Work Ability Assessment Form

# A – PATIENT / CLIENT INFORMATION

|  |  |  |
| --- | --- | --- |
| **Last name:** | **First name:** | **Middle initials:** |
| **Date of Birth (*yyyy-mm-dd*):** | **Nature of illness (not diagnosis):** |

# B – WORK ABILITY (PLEASE CHOOSE FROM OPTIONS BELOW)

|  |  |
| --- | --- |
| **1** | **🞎 Fit for regular duties** |
| **2** | **🞎 Fit for modified or alternate duties**Please identify current limitations or restrictions: |
| **3** | **🞎 Unfit for an duties***If severe mental health condition and unable to perform any meaningful employment.* | **Expected date for graduated return to work *(yyyy-mm-dd)*:** |
| **Date of next appointment (*yyyy-mm-dd*):** |
| **Additional comments:** |

# C – HEALTH CARE PROVIDER INFORMATION

|  |  |
| --- | --- |
| **Health care provider’s name:** | **Health care provider’s signature:** |
| **Today’s date (*yyyy-mm-dd*):** | **Health care provider’s phone number:** |