FUNCTIONAL ABILITIES FORM (FAF)

Disability Management Program

SITE/EMPLOYER: _____

RETURN COMPLETED FORM TO (e): WSH@southernhealth.ca; (f): 204-424-9401

A: EMPLOYEE INFORMATION & AUTHORIZATION (To be completed by the Employee)

Name: _____ **ID**: _____ **Position**: _____

I hereby authorize the Healthcare Provider to complete this form regarding my functional abilities.

Signature:_____ **Date**: _____

B: RETURN TO WORK STATUS & FOLLOW UP (To be completed by Healthcare Provider)

Exam Date:	Re-assessment Date:

Return to: Regular Duties/Hours ☐ Yes (Complete Section G) Effective Date: ☐ No (Complete appropriate sections)

Nature/Area of Illness/Injury:

Based on: ☐ Objective Evidence ☐ Subjective Evidence ☐ Both

C: PHYSICAL ABILITIES

☐ **Full Physical Abilities for all**

FREQUENCY KEY = **Occasional** (Up to 33% of shift) **Frequent** (34-66% of shift) **Constant** (67 to 100% of shift)

Please check	Occasional	Frequent	Constant		Occasional	Frequent	Constant
Bend / Trunk flexion				Neck flexion / Rotation			
Twist / Side flexion				Reach above shoulder			
Squat / Crouch				Reach below shoulder			
Kneel				Fine motor			
Sit				Wrist movement			
Stand				Gripping / Grasping			
Walk				Climb Stairs / Ladder			

Strength/Exertion	0-10 lbs			11-20 lbs			21-35 lbs			35-50 lbs			> 50 lbs		
	Occ	Freq	Cons	Occ	Freq	Cons	Occ	Freq	Cons	Occ	Freq	Cons	Occ	Freq	Cons
Lift floor-waist															
Lift waist-shoulder															
Lift above shoulder															
Carry															
Push/Pull Force															

D: COGNITIVE/PSYCHOSOCIAL ABILITIES

☐ **Full Cognitive/Psychosocial Abilities for all**

If restricted, check *all* that apply:	☐ Decision making	☐ Prioritizing tasks
☐ Meeting deadlines	☐ Adapting to changes or duties	☐ Problem solving
☐ Concentration & alertness	☐ Interaction with co-workers	☐ Working independently
☐ Retention of information	☐ Interaction with public	☐ Following instructions
☐ Confrontational situations	☐ Multi-tasking	☐ Supervising staff (if applicable)

E: RESTRICTIONS

Estimated Duration of Restrictions:	Permanent Restrictions? Yes ☐ No ☐ Unknown☐

If return to work is **not** appropriate at this time, please provide objective reasoning:

Is the Employee actively participating in a treatment program? ☐ Yes ☐ No

Is the Employee medically fit to operate a vehicle or motorized equipment? ☐ Yes ☐ No

Assistive device required (ie: brace or crutches)? ☐ Yes ☐ No If yes, describe:

F: ADDITIONAL COMMENTS THAT MAY ASSIST WITH SAFE RETURN TO WORK

G: HEALTHCARE PROVIDER CONTACT INFORMATION

Signature:		STAMP or Address HERE
Name:	Phone:	
Designation:	Date:	