Functional Abilities Assessment: Template for Employers

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When to use this template

This template is for employers to get information from a health care provider (physician, nurse practitioner, physiotherapist, etc.) about an injured employee's functional abilities after a work-related injury. This information can be used to plan a safe and timely return to work for the employee.

For many injuries, there's no need to wait for a health care provider's input before beginning the return-to-work planning process. If there are concerns about employee function or safety, involve a health care provider to provide input on the employee's functional abilities and/or on a return-to-work plan.

WorkSafeBC does not require that you use this template. It is offered as a tool only. If a health care provider charges a fee for completing a Functional Abilities Assessment, it is your responsibility as the employer to pay the fee.

Additional information about helping an injured employee return to work can be found at worksafebc.com/returntowork.

How to use this template

This template is provided in this ready-to-use PDF version, as well as a Word version that you can customize to fit the specific needs of your workplace.

To use this template:

1. Fill in the blank fields in the letter to the health care provider.
2. Give the letter and blank assessment to your employee who has experienced an injury at work.
3. Ask the employee to take both to their health care provider and then return the completed assessment to you.
4. Use the information in the assessment to help identify suitable work for them.

Sending a Functional Abilities Assessment to WorkSafeBC

Although WorkSafeBC does not require employers to use Functional Abilities Assessments, if you choose to have one completed, please submit a copy to us. Submitting it online is the fastest and easiest way. You can do this through your online services account or by using our document uploader. Alternatively, you can fax a copy of the assessment to 604.233.9777 (or toll-free to 1.888.922.8807).

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's FIPP Office at PO Box 2310 Stn Terminal, Vancouver, BC, V6B 3W5, email **FIPP@worksafebc.com**, or call 604.279.8171.

Reset

Functional Abilities Assessment

Date: _____

Dear Health Care Provider:

At _____, we are committed to supporting our ill and injured workers by providing suitable work that's safe and within their abilities. This includes offering them modified or different duties and hours when needed.

We know that a worker's continued attachment to their workplace contributes to both their physical and mental health. We also know that with appropriate workplace accommodations, workers recover faster and are less likely to have long-term health effects.

Please complete the attached Functional Abilities Assessment form. If possible, return the completed form to your patient/client before the end of the appointment. Your recommendations on their abilities and any safety considerations will help us discuss and develop a return-to-work plan.

If you have any questions and/or concerns, including about what duties we can offer your patient/client, please phone me at _____.

We are willing to pay a fee of up to $_____for the completion of the Functional Abilities Assessment form. Please mail the invoice to _____ or fax it to _____.

Sincerely,

_____

Functional Abilities Assessment

Worker's information

Worker's last name	First name	Middle initial	WorkSafeBC claim number

Dominant hand (if applicable)	Date of assessment (date of service) (yyyy-mm-dd)
☐ Left ☐ Right	

Occupation	Area of injury (please indicate left or right, if applicable)

Please check one:

☐ Worker can return to work with no considerations
☐ Other (please specify)

☐ Worker can return to work with considerations
(please complete the table below)

General abilities and/or considerations

Please indicate the worker's current abilities in relation to the functional activities below.

Walking	**Standing**	**Sitting**	**Reaching**
☐ Less than 30 minutes ☐ About an hour ☐ A few hours ☐ On uneven ground ☐ Full abilities ☐ Other (please specify)	☐ Less than 30 minutes ☐ About an hour ☐ A few hours ☐ Full abilities ☐ Other (please specify)	☐ Less than 30 minutes ☐ About an hour ☐ A few hours ☐ Full abilities ☐ Other (please specify)	☐ Able to reach above shoulder ☐ Able to reach below shoulder ☐ Full abilities ☐ Other (please specify)
Bending	**Squatting**	**Kneeling**	**Driving**
☐ Able to forward bend to some degree ☐ Full abilities ☐ Other (please specify)	☐ Able to squat to some degree ☐ Full abilities ☐ Other (please specify)	☐ Able to kneel to some degree ☐ Full abilities ☐ Other (please specify)	☐ Able to drive to some degree ☐ Full abilities ☐ Other (please specify)
Lifting and carrying	**Using hand(s)** (to type, grip, etc.)	**Stair climbing**	
☐ Up to 5 kg ☐ Up to 10 kg ☐ Up to 20 kg ☐ More than 20 kg ☐ Other (please specify)	☐ Able to use to some degree ☐ Full abilities ☐ Other (please specify)	☐ Able to climb stairs to some degree ☐ Full abilities ☐ Other (please specify)	

Additional recommendations or comments (i.e., specific duty considerations and/or ability to do any activities not listed above, and recommended support strategies)

Provider's information

Health care provider's name (please print or type)	Health care provider's signature

Clinic name	Clinic email address	Clinic phone number