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 regular duties:	Prognosis:

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

What are the patient's functional restrictions/limitations and how do they impact the patient's ability to work?

Will the patient be referred to a specialist?

Is the patient able to return to modified work with restrictions? If yes, please complete 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 *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

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 _____

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

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

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

_____

_____

_____

If this patient is on any medications, do they restrict the ability of him/her to carry out job functions: ☐ yes ☐ no

If yes, please describe:_____

Are these restrictions considered to be temporary or permanent? _____

Estimated date of return to regular duties:_____

Next review required in: _____ days or _____ weeks

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