SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

Functional Abilities Report
Return to Ability Management
Fax #256-4711

Section One – To be completed by the ***Employee***

Last Name:	First Name:

I authorize the release of this information to the Sault Area Hospital.

Employee Signature: Date:

Section Two – To be completed by the ***Health Care Professional***

Illness/Injury Area: (not diagnosis)	Date of examination on which this report is based:

Return to work ☐ With Limitations (see below) Date:__________ ☐ Without Limitations Date:__________ ☐ Unable

Section Three – To be completed by the ***Health Care Professional*** (if applicable)

Capabilities

Walking: ☐ short distances only ☐ long distance __________

Standing: ☐ less than 15 minutes ☐ than 30 minutes__________

Sitting: ☐ less than 30 minutes☐ less than 1 hour __________

Lifting floor to waist: ☐ less than 10lbs ☐ less than 25lbs __________

Lifting waist to shoulder: ☐ less than 10lbs ☐ less than 25lbs __________

Above shoulder activity: ☐ less than 10lbs ☐ less than 25lbs __________

Below shoulder activity: ☐ less than 10lbs ☐ less than 25lbs __________

Push/Pull: ☐ less than 5lbs ☐ less than 10lbs __________

Limited ability to use hand to: ☐ hold objects ☐ grip ☐ type ☐ write

Limitations

☐ Bending or Twisting of : __________

☐ Above-shoulder activity: __________

☐ Below-shoulder activity: __________

☐ Restrictions related to medications (specify):

____

☐ Repetitive movement of: __________

Estimated duration of limitations: __________

____

Recommendation for Work Hours: ☐ Full Time Hours ☐ Modified Hours ☐ Graduated Hours

If graduated/modified, please explain**:** __________

Section Four – To be completed by the ***Health Care Professional*** (if applicable)

Level of ability to:	**Unable**	**Minimal**	**Moderate**	**High**
Perform repetitive, or short cycle work				
Perform at a constant pace				
Maintain attention and concentration				
Understand, remember and carry out complex job instructions				
Interact with the public/patients				
Use judgment and make decisions				
Direct, lead or plan activities of others				
Work alone or apart in physical isolation from others				

Section Five – Prognosis To be completed by the ***Health Care Professional***

Complete recovery expected: ☐ Yes, Date: __________ ☐ No

Name of Health Care Professional (Please Print):

Health Care Professional's Signature: **Reassessment Date:**