# MEDICAL INFORMATION FORM

## PHYSICIAN FORM A

**Documentation of Employee Absence from Work Due to Illness and/or Injury**

1. You are being requested to complete this form because the Employer has requested that your patient provide documentation regarding their current absence from work due to illness and/or injury.
2. The completed form is to be given to your patient.
3. Please confine your comments to the requested information only.
4. Please reference the attached Job Description for the applicable work duties.

Patient Name:_____ Employer Name: _____

Date of Injury/Illness: _____ Date of Assessment: _____

Date of Next Appointment: _____

Is this an occupational injury/illness? ☐ Yes ☐ No

**Step ONE:**

Is the patient able to return to work in any capacity at this time? ☐ Yes ☐ No

If No, what is the estimated date of return to work, if known? _____

If the patient is able to return to work at this time are they able to perform the full duties indicated on the attached Job Description? ☐ Yes ☐ No

If No, please complete **Step Two <u>and</u> the Physician Form B (located below).**

**Step TWO:**

Does the patient require a return to work on a graduated basis? ☐ Yes ☐ No

If Yes, please provide additional information by completing the **Physician Form B (located below).**

Does the patient require a temporary accommodation? ☐ Yes ☐ No

If Yes, what is the anticipated length? _____

Does the patient require an ongoing accommodation? ☐ Yes ☐ No

If Yes, please provide additional information on the **Physician Form B (located below)** and anticipated length of accommodation. _____

Have you recommended a treatment plan for your patient? ☐ Yes ☐ No

If Yes, is the patient following the treatment plan? ☐ Yes ☐ No

Has your patient been referred to a medical specialist? ☐ Yes ☐ No

## PHYSICIAN INFORMATION

Name of Attending Physician (please print) _____ Family Physician ☐ Yes ☐ No

Address _____ City _____ Province _____ Postal Code _____

Phone Number _____ Fax Number _____

Physician's Signature _____ Date (month, day, year) _____

**Please return the completed form to your patient. It is your patient's responsibility to provide the completed form to their Employer in a timely manner.**

We will pay in accordance with the Doctors of B.C. - BCMA fee schedule A00060 (Minimum $10.00 - Maximum $41.35). Please mail your invoice to the Employer. Please note, we require original invoices not faxes. Thank you.

Employer Name _____

Address _____

_____

## PHYSICIAN FORM B

***Indicate patient's physical and/or any other medical limitations - not diagnosis.**

| **Physical Limitations** | **Duration/Comments** |
|---|---|

In an 8 hour day, the employee may:

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Walk | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 hours | ☐ No restriction _____ |
| Stand | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 hours | ☐ No restriction _____ |
| Sit | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 hours | ☐ No restriction _____ |
| Drive | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 hours | ☐ No restriction _____ |

Provide an explanation of the driving limitations _____

| | | | | |
|---|---|---|---|---|
| Vision | ☐ Acuity_____ | ☐ Depth _____ | ☐ Perception | _____ |
| Hand/Wrist | ☐ Single grasping | ☐ Pushing & pulling | ☐ Keyboarding | ☐ No restriction _____ |
| Stair Climbing | ☐ None | ☐ 2-3 steps | ☐ Short flight | ☐ No restriction _____ |
| Ladder Climbing | ☐ None | ☐ 2-3 steps | ☐ Short flight | ☐ No restriction _____ |
| Lifting Floor to Waist | ☐ <10 kg | ☐ <25 kg | ☐ No restriction | _____ |

Lifting Floor to Shoulder ☐ <10 kg ☐ <25 kg ☐ No restriction _____

Above Shoulder Activity _____

Below Shoulder Activity _____

_____

_____

_____

| Cognitive/Mental Limitations | | | | | Duration/Comments |
|---|---|---|---|---|---|
| Attention and Concentration | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |
| Learning and Memory | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |
| Decision Making | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |
| Judgment | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |
| Organization and Planning | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |
| Social Interaction | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |
| Communication | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |
| Adaptation | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |
| Deadlines | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |
| Management of Staff | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ No restriction | _____ |

Other _____

_____

_____

Please provide necessary details about any restrictions or medical limitations you have identified.

_____

_____

_____

Any limitations on current work schedule? ☐ Yes ☐ No

If yes, _____ days/week _____ hours/day _____ starting date _____ end date.

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Employer Name _____

Address _____

_____

*Additional medical information may be required.