Niagara Region

Confidential

TREATMENT MEMORANDUM & FUNCTIONAL ABILITIES REPORT
Health Care Aid/ PSW / Registered Practical Nurse

EMPLOYEE: All sections must be completed to ensure approval of sick leave entitlement and associated benefits.

A. EMPLOYEE TO COMPLETE

Employee Name:	Employee Number:	Phone:
Job Title:	Work Location:	Supervisor Name:

Other Restrictions / Comments:

B. HEALTH CARE PROFESSIONAL TO COMPLETE - Please identify your patients overall abilities and restrictions.

The Region is requesting that our employee receive from you an assessment that will assist with an appropriate workplace accommodation or in certain cases confirm eligibility for sick leave entitlement. For more information please call 905-685-4225 ext. 3636.

1. Date of Assessment

_____
DD MM YYYY

Illness / Injury Commenced

_____
DD MM YYYY

Accident / Illness (Circle One)

Work Related Not Work Related Unknown Motor Vehicle Accident

Nature of Current Illness/Injury (Not Diagnosis):

2. Please identify your patient's return to work status.

☐ The patient can return to work with **no restrictions**.

☐ The patient has **the following restrictions/abilities until** _____
DD MM YYYY

Walking:	Standing:	Sitting:	Bending / Stooping:
☐ **Full abilities (3 hours / day)** ☐ 1 - 3 hours / day ☐ Short distances only ☐ Other Duration: _____	☐ **Full abilities (3 hours / day)** ☐ 1- 3 hours / day ☐ < 1hour / day ☐ Other Duration: _____	☐ **Full abilities (1 hour / day)** ☐ < 1 hour / day ☐ 30 minutes - 1 hour / day ☐ Other Duration:_____	☐ **Full abilities (3 hours / day)** ☐ 1 -3 hours / day ☐ < 1 hour / day ☐ Other Duration:_____
Lifting from waist to shoulder:	**Lifting from floor to waist:**	**Carrying (Less than 10 meters at a time):**	**RPN Only:**
☐ **Full abilities(10 kg 3 hours / day)** ☐ 10 kg (1 hour / day) ☐ < 10 kg (3 hours / day) ☐ < 10 kg (1 hour / day) ☐ Other Weight/Duration:_____	☐ **Full abilities(10 kg 3 hours / day)** ☐ 10 kg (1 hour / day) ☐ < 10 kg (3 hours / day) ☐ < 10 kg (1 hour / day) ☐ Other Weight/Duration:_____	☐ **Full abilities(11 kg 3 hours / day)** ☐ 11 kg (1 hour / day) ☐ < 11 kg (3 hours / day) ☐ < 11 kg (1 hour / day) ☐ Other Weight/Duration:_____	☐ **Capable of administering and monitoring treatment and medication** ☐ Restrictions: _____

Ability to use Hands:	Pushing / Pulling:	Please comment on any **Limitations:**	Ability to drive:
Left ☐ Right ☐ ☐ **Full Abilities** ☐ Limited Fine Motor Control ☐ Limited Gripping ☐ Other: _____	☐ **Full abilities(more than 16 kg)** ☐ 10 – 15 kg ☐ 5 – 10 kg ☐ < 5 kg ☐ Other:_____	☐ Restricted hours of work: ___hours/day ____hours/week ☐ Reaching forward / laterally ☐ Restrictions related to medication use:_____ ☐ Restricted access to medications or controlled substances ☐ Other:	☐ **Yes** ☐ No Ability to use public transit: ☐ **Yes** ☐ No

COGNITIVE Restrictions ☐ No ☐ Yes (Specify)

Attention (focus and concentration):	Critical Thinking (decision making):	Emotional (coping, social interaction):	Global Assessment of Functioning (GAF) Scale:
☐ **No Deficit** ☐ Minimal ☐ Moderate ☐ Major	☐ **No Deficit** ☐ Minimal ☐ Moderate ☐ Major	☐ **No Deficit** ☐ Minimal ☐ Moderate ☐ Major	**Score:** _____

Employee Name:
3. Physician and Patient Follow Up
Is this a recurrence of a previous illness/injury? □ Yes □ No
Has a referral to another Health Care Professional been made? □ Yes (optional – please specify): _____ □ No If yes, will you continue to be the patient's primary health care practitioner? □ Yes □ No
Date of next appointment to review Abilities and/or Restrictions: _____ **DD MM YYYY**

Health Care Professional's Name (Please print):		
Signature:		
Date:		
Phone Number:		**Fax Number:**

C. EMPLOYEE TO COMPLETE – Authorizations for Release of Information	
I hereby authorize my treating Health Professional (name) _____ to release the information requested on this Form. The information provided, with exception of the nature of the current illness/injury will be disclosed to my responsible manager/supervisor of the corporation and/or Human Resource Representatives as per the Work Accommodation Policy (C3.T05) to certify my entitlement to medical benefits, ensure my safety, assist in proper job placement and to accommodate a disability. A photocopy of this authorization will be considered as the original.	Employee Signature: Date:
If clarification regarding what is recorded on this Form is required and to avoid a delay or disruption in benefits or return to work I authorize the Occupational Health Nurse to contact my health professional for such clarification. A photocopy of this authorization will be considered as the original. No new medical information is to be requested pursuant to this paragraph.	Employee Signature: Date:
Voluntary Consent - I hereby authorize my treating Health Professional (name) _____ to release any relevant medical information **related to my current absence** to the Occupational Health Nurse/Department and I also authorize the Occupational Health Nurse to contact my above-noted Health Professional to discuss this medical information with the above-noted Health Professional. A photocopy of this authorization will be considered as the original. Employee Signature: _____ Date: _____ This consent may be signed by the Employee when he or she first provides his or her Treatment Memorandum Form. But it will only be used if the Occupational Health Nurse requires additional information not contained in the Treatment Memorandum Form. Please identify below if you wish the Occupational Health Department to notify you that it is requesting additional information **(check one)**: □ It is not necessary to notify me OR □ Call me and leave a message at _____ if I am not available (only one phone call will be made). OR □ Call me at _____ but do not leave a message if I am not available (no further calls will be made).	

PLEASE RETURN THE COMPLETED FORM:

via Confidential Fax at	(**905)-685-5355** (Do not fax to your Manager) or
via Email to	ehs@niagarareigon.ca or
via Internal Mail Delivery to	**Human Resources** **c/o Disability Management Coordinator**
Contact:	**Tel: 905-685-1571 Ext. 3636**

- This form is also available on-line at http://employee.niagararegion.ca
- Cost of this form is the responsibility of the patient. Reimbursement will be provided for the reasonable and customary cost to complete this form by submitting the original receipt to Employee Health Services.