UNIVERSITY OF SASKATCHEWAN

Medical Restriction Form (Workplace Injury)

Wellness Resources

Patient's Name: **Patient's Date of Birth:**

Date of Injury: **Last Date Worked (full hours and duties):**

Patient's signature gives consent to the health care provider to communicate the information requested on this form to Wellness Resources.

Patient's Signature: X **Date:**

WCB Claim Number (if known): _____

Nature of medical condition(s) currently affecting patient's ability to work:

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-

Is there a prescribed medical treatment plan? ☐ Yes ☐ No **Is the patient compliant with prescribed treatment plan?** ☐ Yes ☐ No

Please check all restrictions and limitations that currently affect your patient's ability to work, due to diagnosed medical condition(s):

Physical, Musculoskeletal Function – Patient has restrictions for:

☐ **Sitting:** maximum continuous duration: _____ min.
break duration: _____min, every _____ min.
total duration/shift: _____ hrs.

☐ **Standing/Walking:** maximum duration: _____ min. distance: _____ft.

☐ **Climbing:**
- ☐ **Stairs:** maximum number _____
- ☐ **Ladders:** maximum height _____ft.

☐ **Low-level Activity:** crouching, squatting, kneeling, crawling

☐ **Bending/Twisting:** ☐ neck ☐ trunk direction_____

☐ **Lifting:**
- ☐ **Floor to waist range:** maximum weight: _____lbs.
- ☐ **Waist to shoulder range:** maximum weight: _____lbs.
- ☐ **Above shoulder range:** maximum weight: _____lbs.

☐ **Carrying:**
- ☐ **Left** ☐ **Right:** maximum weight: _____lbs.

☐ **Pushing/Pulling:** maximum weight: _____lbs.

☐ **Reaching:** ☐ **Left** ☐ **Right:** ☐ forward ☐ overhead ☐ to side

☐ **Gripping:** ☐ **Left** ☐ **Right:** ☐ light ☐ heavy

☐ **Fine dexterity tasks:** keyboarding, precision work, fine manipulation
- ☐ Limited duration: _____min.

☐ **Driving:** ☐ not safe ☐ limited duration: _____min.

☐ **Operating machinery:** ☐ not safe ☐ limited duration: _____min.

☐ **Heavy equipment:** ☐ not safe ☐ limited duration: _____min.

☐ **Working at heights:** ☐ not safe ☐ maximum height _____ ft.

☐ **Visual/Computer work:** limited duration: _____ min.

☐ **Comments/Other:**

Accommodation/Return to Work Plan Recommendations

Expected duration of restrictions: _____ **Is complete recovery expected?** ☐ Yes ☐ No ☐ Unknown

Date patient is medically fit for work:

☐ **Modified duties/schedule,** effective date: _____ ☐ **Full duties/schedule,** effective date: _____

☐ Work schedule restrictions, recommendations**:**

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Is reassessment required? ☐ Yes ☐ No If yes, appointment date: _____

Health Care Provider's Name and Contact Information (Please Print or Stamp):

-
-
-

Signature: **Date:**

X

Updated August 2017

NOTE: Fees incurred for the completion of this form are the responsibility of the patient

Please return this form by mail, email, or fax to: **Wellness Resources, University of Saskatchewan**
Room E140, Administration building, 105 Administration Place, Saskatoon, SK, S7N 5A2
Telephone: (306) 966-4580 ♦ Confidential Facsimile: (306) 966-2882 ♦ Email: wellnessresources@usask.ca