LAKERIDGE HEALTH

Attending Practitioner Report

FAX: 905-743-5943
PH: 905-576-8711 x3710

Employee Information and Consent: **Status:** ☐ FT ☐ PT ☐ Temp **Shift Worker:** ☐ NO ☐ YES ☐ 8 ☐ 10 ☐ 12

Name (Last, First): _____

Address: _____ **Telephone:** _____

First Day Absent: _____ **Department:** _____ **Occupation:** _____

Manager: _____ **Site:** _____ **Email:** _____

I hereby authorize the practitioner, by completing and signing this form, **to fill out and release *all sections* of this form pertaining to my current or recent medical condition**, to my employer's occupational health and abilities department. This information provided is for the purpose of determining my fitness to work and/or the need for any accommodations in my workplace and/or substantiating my absence due to illness or injury and/or eligibility for benefits.

Employee Signature:	**Date:**

All medical information received will be kept in **strict confidence** in the employee's medical file within Occupational Health and Abilities.

Attending Practitioner's Report (to be completed ONLY by the practitioner):

*Please complete this form to assist us in determining your patient's eligibility for sick leave due to total disability. The definition of total disability (as per HOODIP sick benefits plan) is "unable, due to injury or illness, to perform the regular duties pertaining to the occupation in which you participated immediately before becoming disabled. Please note that if your patient is not able to perform the regular duties of his/her job, we are able to provide modified work in most cases. Please complete **all sections** and return this form promptly to ensure continuation of wages and/or benefits for your patient.*

1) Nature of Illness/Injury:
(Disclosure of Diagnosis is not being requested)

(In addition please check any applicable boxes below)

☐ **A communicable disease potentially r*eportable to Public Health***
☐ **Recurrent condition**
☐ **Workplace Injury**
☐ **A surgical matter; OHIP covered** ☐ YES ☐ NO
☐ **Hospitalized/Bed Ridden from**_____ **to**_____
☐ **Mental Health condition with recognized diagnosis under the DSM-V**

2) Date of first visit for current health issue:_____ **Planned follow-up date:**_____

3) Is patient participating in active treatment (i.e. medication/physiotherapy/counseling etc.)? YES ☐ NO ☐ **If no, please explain rationale:**

4) Is the patient presently under the care of a specialist? YES ☐ NO ☐ **If no**, has a referral occurred? YES ☐ NO ☐ N/A ☐

5) *By signing below, I verify that based on my assessment and objective medical evidence, the patient has been:*

☐ **Totally disabled** (unable to perform regular job duties) from _____ (dd/mm/yy) with an expected return to:

A) Modified duties on _____ (dd/mm/yy) **or B) Regular duties on** _____ (dd/mm/yy)

☐ **Partially disabled** (able to perform *some* job duties) from _____ (dd/mm/yy) with an expected return to regular duties on _____ (dd/mm/yy)

Prognosis to resume regular duties: ☐ **Good** ☐ **Poor** ☐ **Uncertain** ☐ **Permanent restrictions required**

6) **Physical Limitations:** ☐ N/A

☐ Lifting up to _____kg
☐ Pushing/Pulling: ☐ Avoid ☐ No Repetitive ☐ Up to _____kg
☐ Over Shoulder work: ☐ Avoid ☐ No Repetitive ☐ Up to _____kg
☐ Standing/Walking _____minutes continuous
☐ Sitting_____ minutes continuous
☐ Bending/Twisting of_____
☐ Gripping/Pinching ☐ Avoid ☐ No Repetitive
☐ Graduated Hours

Cognitive Limitations: ☐ N/A

☐ Graduated Hours
☐ Concentration
☐ Communication (explain): _____
☐ Medication side effects: _____
☐ Other: _____

Comments:

Please **mail *original*** invoice to:
Attn: Occupational Health, 1 Hospital Court, Oshawa ON L1G 2B9
Please **FAX this form ASAP to 905-743-5943**

Practitioner's Stamp

Practitioner's Name: _____

Professional Designation/Specialty (i.e. MD, Chiro, Physio, etc): _____

Phone: _____ Fax: _____

Signature: _____ Date: _____