UNITY HEALTH TORONTO

Workplace Health, Safety and Wellness
T: 416-530-2099
F: 416-864-5405

SMH MEDICAL QUESTIONNAIRE (ONA only, hired before Jan 1, 2006)

Name:_____ Telephone Number: _____
Department:_____ Date last worked: _____

I hereby authorize my healthcare practioner (HCP) _____, by completing and signing this form, to release medical/functional information pertaining to my current medical absence to Workplace Health, Safety and Wellness (WHSW) at St. Michael's Hospital. I understand that this information is for the purpose of determining my fitness to work and/or the need for any accommodation in my workplace and / or to substantiate my absence due to illness and/or eligibility for benefits. I also authorize the staff of WHSW to contact my healthcare practitioner for the development and implementation of my Early and Safe Return to Work Plan, if needed.

This authorization is effective (check one - if no box is checked then consent will be assumed for this single authorization only):
☐for the duration of my current disability
☐for this Statement of Fitness to work only - I will be required to provide written consent for every subsequent communication

I understand that I may revoke this authorization at any time either in a written document signed by me or electronically, provided sufficient authentication to establish my identity. I understand that only information regarding to my ability to work and my medical restrictions will be shared with my manager/ supervisor, my union and Human Resources.

Employee signature: _____ Date: _____

Nature of Illness/Injury (general statement of a person's illness or injury in plain language without any technical medical details or diagnosis):

Date Illness/Injury forced cessation of work	Date of first visit	Date of most recent visit	Date of next visit

Is this injury/illness related to work? ○ Y ○ N
Has your patient been hospitalized? ○ Y ○ N Dates of admission and discharge:

Is this employee fit to return to work now without restrictions? ○ Y ○ N
If YES - Please sign and date form below
If NO - Please sign and date form below and **complete questions overleaf**

Specialty	Date	Office Stamp
HCP name	HCP signature	
Address		
City	Postal Code	
Telephone	Fax	

Name: _____

When can he/she resume his/her full duties? Date: _____ ◯ date unknown
Can your patient return to work with restrictions before this time? When?:_____

Based on these difficulties, what restrictions do you recommend to safely return your patient back to work?

Activity	Work Restrictions
Walking	
Standing	
Sitting	
Lifting floor to waist (R or L - please specify)	
Lifting waist to shoulder (R or L - please specify)	
Lifting above shoulder (R or L - please specify)	
Reaching above or below shoulder (R or L - please specify)	
Pushing/pulling	
Climbing stairs/ladders	
Gripping (R or L - please specify)	
Bending / twisting (at neck or waist - please specify)	
Shift restrictions (please specify and explain)	
Cognitive (coherence, judgement, concentration, ability to work independently - please specify)	

Is there any medical contraindication to increasing your patient's work duties and hours back to her/his full duties and hours? Please explain:

HCP signature	Date