Occupational Fitness Assessment

After making an assessment of your patient, please complete this form:

CONFIDENTIAL INFORMATION *(To be completed by attending physician)*

Patient's name: _____

Date of Birth: _____

Date of injury/illness: _____

Expected date of return to work: _____

Reason for absence: ☐ Illness ☐ Injury

Work related: ☐ Occupational ☐ Non-Occupational

Primary diagnosis: _____

Secondary diagnosis: _____

If psychiatric diagnosis, DSM AXIS I: _____

Medications: _____

Treatment Plan:

_____

_____

_____

_____

_____

Is there any aspect of the treatment plan which may negatively impact your patient's ability to function appropriately or safely in the workplace? _____

Date of first visit: _____ Date of most recent visit: _____

Date of next planned visit: _____ Frequency of visits: _____

When do you expect improvement? _____

Names of other treating physicians: _____

Functional Restrictions/Limitations

If there are any functional restrictions/limitations that limit your patient's functions or abilities, please complete the sections below. Transitional and modified work may be available and may meet the functional and medical requirements.

Physical Restrictions/Limitations - *please indicate any applicable physical limitations*

Walking: ☐ short distances ☐ medium distances
☐ other, *please explain*: _____

Continuous Standing: ☐ 15 min maximum ☐ 30 min maximum
☐ other, *please explain*: _____

Continuous Sitting: ☐ 15 min maximum ☐ 30 min maximum ☐ other, *please explain*: _____

Lifting: ☐ 5 kg maximum ☐ 10 kg maximum ☐ other, *please explain*: _____

Pushing/Pulling: ☐ 10 kg maximum ☐ 15 kg maximum ☐ Other, *please explain*: _____

Bending/Stooping: ☐ 10 repetitions/hour ☐ 20 repetitions/hour☐ other, *please explain*: _____

Gripping and grasping: ☐ limitations exist, *please explain*: _____

Typing and/or Writing: ☐ limitations exist, *please explain:*
_____

Stair climbing: ☐ no tolerance ☐ One flight maximum ☐ other, *please explain*:
_____

Reach above shoulder: ☐ 10 repetitions/hour ☐ 20 repetitions/hour☐ other, *please explain*: _____

Vision: ☐ limitations exist, *please explain:*
_____

☐ Other Limitations: *Please explain:*
_____

Anticipated duration of physical limitations: _____ ***week(s)*** _____ ***month(s) other:***
_____

Psychosocial and Cognitive Restrictions/Limitations - *Please indicate any applicable psychosocial and cognitive limitations. Please describe.*

Attention and Concentration: _____

Learning and Memory: _____

Decision-Making: _____

Judgment: _____

Organization and Planning: _____

Social interaction: _____

Communication: _____

Adaptation: _____

Other: _____

Anticipated duration of psychosocial/cognitive limitations: _____ ***week(s)*** _____ ***month(s) other:***
_____

When will your patient be able to participate in a graduated return to work program (keeping in mind modified duties may be available)?

_____

_____

Are there any other factors which represent a barrier to your patient's return to work? If so, please describe.

ADDITIONAL RECOMMENDATIONS/COMMENTS

PHYSICIAN INFORMATION

Name of Attending Physician *(please print)*	Specialty *(if applicable)*
Address	City, Province, Postal Code
( ) Phone Number	( ) Fax Number
Physician's Signature	Date: (month, day, year)

Billing Instructions

Please submit your invoice in accordance with BCMA fee schedule #A00032 of $37.50 for completion of this form to:

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