

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 this form to Employee Wellness at Mount Royal University.	on Date:
Patient Signature:	
Part 2 Attending Physician's Statemen	t To be completed by physician
Date illness/injury will prevent patient from workir	ng: 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 conditi	ion?
Has or will the patient be referred to a specialist?	
What are the patient's functional restrictions/limita perform their regular duties?	ations and how do they impact the patient's ability to
We are able to provide modified duties for the pawork? ☐ yes ☐ no	tient to engage in. Is the patient able to return to modified
If yes, please provide further information about	ut their restrictions/limitations on page 2 of this form.
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	То	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, ple their hours of work for each we		· information at	oout the patients ability to	gradually increase	
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/Restrict	ions:				
Walking: Standing: Sitting: Climbing: Lifting: Carrying: Pushing/Pulling: Fine Dexterity: Vision: Other:	□ able □ una	ble	ad to		
Avoid repetitive movement of:			☐ upper extremity der ☐ other:		
Non-Physical Limitations/Res	strictions:				
Concentration/Focus: Thinking/Reasoning: Memory: Interactions with others: Decision making: Alertness: Other: Please describe in detail any lir duties associated with their pos	☐ functional ☐☐ ☐ functional ☐☐ ☐ functional ☐☐ ☐ functional ☐☐ ☐ functional ☐☐☐ ☐ functional. ☐☐☐ mitations noted abo	limited limited limited limited limited limited	ney impact the patient's ab	oility to perform the	
If this patient is on any medicat	•	ict their ability t	o carry out job functions:		
If yes, please describe:					
Are these restrictions considered	ed to be temporary	or permanent	?		
Next review required in:	days or	W	eeks		

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