FUNCTIONAL ABILITIES FORM

For Early And Safe Return To Work Non Occupational

UHN Canada's #1 Hospital

Please PRINT in black ink.

Worker's Last Name	First Name

The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment DD MM YYYY	2. Please check one: ☐ Patient is capable of returning to work with **no restrictions**.	☐ Patient is capable of returning to work **with restrictions.**	☐ Patient is physically unable to return to work at this time.

Abilities and/or Restrictions

1. Please indicate **Abilities** that apply, include additional details in section 3.

Walking:	Standing:	Sitting:	Lifting from floor to waist:
☐ Full abilities ☐ Up to 100 metres ☐ 100 – 200 metres	☐ Full abilities ☐ Up to 15 minutes ☐ 15 – 30 minutes	☐ Full abilities ☐ Up to 30 minutes ☐ 30 minutes – 1 hour	☐ Full abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms
Lifting from waist to shoulder:	**Stair climbing:**	**Ladder climbing:**	
☐ Full abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms	☐ Full abilities ☐ Up to 5 steps ☐ 5 – 10 steps	☐ Full abilities ☐ 1 – 3 steps ☐ 4 – 6 steps	

2. Please indicate **Restrictions** that apply, include additional details in section 3.

☐ Bending/twisting repetitive movement of (please specify)	☐ Work at or above shoulder activity:	☐ Environmental exposure to: (e.g. heat, cold, noise or scents).	☐ Limited use of hand(s): Left ☐ ☐ ☐ Gripping / Pinching / Other (please specify) ☐ ☐ ☐ Right
☐ Limited pushing/pulling with: ☐ Left arm ☐ Right arm ☐ Other (please specify)	☐ Operating motorized equipment: (e.g. forklift):	☐ Potential side effects from medications (please specify. Do not include names of medications.)	☐ Exposure to vibration: ☐ Whole body ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions**.

4. From the date of this assessment, the above will apply for approximately:

☐ 1 – 2 days ☐ 3 – 7 days ☐ 8 – 14 days ☐ 14+ days

Date of Next Appointment

Recommended date of next appointment to review Abilities and/or Restrictions. DD MM YYYY

Treating Practitioner's Name and Title: Telephone: Fax:	Address:	Signature: Date: