Functional Abilities Form

For Early and Safe Return to Work

Please PRINT clearly

Employee's Last Name	Employee's First Name

The following information should be completed by the treating Practitioner to identify the patient's overall abilities and restrictions.

Date of Assessment

DD | MM | YYYY

Abilities and/or Restrictions

1. Please indicate Abilities that apply, include additional details in section 3.

Walking	**Standing**	**Sitting**	**Lifting from floor to waist**
☐ Full abilities	☐ Full abilities	☐ Full abilities	☐ Full abilities
☐ Up to 100 metres	☐ Up to 15 minutes	☐ Up to 30 minutes	☐ Up to 5 kilograms
☐ 100 – 200 metres	☐ 15 – 30 minutes	☐ 30 minutes – 1 hour	☐ 5 – 10 kilograms

Lifting from waist to shoulder	**Stair climbing**	**Ladder climbing:**
☐ Full abilities	☐ Full abilities	☐ Full abilities
☐ Up to 5 kilograms	☐ Up to 5 steps	☐ 1 – 3 steps
☐ 5 – 10 kilograms	☐ 5 – 10 steps	☐ 4 – 6 steps

2. Please indicate Restrictions that apply, include additional details in section 3.

Check all that apply and fill in specifics

☐	Bending/twisting repetitive movement of (please specify)	☐	Work at or above shoulder activity:	☐	Environmental exposure to (e.g. heat, cold, noise or scents)	Left	Limited use of hand (s):	Rght
						☐	Gripping	☐
						☐	Pinching	☐
						☐	Other (please specify)	☐

Limited pushing/pulling with: Circle One	☐ Left Arm ☐ Right Arm ☐ Other:	☐	Operating motorized equipment (e.g. forklift)	☐	Potential side effects from medications (please specify. Do not include names of medications)	☐	Exposure to vibration Circle One	☐ Whole body ☐ Hand ☐ Arm

3. Additional Comments on **Abilities and/or Restrictions**:

4. **From the date of this assessment, the above will apply for approximately**:

☐	1 – 2 days	☐	3 – 7 days	☐	8 – 14 days	☐	14 + days

Date of Next Assessment: DD MM YYYY

Treating Practitioner's Name & Title: Telephone: Fax:	Address:	Signature: Date:

All requests for reimbursement of APS forms must be made **within 3 months** from the date of service.