Medical Assessment Form

Part 1 **Patient Authorization**	*To be completed by patient*
Name:	Position at Mount Royal University:
I hereby authorize the release of the information on this form to Employee Wellness at Mount Royal University. Patient Signature:	Date:

Part 2 **Attending Physician's Statement**	*To be completed by physician*
Date illness/injury will prevent patient from working:	Expected date of return to modified duties:
Prognosis for recovery:	Expected date of return to regular duties:

What is the general nature of the patient's condition?

Has or will the patient be referred to a specialist?

What are the patient's functional restrictions/limitations **and** how do they impact the patient's ability to perform their regular duties?

Is the patient able to return to modified work? ___yes ___no

If yes, please provide further information about their restrictions/limitations on **page 2** of this form.

If no, and there are workplace issues contributing to the patient's inability to attend work, are they medically able to participate in an intake meeting with Human Resources and a follow up meeting with Human Resources and their leader regarding these issues? ___ yes ___no ___not applicable

When is the next medical review?

Part 3 **Physician Authorization**	*To be completed by physician*

Physician's Name/Stamp	Date	Physician's Signature	Phone Number

Part 4 Required Work Modifications *To be completed by physician*

Date patient is able to return to modified duties: _____

Hours of work: ☐ regular hours ☐ limited to _____ hours/day _____ days/week

If hours of work are limited, please provide further information about the patients ability to gradually increase their hours of work for each week:

Week: _____ Hours per day: _____ Days per week_____

Week: _____ Hours per day: _____ Days per week_____

Week: _____ Hours per day: _____ Days per week_____

Date patient will be able to return to regular hours: _____

Physical Limitations/Restrictions:

Walking:	☐ able	☐ unable	☐ limited to _____
Standing:	☐ able	☐ unable	☐ limited to _____
Sitting:	☐ able	☐ unable	☐ limited to _____
Climbing:	☐ able	☐ unable	☐ limited to _____
Lifting:	☐ able	☐ unable	☐ limited to _____
Carrying:	☐ able	☐ unable	☐ limited to _____
Pushing/Pulling:	☐ able	☐ unable	☐ limited to _____
Fine Dexterity:	☐ able	☐ unable	☐ limited to _____
Vision:	☐ able	☐ unable	☐ limited to _____
Other: _____	☐ able	☐ unable	☐ limited to _____

Avoid repetitive movement of: ☐ neck ☐ back. ☐ upper extremity
☐ right shoulder ☐ left shoulder ☐ other: _____

Non-Physical Limitations/Restrictions:

Concentration/Focus:	☐ functional	☐ limited
Thinking/Reasoning:	☐ functional	☐ limited
Memory:	☐ functional	☐ limited
Interactions with others:	☐ functional	☐ limited
Decision making:	☐ functional	☐ limited
Alertness:	☐ functional	☐ limited
Other: _____	☐ functional.	☐ limited

Please describe in detail any limitations noted above and how they impact the patient's ability to perform the duties associated with their position:

_____

_____

_____

If this patient is on any medications, do they restrict their ability to carry out job functions:
☐ yes ☐ no

If yes, please describe:_____

Are these restrictions considered to be temporary or permanent? _____

Next review required in: _____ days or _____ weeks

Protection of Privacy

The personal information that you provide to Mount Royal University is collected under the authority of the Post-Secondary Learning Act (s.65) and the Protection of Privacy Act (ss. 4(a) and (c)). The information will be used for the purpose of accommodation matters while being employed at the University. Questions regarding the collection of personal information can be directed to:

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