SIOUX LOOKOUT
Meno Ya Win
HEALTH CENTRE

Fit for Work Statement

Tel: 807-737-6577 Fax: 807-737-6273
Email: occupationalhealth@slmhc.on.ca

Name: _____

Phone: _____

A: To be completed by the Health Care provider
Assessment date: dd/mm/yy
Date illness/injury began: dd/mm/yy
Nature of illness:
Secondary to:
Under active, continuous care, and treatment from a physician: □ Yes □ No
Describe treatment plan:
Is the patient compliant with treatment plan: □ Yes □ No

B: Current Physical Restrictions (only check those which apply) **N/A** □

To be completed by the Health Care provider.

Walking □ 10-30 minutes □ 1-10 minutes □ no walking	**Standing** □ 10-30 minutes □ 1-10 minutes □ no standing	**Sitting** □ 10-30 minutes □ 1-10 minutes □ no sitting	**Stairs** □ unable
Lifting □ 5 - 10 kg □ 1 - 5kg □ < 1kg □ no lifting	**Pushing/pulling** *Lt arm* *Rt arm* □ 5-10 kg □ □ 1-5 kg □ □ < 1 kg □ □ no pushing/pulling □	**Gripping/pinching** *Lt hand* *Rt hand* □ 1-5 kg □ □ up to 1kg □ □ no gripping/pinching □	**Visual** □ depth □ color □ field □ _____
Vibration exposure □ whole body □ hand/arm □ other _____	**Environmental exposure** □ heat/cold □ noise □ scents □ other _____	**Side-effects from medication** _____ □ Permanent □ Short-term	

Other: □ Bending/Twisting of _____
□ Repetitive movement of _____
□ Chemical exposure of _____

Additional details of restrictions:

Duration of restrictions: (dd/mm/yy) _____

C. Current Cognitive Restrictions (only check those which apply) **N/A** □

To be completed by the Health Care provider.

Attention/Concentration/ Decision making □ Limited □ no attention/ concentration/decision	**Communication** □ Speech □ Writing	**Understanding/memory** □ limited □ no understanding/ memory	**Public Contact** □ Limited □ no public contact

□ **Medication/s limiting cognitive abilities** (i.e.: analgesic/sedatives, etc.)
List medication and symptoms causing impairment
_____

Additional details of restrictions:

Duration of restrictions: (dd/mm/yy) _____

Revised Oct 2018 1992

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D. Current Infectious Restrictions (only check those which apply) **N/A** □			
To be completed by the Health Care provider	□ Contact (Gastro, C-Diff, MRSA, VRE)	□ Droplets (Cold, Influenza)	□ Airborne (Active TB, chicken pox)
	Additional details of restrictions: **Duration of restrictions: (dd/mm/yy)** _____		

E. Other Restriction/Limitations that may limit return to work and/or Comments N/A □
To be completed by the Health Care provider
□ **Pain limiting return to work** Details:
□ **Other restrictions/limitations/comments** Details:
Additional details of restrictions: **Duration of restrictions:** (dd/mm/yy) _____

F. Follow-up plan	
To be completed by the Health Care provider	Reassessment required: □ Yes □ No
	Date of next appointment: (dd/mm/yy)

G. To be completed by the Health Care provider
By affixing my signature below, I certify that I am a qualified registered health care professional and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.
Physician/practitioner Name: (Please print)_____ **Telephone:**_____ **Signature:** _____

H. To be completed by the Staff Member
I authorize the practitioner to complete and release all sections of this form, pertaining to my current or recent medical condition, to my employer's Staff Health/Occupational Health Specialist. Signature:_____ Date: _____

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