Functional Abilities Form for Return-to-Work

DMI DISABILITY MANAGEMENT INSTITUTE INC.

The Employer authorizes payment of this **fully completed** form in accordance with the provincially recommended fee code upon receipt of invoice. This form provides general information about the worker's functional abilities to help plan an early and safe return to work.

WORKER (PATIENT) INFORMATION: To be completed by Worker

I authorize the release of the information below to my employer & Disability Management Institute (DMI).

Worker Name: _____ Worker Signature: _____ Date: _____

Current Position: _____ ☐ A Job Description or Position Summary is attached

CURRENT MEDICAL INFORMATION: To be completed by Physician

Date of Exam (dd/mm/yy): _____ Date of Next Appointment:_____

☐ Patient is **FIT for REGULAR DUTIES** and **FULL WORK SHIFT**.

☐ Patient is **FIT for GRADUATED WORK SCHEDULE**: hrs/day_____ for week(s)_____

☐ Patient is **FIT for MODIFIED / ALTERNATE DUTIES** (please complete limitations section below).

☐ Patient is not expected to return to work.

Complete Recovery Expected: Yes ☐ No ☐ **Anticipated date, return to full duties**_____

OPERATING MOVING EQUIPMENT / DRIVING (select one)

☐ **CAN** operate moving equipment / drive ☐ **CANNOT** operate moving equipment / drive

Is your patient capable of performing the duties of a **Safety Sensitive Position**? ☐ Yes ☐ No

Is your patient taking any medication that would affect their ability to perform their job duties safely? ☐ Yes ☐ No

WALKING (select all that apply)

- ☐ No limitations
- ☐ Limited uneven ground (loose rock, steep slopes, heavy/deep snow)
- ☐ No prolonged periods > 30 minutes
- ☐ Not more than 100 meters
- ☐ Unable to walk without assistance (cane, crutches)

STRENGTH (lifting, carrying, pushing, pulling)

- ☐ No limitations
- ☐ Heavy >20 kg occasionally
- ☐ Medium - up to 10 kg regularly and 20 kg occasionally
- ☐ Light - up to 5 kg regularly and 10 kg occasionally
- ☐ Sedentary – up to 5 kg occasionally

POSTURES (select all that apply)

- ☐ No limitations
- ☐ Must be able to change from sitting to standing at own discretion
- ☐ No sitting duration > 30 minutes
- ☐ No standing duration > 30 minutes

CLIMBING AND BALANCE (select all that apply)

- ☐ No limitations
- ☐ Stairs only
- ☐ No vertical ladders
- ☐ No working at heights (over 6 feet)

UPPER LIMB (select all that apply)

- ☐ No limitations
- ☐ No above shoulder reaching: ☐ Left ☐ Right
- ☐ No firm gripping or twisting: ☐ Left ☐ Right
- ☐ No writing or keyboard use: ☐ Left ☐ Right

ESTIMATED DURATION OF RESTRICTIONS/MODIFIED DUTIES: _____ week(s)/days(s)

☐ **Over 3 months**

Comments:

Medical Provider's Signature _____ Date: _____

Medical Provider's Name (print) _____ Phone: _____

Please Fax the Completed Form to DMI at 1-888-994-9047