UNITY HEALTH TORONTO

SJHC MEDICAL QUESTIONNAIRE (for CUPE, SEIU, Non-Union)

Workplace Health, Safety and Wellness
T: 416-530-2099
F: 416-530-6733

PART I To be completed by the employee:

Name _____ Address _____

City _____ Postal Code_____ Telephone _____

Position _____ Department _____

Full-time ☐ Part-time ☐ Casual ☐

Date of last day worked: Day _____ Month _____ Year _____

I authorize Dr. _____ to release in strict ***confidence*** information relevant to my present condition as requested in Part II of this form, to the Workplace Health, Safety and Wellness at St. Joseph's Health Centre.

_____ _____
Employee's Signature Date (dd/mm/yy)

PHYSICIAN STATEMENT

PART II To be completed by the Attending Physician:
Please provide us with the following medical information to assist our employee to return to work and/or to assure the payment of Short Term Disability benefits. To ensure strict confidentiality, please mail, fax or have employee (your patient) return the completed form in the attached envelope to the address provided.

1. History

(a) When did symptoms first appear or accident happen? Day _____ Month_____ Year_____

(b) What date did medical impairment commence? Day _____ Month _____ Year_____

(c) Has patient ever had same or similar condition? Yes ☐ No ☐

If yes, explain: _____

d) Has a Physician First Report (Form 8) been submitted to WSIB? Yes ☐ No ☐

2. Diagnosis

(a) Primary: _____

Secondary (if applicable): _____

(b) Objective findings (including results of current X-rays, bloodwork, ECG's or other tests) _____

_____ **For**

psychiatric diagnosis, please include GAF SCORE _____

(c) If condition is a complication of pregnancy, what is expected date of delivery? _____

_____
Date (dd/mm/yy)

3. Treatment

a) Date of first visit for this condition Day _____ Month _____ Year _____
b) Date of most recent visit Day _____ Month _____ Year _____
c) Frequency of visitations _____

d) Medication(s) prescribed _____

e) Active treatment program _____

f) Is your patient following recommended treatment program? Yes ☐ No ☐ (please comment)

_____

_____

4. **Specialist Referral/Hospitalization**

(a) Referral to a specialist? Yes ☐ No ☐ Name: _____
Specialty_____ Date (dd/mm/yy): _____

(b) Clinical findings of specialist

_____

(c) Hospitalization required? Yes ☐ No ☐ Admission Date: _____ Discharge Date: _____
Date (dd/mm/yy) Date (dd/mm/yy)

Surgical procedure(s) performed:

_____ Day _____ Month _____ Year _____

Any Complications: Yes ☐ No ☐
(If yes, please describe): _____

5. Rehabilitation St. Joseph's Health Centre has a modified return to work program. Please see attached literature.

Please detail extent of present impairment

_____

_____

(a) Have you discussed return to work with your patient? Yes ☐ No ☐

Anticipated date of return: Day _____ Month _____ Year _____

(b) Are there any recommended medical restrictions for a safe and early return to work? Yes ☐ No ☐

(If yes, please explain): _____

_____

(c) Are there any diagnostic, therapeutic or rehabilitative interventions that can be accessed in a timely manner by Workplace Health, Safety and Wellness to assist your patient? Yes ☐ No ☐

Physician's name (please **PRINT**) _____

Address _____ Telephone (_____) _____

Specialty _____ Signature _____ Date (dd/mm/yy) _____