[Company Logo] **Company Name**

Functional Abilities Assessment Form

A Worker's Information (completed by RTW Coordinator or employee)

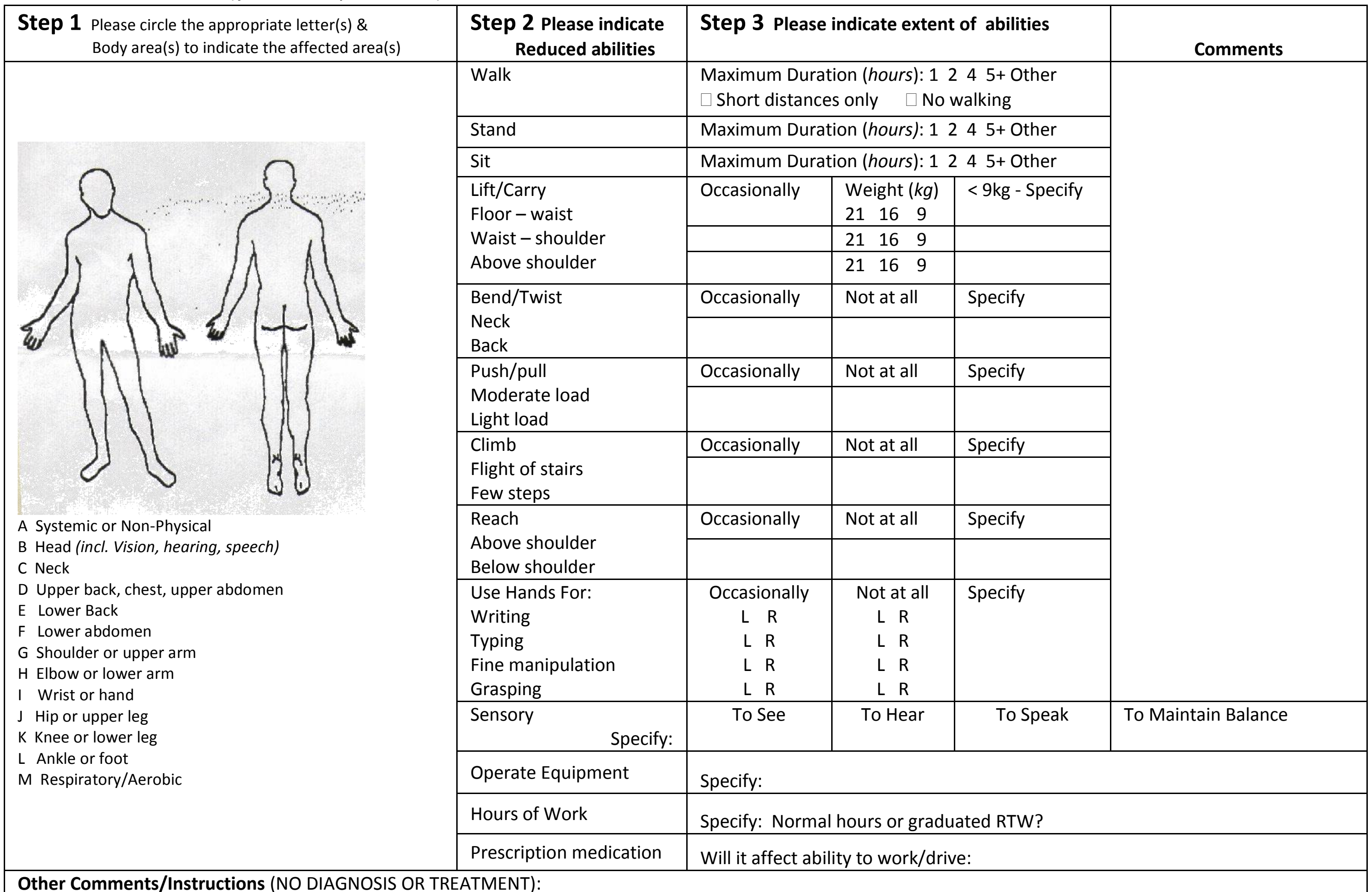
Employee's Surname	First Name	☐ Occupational ☐ Non-Occupational	Date of Injury / Illness	Unit
Employee's Job Title	RTW Coordinator Name: Tel. No. ( ) -	Fax. No. ( ) -		Today's Date

It is the intention to assist our employees to safely return to their regular duties as soon as medically practical. In doing so, we are able to offer the employee modified duties as a means to transition to their regular duties. The following will assist in this process.

B Assessment (Part B, C and D to be completed by attending physician)

Due to injury or illness this employee has:	☐ **Normal functional Abilities** (*Fit for Regular Duties*) (No additional information needed. Please sign section E)	☐ **Reduced Functional Abilities** (Please complete Section C , D & sign section E)

C Functional Abilities: *(If unable to test, please estimate)*



Step 1 Please circle the appropriate letter(s) & Body area(s) to indicate the affected area(s)

A Systemic or Non-Physical
B Head *(incl. Vision, hearing, speech)*
C Neck
D Upper back, chest, upper abdomen
E Lower Back
F Lower abdomen
G Shoulder or upper arm
H Elbow or lower arm
I Wrist or hand
J Hip or upper leg
K Knee or lower leg
L Ankle or foot
M Respiratory/Aerobic

Step 2 Please indicate Reduced abilities	**Step 3 Please indicate extent of abilities**			**Comments**
Walk	Maximum Duration (*hours*): 1 2 4 5+ Other ☐ Short distances only ☐ No walking			
Stand	Maximum Duration (*hours)*: 1 2 4 5+ Other			
Sit	Maximum Duration (*hours*): 1 2 4 5+ Other			
Lift/Carry	Occasionally	Weight (*kg*)	< 9kg - Specify	
Floor – waist		21 16 9		
Waist – shoulder		21 16 9		
Above shoulder		21 16 9		
Bend/Twist	Occasionally	Not at all	Specify	
Neck Back				
Push/pull	Occasionally	Not at all	Specify	
Moderate load Light load				
Climb	Occasionally	Not at all	Specify	
Flight of stairs Few steps				
Reach	Occasionally	Not at all	Specify	
Above shoulder Below shoulder				
Use Hands For:	Occasionally	Not at all	Specify	
Writing	L R	L R		
Typing	L R	L R		
Fine manipulation	L R	L R		
Grasping	L R	L R		
Sensory Specify:	To See	To Hear	To Speak	To Maintain Balance
Operate Equipment	Specify:			
Hours of Work	Specify: Normal hours or graduated RTW?			
Prescription medication	Will it affect ability to work/drive:			

Other Comments/Instructions (NO DIAGNOSIS OR TREATMENT):

D

Normal functional abilities may resume in: 1-3 days 4-7 days 8-14 days Specify:	
*Other: Employee is not medically fit for regular duties, will require periodic reassessments for effective rehabilitation.	Scheduled reassessment date for:

This authorizes my attending physician to provide the information requested above to COMPANY NAME	Employee's Signature:	Date:

E

Physician's name & address:	Physician's Signature:
	Physician's Telephone No:
	Date: