:



The following details the employee's current capabilities: *(please checkmark as appropriate)*

	1 to 2lbs	3 to 5 lbs	6 to 10lbs	11 to 20lbs	21 to 30lbs	31 to 40lbs	41 + lbs
Lifting							
Carrying							
Push/Pull							

	minimal	Under 1 hour	1 - 2 hours	2 - 3 hours	3 - 4 hours	4 - 5 hours	5 - 6 hours	8 hours
Sitting								
Standing								
Walking								

Squatting	Yes		No	
Bend/twist at Waist	Yes		No	
Reaching	Yes		No	
Work Above Shoulder	Yes		No	

Anticipated Duration of Limitations

_____ (Date)

When do you anticipate the employee's return to regular duties?

☐ Immediately Date if unable to return immediately: _____

Please note that if so indicated we will restrict all movement of the affected body part as part of the return to work program. Is this something required to facilitate an immediate return to work? ☐ Yes ☐ No, not a necessity

Will the employee be taking any medication which will affect their ability to perform their job? ☐ Yes ☐ No, not a concern given certain directions provided to the patient

When do you anticipate the employee's return to modified duties?

☐ Immediately Date if unable to return immediately: _____

Thank-you,

Health and Safety Coordinator

Comments/Additional Relevant Information to Facilitate a Successful Return to Work:

Did our employee inform you that we aspire to meet all restrictions/capabilities you detail?

☐ yes ☐ no

In your professional opinion where the injuries incurred through the course of employment?

☐ yes ☐ no

Alternate, modified, or light duties are available. For further information contact:

[COMPANY NAME] FUNCTIONAL CAPABILITIES FORM

Patient Name: _____ Date: _____

Physician [ ] Physiotherapist [ ] Chiropractor [ ] Other [ ] _____

Work related injury/illness Yes [ ] No [ ]

On the basis of my examination of this patient he/she is:

- Able to return to work without restrictions: Yes [ ] No [ ]
- Capable of returning to work in modified/alternate duties with restrictions: Yes [ ] No [ ]
- . Limited to a number of hours per day/week: Yes [ ] No [ ] Number of hours per day/week: _____

Indicate the patient's restrictions by circling (Yes / No) if it <u>is applicable</u> to the disability/illness:					
1	Balance	Yes / No	16	Raising right arm above shoulder	Yes / No
2	Crawling	Yes / No	17	Raising left arm above shoulder	Yes / No
3	Crouching	Yes / No	18	Tactile sensation - Indicate extremities	Yes / No
4	Climbing Ladders	Yes / No	19	Operating heavy equip. (forklift, crane)	Yes / No
5	Climbing Stairs	Yes / No	20	Operating motor/transport vehicle	Yes / No
6	Kneeling	Yes / No	21	Use of both hands	Yes / No
7	Stooping / Bending	Yes / No	22	Use of right hand partial use of left	Yes / No
8	Standing Duration _____	Yes / No	23	Use of left hand partial use of right	Yes / No
9	Walking Duration _____	Yes / No	24	Use of right hand only	Yes / No
10	Sitting Duration _____	Yes / No	25	Use of left hand only	Yes / No
11	Lifting up to 10 Lbs	Yes / No	26	Heat / Cold	Yes / No
12	Lifting up to 25 Lbs	Yes / No	27	Vibration / Excessive noise	Yes / No
13	Lifting up to 50 Lbs	Yes / No	28	High places	Yes / No
14	Push/Pull up to _____Lbs	Yes / No	29	Mechanical hazards/moving machinery	Yes / No
15	Reaching	Yes / No	30	Chemical exposures /Allergies	Yes / No

Describe using specific details, any other restrictions that may directly affect the patient:

_____
_____
_____
_____

Additional comments or other factors to be considered for a successful Return to Work program:

_____
_____
_____

Restrictions are to apply from: _____ to: _____

Reassessment date: _____

Estimated return date to regular duties: _____

Signature of attending: _____ Date: _____

Print Name: _____ Telephone: _____

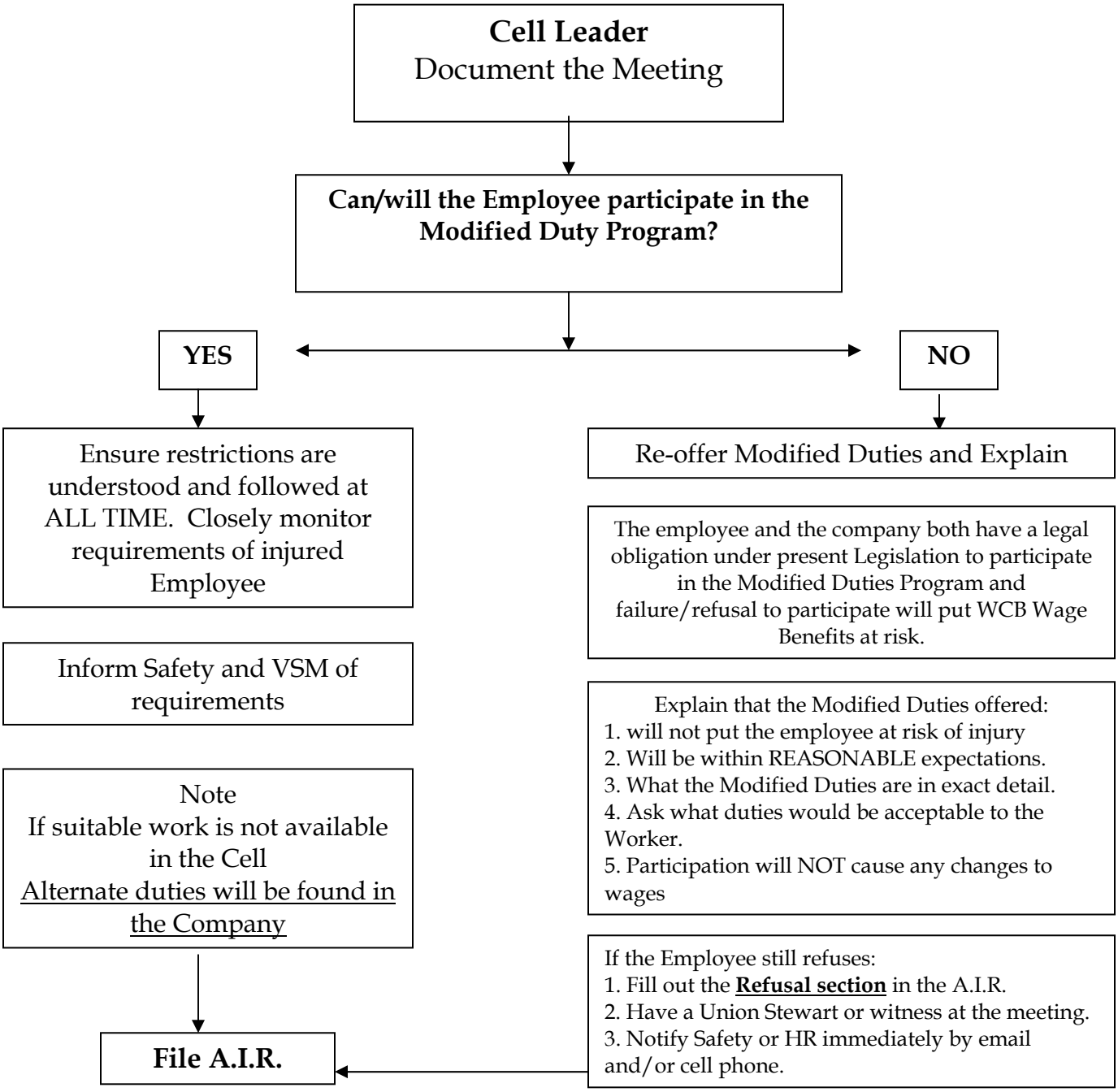
Business address: _____

<u>Authorization to release information</u>

I am aware that alternate/modified duties are available in my workplace, and hereby authorize my attending healthcare provider to release my functional (work) abilities with my employer. I understand that all information, discussions and reports will be held in the strictest of confidence.

Patient's signature: _____ Date:_____

Modified Duty Flow Chart



SOME possible Modified Duties (but can be modified/expanded as required)
Painting of equipment and guards (one handed); Data entry; Phone and clerical duties; Expediting orders etc.