Non – Occupational Injury/Illness Status Report (ISR)

EMPLOYEE: This form must be completed in full to ensure eligibility for sick leave entitlement.

HEALTH CARE PROVIDER: The City of St. Catharines is requesting that you provide our employee with an assessment to identify appropriate modified work or to confirm eligibility for sick leave entitlement.

Employee Section:

Employee Name: _____ **Employee Number:** _____

Job Title: _____ **Department:** _____

Current Contact Telephone Number: _____ **Alternate Telephone Number:** _____

Supervisor Name: _____

Voluntary Authorization for Release of Information: If clarification regarding what is recorded on ***this form*** is required to avoid delay or disruption in benefits or return to work, I authorize Human Resources to contact my health professional. ***No new medical information will be requested.***	**Employee Signature:** _____ **Date:** _____
PLEASE RETURN THE COMPLETED FORM: Via Confidential Fax at: **(905) 688-9694** Via E-mail at: **absencereports@stcatharines.ca** Hand Deliver to: **Human Resources** **This form is also available on-line at: http://www.stcatharines.ca/ISR**	**The cost of this form is the responsibility of the employee.** **Employees will be reimbursed in accordance with Corporate Policy.**

Health Care Provider Section:

Nature of Current Injury/Illness (*Not Diagnosis*):	Date Injury/Illness Commenced:
Date of this Assessment:	Date First Assessed (for this condition):

Has a referral to another Health Care Professional been made? □ Yes (optional – please specify): _____ □ No

If yes, will you continue to be the patient's primary health care practitioner? □ Yes □ No

Follow-up appointment required? □ Yes (date of next appointment): _____ □ No

. . . please continue to page 2

Employee Name: _____

Health Care Provider to Complete:

Section A **Please check the box below that reflects your overall assessment of this patient:**

☐ Capable of returning to work with **no restrictions** effective immediately. **Please proceed to *SIGN-OFF* at bottom of page.**	☐ Capable of returning to work **with restrictions** effective immediately. **Estimated duration:** _____ **Please *complete Section B* below.**	☐ Unable to return to work at this time. ***ADDITIONAL INFORMATION REQUIRED FOR BENEFIT ENTITLEMENT:*** ***Estimated* Date of Return to Work:** _____ ***Section B MUST be completed* below to identify how the injury/illness currently prevents your patient from returning to work in any capacity.**

Section B

Contagious/Infectious Illness: ☐ Yes ☐ No	**Restrictions related to medication use:** ☐ Yes (list restrictions) ☐ No	**Restrictions related to driving/operating equipment:** ☐ Yes (specify) ☐ No	**Walking:** ☐ Full abilities ☐ Up to 100 metres ☐ 100 to 200 metres ☐ Other:
Standing: ☐ Full abilities ☐ Up to 15 minutes ☐ 15 to 30 minutes ☐ Other:	**Sitting:** ☐ Full Abilities ☐ Up to 30 minutes ☐ 30 minutes to 1 hour ☐ Other:	**L** / **Ability to use hands:** / **R** ☐ Full Abilities ☐ ☐ Limited gripping ☐ ☐ Limited keyboarding/writing ☐ ☐ Other: _____ ☐	**Pushing/Pulling:** ☐ Full Abilities ☐ Up to 10 kilograms ☐ 10 to 15 kilograms ☐ Other:
Lifting from floor to waist: ☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 to 10 kilograms ☐ Other:	**Lifting from waist to shoulder:** ☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 to 10 kilograms ☐ Other:	**Ladder Climbing:** ☐ Full Abilities ☐ 1 to 3 steps ☐ 4 to 6 steps ☐ Other:	**Stair Climbing:** ☐ Full Abilities ☐ Up to 5 steps ☐ 5 to 10 steps ☐ Other:
Cognitive Restrictions? ☐ Yes; ***Please continue*** → ☐ No	**Attention:** ☐ No Deficit ☐ Mild Deficit ☐ Moderate Deficit ☐ Severe Deficit	**Critical Thinking:** ☐ No Deficit ☐ Mild Deficit ☐ Moderate Deficit ☐ Severe Deficit	**Emotional:** ☐ No Deficit ☐ Mild Deficit ☐ Moderate Deficit ☐ Severe Deficit
If reduced or graduated hours are required, please specify:		**Other restrictions/Comments:**	

(OFFICE STAMP) **SIGN-OFF:**	**Health Care Provider's Name:**	
	Signature:	
	Date:	
	Phone Number:	**Fax Number:**