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

UNITY HEALTH TORONTO

SMH MEDICAL QUESTIONNAIRE (ONA hired Jan 1, 2006 or after / all other employees)

Name:_________________________________ Telephone Number: ________________
Department:_____________________________ Date last worked: __________________

I hereby authorize my medical doctor (MD) ____________________, by completing and signing this form, to release medical/functional information pertaining to my current medical absence to the Workplace Health, Safety and Wellness (WHSW) at St. Michael's Hospital. I understand that this information is for the purpose of de-termining 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 health-care 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
Is this absence due to an optional medical procedure not covered by OHIP? Y N
Has your patient been hospitalized? (Dates:) Y N

Treatment (please list)	Date initiated and date last modified	Response to treatment

I confirm that this employee is under my active and continuous care based on current best practice recommendations and is following the treatment which I have prescribed Y N

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**

MD signature	Date
MD name	
Address	
City	Postal Code
Telephone	Fax

Office Stamp

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