# ATTN EMPLOYEE:Medical Inquiry Form

* Please fill out all requested information in the box below, under the heading of “EMPLOYEE TO COMPLETE”.
* Once completed and signed, provide a copy of your position description\* and the remainder of this form to your treating physician for medical inquiry response.
* The physician may choose to submit the completed form to Human Resource Services or return it directly to the employee once complete, but in either case, it ultimately remains the employee’s responsibility to ensure its submission to the College.
* Please note: If your physician charges you for the completion of this medical form, you may submit an expense claim form (via Maestro), along with the physican’s invoice and your proof of payment (receipt) to your budget centre manager for reimbursement. For questions about the expense claim process, please contact [financeprocesssupport@rrc.ca](mailto:financeprocesssupport@rrc.ca)

\**Position descriptions are available through the employee’s direct supervisor or Human Resource Services*.

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| --- | --- |
| **EMPLOYEE TO COMPLETE** | |
| **Name:** |  |
| **Department/School:** |  |
| **Direct Supervisor:** |  |
| **Position Title:** |  |
| **Personal Phone Number:** |  |
| **Personal Email Address:** |  |
| **CONSENT FOR PHYSICAN:** | |
| I hereby consent to and authorize my treating physician and/or care provider to receive, release and exchange pertinent medical information acquired in the course of my examination(s) and/or treatment(s) to my employer, Red River College or its representative as it pertains to my medical status, functional abilities and/or time loss from work. I understand that this medical information will be used for the purpose(s) of assessing my current medical standing as it relates to my ability to perform my work responsibilities in the workplace, to identify any restrictions or limitations that may need to be accommodated, to determine a return to work strategy,  if appropriate and/or to validate the need for ongoing or extended medical absence from work. I understand that this consent and authorization may be revoked at any time by my providing written instructions to my physician, with a copy to my employer. | |
| **Employee Signature:** |  |
| **Date:** |  |

# ATTN PHYSICIAN:

Red River College (RRC) is committed to supporting employees to maintain their health and to recover from illness or injury when it occurs by providing the opportunity for workplace accommodation and/or reintegration in an effort to assist its employees with medical concerns during or after periods of disability.

The College is also respectful of the principles articulated in Canadian Medical Association policies on the physician’s role in supporting ill or injured employees as well as the employer’s duty to accommodate. As such, modified or alternate duties and/or work schedules may be temporarily or permanently provided to ill, injured or medically restricted employees with medical needs and/or reduced functional abilities.

The purpose of this inquiry is to seek your expert medical feedback so as to better understand any medically supported and work-relevant restrictions or limitations that your patient may have. We strive to enable employees to remain at work by accommodating their medical needs, or to return them to work as soon as it is medically appropriate in order to further facilitate their recovery and maintain their connection to the workplace. We greatly appreciate your time and assistance in advancing these efforts on behalf of your patient.

**PHYSICIAN TO COMPLETE**

1. Are you this employee’s regular treating physician (GP) or specialist? YES NO
2. Date of Examination (*most recent*):
3. Please describe the general nature of your patient’s current medical condition(s).
4. i) Has a treatment plan or program been determined and commenced for your patient?

YES NO

ii) If NO, please advise why treatment has not commenced.

1. Please provide your medical opinion on how your patient’s current medical condition impacts their ability to undertake the following activities:

The following describe the ratings terms:

* **None** - Absent or minimal limitations
* **Mild** - There is a slight limitation but the individual can generally function well
* **Moderate** - More than slight limitation but the individual is able to function satisfactorily
* **Marked** - There is serious limitation. Substantial loss in ability to effectively function
* **Extreme** - There is major limitation. No useful ability to function

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | None | Mild | Moderate | Marked | Extreme |
| **Organizational** | | | | | |
| Ability to effectively manage work time |  |  |  |  |  |
| Ability to focus and concentrate |  |  |  |  |  |
| Ability to pay attention to detail and with accuracy |  |  |  |  |  |
| Ability to organize information |  |  |  |  |  |
| Ability to perform memory related tasks |  |  |  |  |  |
| **Cognitive and Behavioral** | | | | | |
| Understand and remember instructions |  |  |  |  |  |
| Carry out instructions as directed |  |  |  |  |  |
| Make judgments on simple work-related decisions without immediate supervision |  |  |  |  |  |
| Make judgments on complex work-related decisions without immediate supervision |  |  |  |  |  |
| Ability to adapt to changing work scenarios and perform independently within job scope |  |  |  |  |  |
| Ability to interact with colleagues and clients in professional, respectful manner |  |  |  |  |  |

1. WHETHER OR NOT YOUR PATIENT IS CURRENTLY DEEMED CAPABLE OF WORKING IN ANY CAPACITY:

Please outline any and all objective medical restrictions/limitations that are currently impacting your patient’s functional abilities (I.e. which are preventing return to work and/or require accommodation consideration) and provide specific details regarding what (if any) objective medical information supports each restriction/limitation or medical need for accommodation.

**NOTE:** If there is no objective medical rationale provided for any/each listed restriction/limitation, it will be considered a recommendation – not a medically supported restriction.

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| **Medical Restriction/Limitation** | **Identify the Specific Objective Medical Rationale for the Restriction/Limitation** |
| *Ex. 1: No overhead reaching* | *Reduced range of motion at injury site during the recovery period* |
| *Ex. 2: Unable to work in any capacity* | *Compromised decision-making abilities, loss of focus, concentration* |
| *Ex. 3: Requires gradual return to work plan* | *Given length of absence, requires work hardening with a gradual return to full time over a 4-week period* |
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1. From the date of this assessment, the above will apply for approximately:

|  |  |
| --- | --- |
| * 1-7 days | * 3-6 months |
| * 1-4 weeks | * More than 6 months |
| * 2-3 months | * Until next reassessment |
| OR to (specify date or permanent): |  |

1. What is your patient‘s anticipated return to work date - with or without restrictions (if applicable)? (I.e. not applicable if there are no required absence(s) from work related to restrictions/limitations)
2. What is the date of your patient’s next scheduled appointment to review functional abilities and/or restrictions (reassessment)?
3. Please advise whether there are any risk factors to your patient, their coworkers, students or others that we need to be made aware of to maintain a safe work environment and if so, what factors and/or additional considerations should the College be aware of to ensure safety?

Physician’s Address Stamp *(optional)*

# Physician’s Name:

*(Print Name)*

# Physician’s Signature:

**Date:**

When completed, please submit this form in confidence to:

ATTN: Human Resource Services

Red River College Polytechnic, C409-2055 Notre Dame Avenue, Winnipeg, Manitoba, Canada R3H 0J9 Email: [humanresources@rrc.ca](mailto:humanresources@rrc.ca)

Fax: 204-694-0750