UNITY HEALTH TORONTO

SJHC MEDICAL QUESTIONNAIRE (for ONA employees)

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: _____

Are you seeking short-term disability benefits for any period during which you were on vacation? Yes ☐ No ☐

If hired prior to January 1, 2006, are you currently engaged in any gainful occupation? Yes ☐ No ☐

If yes, please comment: _____

I authorize Dr. _____ to release in writing in strict confidence information relevant to my present condition as requested below, to the Workplace Health, Safety and Wellness Department of St. Joseph's Health Centre.
Employee's Signature : Date: _____

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 occur? Date: _____
   (b) What date did medical impairment commence for current condition? Date: _____
   (c) Is your patient unable to perform the regular duties of her/his occupation due to injury of illness? Yes ☐ No ☐
   If no, please explain: _____
   (d) Has a Physician First Report (Form 8) been submitted to WSIB? Yes ☐ No ☐
2. Nature of Illness/Injury
   (a) Nature of Illness/Injury (without including diagnosis or symptoms):
   _____
   (b) If condition is a complication of pregnancy, what is expected date of delivery?_____
   (c) Is the absence due to a communicable disease, exposure to which poses a risk of transmission to persons at the workplace? Yes ☐ No ☐
   If yes, please explain: _____
   (d) Is the claim for Short-Term Disability benefits related to a medical procedure not covered by OHIP? Yes ☐ No ☐

3. Treatment
   (a) Date of first visit for current condition: _____
   (b) Date of most recent visit: _____
   (c) Date of next visit: _____
   (d) Active treatment program – Is there any active treatment program which may affect the performance by your patient of the duties and responsibilities of the position as of the anticipated date or return? Yes ☐ No ☐
   If yes, please explain: _____
   (e) Is your patient following the recommended treatment program? Yes ☐ No ☐
   If no, please comment: _____
4. Rehabilitation: St. Joseph's Health Centre has a modified return to work program. Please see attached literature.
   (a) Have you discussed return to work with your patient? Yes ☐ No ☐
   Anticipated date of return: _____
   (b) Are there any recommended medical restrictions for a safe and early return to work? Yes ☐ No ☐ If yes, please explain in terms of objective impairment:
   _____
   (c) Are there any diagnostic, therapeutic or rehabilitative interventions that can be accessed in a timely manner by Workplace Health, Safety and Wellness Department to assist your patient? Yes ☐ No ☐
   If yes, please explain _____
   (d) Have any medications been prescribed which may affect your patient's ability to safely perform the duties and responsibilities of their position and/or which may impair their judgment as of the anticipated date of return? Yes ☐ No ☐
   If yes, please explain: _____
   (e) Are there any clinical findings of a specialist which may give rise to a concern about your patient's ability to safely perform the duties and responsibilities of their position and/or any impairment of their judgment as of the anticipated date of return: Yes ☐ No ☐
   If yes, please explain: _____

Physician's Name: _____

Address: _____ Telephone: _____

Speciality: _____

Signature: Date: _____