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

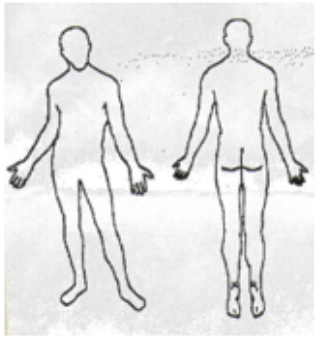
Employee's Job Title	RTW Coordinator Name: Tel. No. ( ) - Fax. No. ( ) -	Today's Date

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)	**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 Floor – waist Waist – shoulder Above shoulder	Occasionally	Weight (*kg*) 21 16 9 21 16 9 21 16 9	< 9kg - Specify	
	Bend/Twist Neck Back	Occasionally	Not at all	Specify	
	Push/pull Moderate load Light load	Occasionally	Not at all	Specify	
	Climb Flight of stairs Few steps	Occasionally	Not at all	Specify	
	Reach Above shoulder Below shoulder	Occasionally	Not at all	Specify	
	Use Hands For: Writing Typing Fine manipulation Grasping	Occasionally L R L R L R L R	Not at all L R L R L R L R	Specify	
	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:			

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

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 Northern Lights Library System	Employee's Signature:	Date:

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