

## **Physiotherapy/ Occupational Therapy**

## Functional Abilities Report - Form C

Date of Initial Assessment    YY							WSCC Claim Number							
Worker Information														
Last Name First Na				st Name				Middle Initial Ar			rea and Type of Injury			
Employer Name														
Employer Contact Name					Phone									
Health Care Provider I	nformation													
Provider Name						Practitioner ID Number								
Practitioner Name				Phone					Fax					
Physical Abilities Asse	essment													
Weights Pounds ☐ Kilograms				Period 1 Perio			od 2 Period 3 Pe			P	Pre-injury Job Demands			
Ability	Test Date		IM DD nm dd	yy M			M DD m dd		M DD m dd	Weights reported by:			by:	
<b>F</b> = Frequent (66%) <b>O</b> =	Occasional (33%)	F	o	F	0	F	o	F	o	Worke	er	Employer	Other	
Lifting														
Above Shoulder														
Horizontal														
Floor/Waist														
Carrying														
Right Hand														
Left Hand														
Both Hands														
Pushing														
Pulling														
Tolerance										Tin	ne reported b	py:		
<b>R</b> = Reported <b>O</b> = Obse	erved	R	О	R	0	R	0	R	o	Worke	ər	Employer	Other	
Standing (minutes)														
Sitting (minutes)														
Walking (distance)														
Grip Strength <b>R</b> = Right	<b>L</b> = Left	R 🗆	L $\square$	R 🗆	L 🗆	R $\square$	L	R $\square$	L					

Physical Abilities Assessment (continued)											
Other Essential/Critical Job Tasks											
	Р	eriod 1		Period 2	2		Period 3			Period 4	1
	УУ	MM DD dd	УУ	MM mm	DD dd	YY уу	MM mm	DD dd	YY уу	MM mm	DD dd
Work Capability <b>P</b> = Pre-injury Job Duties <b>M</b> = Modified Duties	Р	м 🗆	Р□	м		Р□	м□		Р□	м	
Overall Functional Progress  I = Improving N = No Change D = Declining	ı	N □ D □	ı□	N $\square$	<b>D</b> $\Box$	ı□	Ν□	<b>D</b> $\square$	ı	<b>N</b> □	<b>D</b> $\Box$
Tester's Initials											
Comments											
Return to Work/Stay at Work Plan (if M duties	selected	d above) <b>F</b>	inal Re	turn to	Work	Outcor	ne (com	pleted	on dis	charge)	
Period 1			☐ No tir	ne lost			] Pre-inju	ury Da	ate YY	MM mm	DD dd
Period 2				ot return reason)			Suitable	e Da	ate YY	MM mm	DD   dd
Period 3											
P. 114			ischarge	e Date	YY MN	/ DD					

Copied to Physician, Employer, and WSCC

The WSCC may use this information for the administration of legislation under our authority, including the Workers' Compensation Acts, the Safety Acts, and/or the Mine Health and Safety Acts, and their associated Regulations, and to contact you in relation to the requirements under the relevant legislation. It is your responsibility when providing an email address to ensure reasonable safeguards are in place to protect the confidentiality and security of your personal information within your email account.

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