PHONE: 705-743-2121 FAX: 705-876-5132

PRHC
Peterborough Regional Health Centre

OCCUPATIONAL HEALTH, SAFETY & WELLNESS

ATTENDING PRACTITIONER REPORT

REVISED JULY 2017

EMPLOYEE INFORMATION AND CONSENT (to be completed in full by employee ONLY)

NAME (Last, First): ______________ CONTACT NUMBER: ______________ STATUS: ☐ FT ☐ PT ☐ TEMP
MANAGER: ______________ DEPARTMENT: ______________
OCCUPATION: ______________ FIRST DAY ABSENT: ______________

I hereby authorize the practitioner, by completing and signing this form, to fill out and release **all sections** of this form to my employer's Occupational Health, Safety & Wellness Department (OHSW) for the purposes of validating and managing my medical leave of absence, as it relates to my fitness for work. I understand that OHSW will keep my medical information confidential and it will be used to facilitate my return to work. I consent to allow OHSW to release the status of my absence, the duration, and my ability to return to work (including any restrictions) to only those individuals necessary to facilitate my medical leave, return to work, and/or accommodation.

By signing below, I acknowledge my understanding of the information above and I agree to provide my consent accordingly.

EMPLOYEE SIGNATURE: ______________ DATE: ______________

PRACTITIONER'S REPORT (to be completed in full by MD, NP or Physiotherapist ONLY)

Please complete this form to assist us in determining your patient's eligibility for sick leave due to total disability.
Please note that if your patient is not able to perform the regular duties of their job, we may be able to provide suitable modified work.
Please complete all applicable sections and return this form promptly to ensure continuation of wages and/or benefits for your patient.

If this is a workplace injury or illness, STOP! Do not use this form. Complete a WSIB Form 8.

1. Nature of illness/injury (no diagnosis required), e.g. neurological, orthopedic, respiratory, mental health:
____
____

☐ Communicable disease potentially reportable to Public Health ☐ Surgical Matter: OHIP Covered ☐ YES ☐ NO
☐ Hospitalized or fully bedridden from ________ to ________ ☐ Recurrent condition

2. First date of injury/illness: ______________ Date of first visit for current health issue: ______________
3. Is the patient participating in an active treatment plan? ☐ YES ☐ NO
4. If the patient is participating in an active treatment plan (e.g. medication/physiotherapy/counseling, etc.) please provide details
Please note: if your patient is a Registered Nurse, hired by PRHC prior to January 1, 2006, you do not need to complete question #4.
____
____
5. Is the patient presently under the care of a physician/other specialist? ☐ YES ☐ NO **If no, has a referral occured?** ☐ YES ☐ NO ☐ N/A
6. Unable to perform job duties as of this date: ______________ Expected return to regular duties: ______________

FUNCTIONAL ABILITIES (to be completed by qualified MD, NP, or Physiotherapist)

Was a formal assessment, testing, or measurement done to determine functional abilities? ☐ YES ☐ NO

PHYSICAL ABILITIES Physical limitations ☐ N/A

Lifting floor to waist	☐ 5-10kg	☐ up to 5kg	☐ other: ______
Lifting waist to shoulder	☐ 5-10kg	☐ up to 5kg	☐ other: ______
Lifting at or above shoulder	☐ 5-10kg	☐ up to 5kg	☐ other: ______
Reaching	☐ no over shoulder	☐ no overhead	☐ other: ______
Sitting/standing/walking	☐ up to 60 min.	☐ up to 30 min.	☐ other: ______
Pushing/pulling	☐ occasional		☐ other: ______
Bending/crouching/kneeling/climbing	☐ occasional		☐ other: ______
Hand function	☐ avoid gripping/pinching		☐ other: ______

COGNITIVE ABILITIES Cognitive limitations ☐ N/A

☐ Concentration ☐ attention ☐ memory ☐ communication
☐ Judgment (explain): ______________
☐ Ability to use motorized vehicle, machinery and/or equipment
☐ Medication side effects: ______________
☐ Other: ______________

COMMENTS: ______________
____
____
____

Practitioner's Stamp

Practitioner's Full Name: ______________
Professional Designation/Specialty: ______________
Signature: ______________ Date: ______________

Employees are responsible for the cost of the form being completed at the time of service and must submit the invoice to OHSW within one month of the service for reimbursement. A maximum of $40 will be paid to the employee. Please provide the employee with a receipt if they have paid the fee.