Physical FAF with Cover Letter - Sample

**(Organization's Logo) Functional Abilities Form - Physical**

**Modified and Alternate Duties Available**

Please return completed form to your patient prior to the end of the appointment.

To be completed in keeping with the requirements outlined by The College of Physicians & Surgeons of Manitoba, Standards of Practice of Medicine, Confidentiality and Privacy, Medical Information to Third Parties and Sickness Certificates.

Dear Healthcare Professional:

The patient you are about to treat sustained an injury/illness at work. This letter is to request your assistance in guiding your patient in their home and work activities while they recover.

To support injured/ill workers, we provide a comprehensive return to work program. All return to work plans are created in collaboration with our worker, their supervisor, the union if required, and you – the treating healthcare provider.

Due to our various operations, we are fortunate to be able to offer a wide range of work accommodations, including the ability to modify regular work duties/hours or providing alternate work duties.

We have had an opportunity to discuss the return to work program with our worker, and would also appreciate your support and involvement so that we may have a complete understanding of recommended abilities and limitations.

Please complete the attached Functional Abilities Form to assist us in providing a tailored work plan for your patient and return this form to your patient prior to the end of the appointment. If there are charges for the completion of the form, we would be pleased to pay you directly. Alternatively, should your patient pay for the form, please provide them with a paid in full receipt for us to reimburse them.

If there is a concern about any duties which may be available, please note them on the form.

Thank you for your assistance in treating our team member and helping us return them back to work quickly and, most importantly, safely.

Should you have any questions, please contact me at any time.

NAME: TITLE:

ORGANIZATION: PHONE NUMBER:

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|  |  |
| --- | --- |
| Patient’s Name: | Date of Appointment: |

|  |  |
| --- | --- |
| Areas of Injury: | Is the patient fit for full regular duties? Yes □ No □  (If no, complete next section.) |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Weight Restrictions** | **Full Ability** | | | **11-25kgs / 24-55lbs** | | | **6-10kgs / 13-23lbs** | | **Up to 5kgs / 12lbs** | |  |
| Spine | | Extremity | Spine | | Extremity | Spine | Extremity | Spine | Extremity |  |
|  | Lift/Carry - Floor to Waist | □ | | L R | □ | | L R | □ | L R | □ | L R |  |
|  | Lift/Carry - Waist to Shoulder | □ | | L R | □ | | L R | □ | L R | □ | L R |  |
|  | Lift/Carry - Above Shoulder | □ | | L R | □ | | L R | □ | L R | □ | L R |  |
|  | Push/Pull | □ | | L R | □ | | L R | □ | L R | □ | L R |  |
| \*If abilities above are frequent, occasional or other, please outline details in comments section.\* | | | | | | | | | | | | |
|  | **Activities** | | **Full Ability** | | | **Frequently (up to 66% / day)** | | **Occasionally (up to 33% / day)** | | **Should Not Perform -- Please Explain Below** | |  |
|  | Walk | |  | | |  | |  | |  | |  |
|  | Stand | |  | | |  | |  | |  | |  |
|  | Sit/Sedentary | |  | | |  | |  | |  | |  |
|  | Climb (Stairs/Ladder) | |  | | |  | |  | |  | |  |
|  | Bend | |  | | |  | |  | |  | |  |
|  | Twist | |  | | |  | |  | |  | |  |
|  | Squat | |  | | |  | |  | |  | |  |
|  | Kneel | |  | | |  | |  | |  | |  |
|  | Grip/Grasp | | L R | | | L R | | L R | | L R | |  |
|  | Hand Dexterity | | L R | | | L R | | L R | | L R | |  |
|  | Reach Overhead | | L R | | | L R | | L R | | L R | |  |
|  | Reach Below Shoulder | | L R | | | L R | | L R | | L R | |  |
|  | Repetitive Motion | | L R | | | L R | | L R | | L R | |  |
|  | Driving (If no please explain) | |  | | |  | |  | |  | |  |
|  | Use Public Transportation | |  | | |  | |  | |  | |  |

|  |  |
| --- | --- |
| Estimated duration of limitations: | Complete recovery expected: Yes □ No □ |
| Does the worker have a pre-existing condition involving the same area of injury which may prolong or impact their rate of  recovery? Yes □ No □ | |
| Recommended work hours: Full Time Hours □ Reduced Hours □ (Please provide daily/weekly schedule) | |
| Reassessment Date: | Healthcare Professional Name/Address/Phone/Fax or STAMP |
| Additional Comments/Rationale |
| Date: |

**Please return completed form to your patient prior to the end of the appointment.**