

Cognitive Functional Abilities for a Safe Return to Work

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

To be completed in keeping with *Section 40 (2) Medical Information to Third Parties and Sickness Certificates* from *Bylaw 11 Standards of Practice of Medicine*, Manitoba College of Physicians and Surgeons.

Dear Healthcare Professional:

The patient you are about to treat sustained an injury/illness at work. This letter is to request your assistance to help us return our team member to safe accommodations at work while they are recovering from their injury/illness.

To assist injured/ill employees, we provide a comprehensive alternate work program, at no base wage loss to the employee. All return to work plans are created in collaboration with our team member, you – the treating healthcare provider, the team member’s supervisor, the Health and Safety Department and the Workers Compensation Board (WCB).

Due to our various operations, we are fortunate to be able to offer a wide range of work accommodations. **These include the ability to take more frequent breaks, work reduced hours, as well as modified or alternate work which can include sedentary duties if required.**

We have had an opportunity to discuss the Return to Work Program with this employee, but would also appreciate your support and involvement so that we may have a complete understanding of recommended abilities and limitations.

Please complete the attached Cognitive Functional Abilities Form to assist us in providing a tailored work program for your patient. Please 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 and we will ask the WCB to contact you directly for clarification.

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:

COMPANY:

PHONE NUMBER:

Cognitive Functional Abilities Form - Modified Duties Available

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Patient Name	Date of Appointment
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Is the patient fit for full regular duties? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, complete next sections.)
Is the patient capable of performing modified or alternate duties? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please provide rationale for total disability.)

Activity	Full abilities	If limited, specify abilities
Exercise full cognitive abilities		
Maintain concentration/attention span		
Handle multiple simultaneous demands		
Exercise full memory capabilities		
Operate motorized equipment		
Work and problem solve with accuracy		
Work and problem solve with speed		
Exercise sound judgment		
Maintain stamina		
Handle tight deadlines		
Handle shifting priorities		
Work independently		
Work with others		
Receive and act upon written/verbal instructions		
Driving (If no please explain)		
Other		

Estimated duration of limitations:	Complete recovery expected: <input type="checkbox"/> Yes <input type="checkbox"/> No
Recommended work hours: Full Time Hours Reduced Hours (Please provide daily/weekly schedule.)	
Frequency of treatment:	Estimated date of return to regular abilities:
Reassessment date:	Additional comments:
Healthcare Professional Name/Address/Phone/Fax or STAMP	Date

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