

g) Future treatment plan:

h) Prognosis:

2. Secondary Diagnosis

a) Diagnosis:

b) To what extent does the secondary diagnosis contribute to the patient's condition?

Significantly

Slightly

Equally with primary diagnosis

Not a contributing factor

c) Supportive evidence:

d) Present treatment:

e) Future treatment plan:

f) Prognosis:

3. Other Complicating Factors

a) Diagnosis:

b) Supportive evidence:

c) Present treatment:

d) Future treatment plan:

e) Prognosis:

4. Specialists

a) Names, addresses and specialities of other treating and consulting physicians:

b) If patient has not seen a specialist, please indicate reason:

5. Current Functional Limitations

a)	FUNCTION	DEGREE OF LIMITATION				
		None	Slight	Moderate	Severe	Don't know
	Judgement _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Decision-making _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Attention _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Concentration _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Speaking _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hearing _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sensation _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Driving _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walking _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Standing _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Climbing _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sitting _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bending _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lifting _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Please indicate maximum recommended weight _____ <input type="checkbox"/> lbs <input type="checkbox"/> kgs					
	Dexterity _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vision _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please add any other functions limited by the illness or injury:

_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) Describe any functional limitations, physical or psychological, which you consider to be major obstacles to the patient's ability to work.

c) Were any functional capacity evaluations performed? Yes No

If "Yes", state type, provide date performed and enclose copy, if available:

Day	Month	Year	

d) What return-to-work goals have been discussed with your patient? Please explain:

e) What date has been discussed for your patient's return to work:

Day	Month	Year	

f) Regular duties: Can your patient return to full regular duties? Yes No

If no, please describe what job modifications would be needed in order to return to work:

g) Please provide any other information that will help us to understand the patient's current condition, recovery goals and prognosis:

h) Would your patient benefit from medical or vocational rehabilitation services (i.e. conditioning program, psychological counselling, addition program, vocational counselling, etc.)? Yes No

6. Functional Overlay

a) Are the clinical findings proportional to the patient's complaints? Yes No If no, explain:

b) If answer to a) is "no", has the patient been referred for psychiatric assessment and/or treatment? If not, would a psychiatric assessment and/or treatment be useful?

7. Clinical Findings and Observations

a) Please describe how the condition(s) have impacted the following, and to what degree:

DEGREE OF IMPACT

	None	Slight	Moderate	Severe
Appearance _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy vigour _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decision making _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialization _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration/focus _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect/mood _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insight/judgment _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-criticism _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) Observations or comments supporting the above:

8. Complicating Factors

a) Indicate all factors that have contributed to the clinical problem(s) and may complicate the patient's recovery period:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Workplace issues | <input type="checkbox"/> Social/family issues | <input type="checkbox"/> Financial/legal problems | <input type="checkbox"/> Physical condition |
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Medication side effects | <input type="checkbox"/> Pain perception | <input type="checkbox"/> Coping skills |
| <input type="checkbox"/> Personality/motivation | <input type="checkbox"/> Other | | |

Please describe:

b) Please describe the supports in place, or planned, to assist with these issues:

9. Additional Information