UNITY HEALTH TORONTO

PHC MEDICAL QUESTIONNAIRE

Workplace Health, Safety and Wellness
T: 416-530-2099
F: 416-285-3762

PART A - Employee Information & Consent (to be completed by employee)

Name (last, first):
Status: ◯ FT ◯ PT ◯ C _____ DOB: _____

Manager: _____ Unit/Department: _____ Job Title/Occupation: _____
Home Address: _____ Home/Cell Phone #:

I hereby authorize the practitioner, by completing and signing this form, to complete and release Medical/functional information pertaining to my current medical absence to the Employer. This information provided is for the purpose of determining my fitness to work and/or the need for any accommodation in my workplace and/or to substantiate my absence due to illness and/or eligibility for benefits. I also authorize the Occupational Health Nurse/Physician to contact my practitioner for the development and implementation of my Early and Safe Return to Work Plan.

Employee Signature: _____ Date: _____

All medical information received will be kept in strict confidence in the employee's medical file.
All sections must be completed for reimbursement

*****Patient must pay physician directly and submit receipt to the Workplace Health, Safety and Wellness within 90 days of service for reimbursement*****

PART B – Attending Physician's Report (to be completed ONLY by the physician/therapist)

*The Ontario Medical Association (OMA) outlines in its "**Position in Support of Timely RTW Programs and the role of the Practitioner",** that practitioners should provide objective reports on impairment, medical restrictions and other supporting advice to the employee. Upon receipt of this information, Providence Healthcare will offer, when necessary, a modified or graduated "RTW" program, time limited (4-6wks) designed to facilitate the timely and safe return of employees who are recovering from injury or illness.*

Type of Disability: ◯ Illness/Injury ◯ A communicable disease ◯ MVA ◯ Optional Medical Procedure Not Covered by OHIP

Nature of Illness/Injury: _____

Date of first visit: _____ Last visit: _____ Planned follow-up: _____

In my opinion, supported by **objective medical findings** to support total or partial disability, the patient has been:

◯ **Totally** disabled **(meaning totally incapable of performing acts of daily living)** _____

◯ **Partially** disabled
From: To:

Are you aware of any pre-existing/contributing conditions influencing length/nature of current disability? No Yes, indicate;

Is a specialist referral required? ◯ No ◯ Yes **Hospitalization required**? ◯ No ◯ Yes, Dates:

Is the employee participating in active treatment, counseling, rehabilitation or therapy? ◯ No ◯ Yes,

Specify type of treatment, frequency of visits, medical interventions (medications, referrals, planned interventions), etc;

_____

Prognosis for Return to Work: ○GOOD ○POOR ○UNCERTAIN **Expected return to work date:**_____

○Regular Duties ○Modified Duties: ○3-7 days; ○up to 14 days; ○14+ days ○Permanent restrictions

Regular hours ☐Graduated hours; starting at _____hours per day and indicate frequency and amount of increase in hours;

_____

Physical Limitations: ☐ Lifting floor to waist up to_____kg

☐ Lifting waist to shoulder up to_____kg

☐ Pushing / pulling up to_____kg

☐ Overhead Work

☐ Standing Continuously_____hours at a time

☐ Sitting Continuously_____hours at a time

☐ Walking Continuously:_____hours at a time

☐ **Repetitive** Bending/Twisting of: _____

Comments:

_____

_____

_____

Physician's Name: _____

Address: _____

Phone:_____ **Fax:** _____

Family Physician ☐Yes ☐No **Specialist** (Indicate specialty) _____

Signature:_____ **Date:** _____

Payment per OMA Fee Schedule for Certificate of Health Practitioner, Form #OCF-8

Physician's Stamp