

This form is for out-of-province providers to complete.
 Please fax or mail the completed form to us using the
 information on the form.

 Date of Initial
 Assessment: dd | mm | yyyy

WCB Claim #:

Health Card #:

WORKER INFORMATION

Worker's Name:		Area and Type of Injury:	
Employer's Name:			
Employer Contact Name:			Phone:

HEALTH CARE PROVIDER INFORMATION

Provider Name:		ID#:
Practitioner Name:	Phone:	Fax:

PHYSICAL ABILITIES ASSESSMENT (refer to Work Capabilities – Definitions)

Weights: ☐ pounds ☐ kilograms	Period 1		Period 2		Period 3		Period 4		Pre-injury Job Demands				
ABILITY Test Date:	dd	mm	yyyy	dd	mm	yyyy	dd	mm	yyyy	dd	mm	yyyy	Reported by: Worker Employer Other
F = Frequent (66%) O = Occasional (33%)	F	O	F	O	F	O	F	O	F	O			
Lifting													
Above Shoulder													
Horizontal													
Floor/Waist													
Carrying													
Right Hand													
Left Hand													
Both Hands													
Pushing													
Pulling													
Tolerance (check box below: subjectively reported by worker or observed during assessment)													
Standing ☐ reported ☐ observed													
Sitting ☐ reported ☐ observed													
Walking ☐ reported ☐ observed													
Grip Strength R = Right L = Left	R	L	R	L	R	L	R	L	R	L			

Other Essential/Critical Job Tasks:

Work Capability P = Pre-injury Job Duties T = Transitional Duties	P	T	P	T	P	T	P	T	Comments:
Overall Functional Progress I = Improving N = No Change D = Declining									
Tester's Initials									

RETURN TO WORK/STAY AT WORK PLAN (if **T** duties selected above)

FINAL RTW OUTCOME: (completed on discharge)

Period 1	☐ No time lost ☐ Pre-injury Date: dd mm yyyy ☐ Did not return ☐ Suitable Date: dd mm yyyy (state reason): Discharge Date: dd mm yyyy
Period 2	
Period 3	
Period 4	