

# Appendix C – Authorization & Occupational Fitness Assessment (OFA) Form



#1200 – 1333 W. Broadway, Vancouver, BC V6H 4C1

Phone: 604-630-1456 Fax: 604-630-1475

## Early Intervention Program (EIP) AUTHORIZATION & OCCUPATIONAL FITNESS ASSESSMENT (OFA) FORM

### PURPOSE

This **confidential** form will assist the EIP Early Intervention Coordinator and Medical Case Manager

- confirm the anticipated duration of your sick leave
- determine the type of work suitable to your medical restrictions
- determine if other medical or rehabilitation processes would be beneficial

### AUTHORIZATION TO ACCESS INFORMATION (To Be Completed By Employee)

#### Purpose of the Authorization

The purpose of this authorization is to allow the Healthcare Benefit Trust (“HBT”)<sup>1</sup> to collect, use and disclose information about me that is necessary for providing “early intervention services”<sup>2</sup> to me. It is also the purpose of this authorization to protect my right to privacy by restricting the collection, use and disclosure of my information about me which is necessary for the effective delivery of early intervention services to me. It is a condition of this authorization that only those employees, agents or contractors of HBT that need access to my information about me for the effective delivery of early intervention services to me will have access to my information.

#### Authorization to My Health Care Providers

I authorize my health care providers<sup>3</sup> to disclose to the Healthcare Benefit Trust (HBT) medical information<sup>4</sup> about the illness or injury for which I may receive early intervention services, and other personal information<sup>5</sup> about me that is necessary for the delivery of early intervention services to me in relation to this illness or injury.

#### Authorization to My Employer

I authorize my employer to disclose to HBT “employment information”<sup>6</sup> that is necessary for the effective delivery of early intervention services to me.

#### Authorization to Healthcare Benefit Trust

I authorize the HBT to disclose my medical, personal and employment information to:

1. other health care providers,
2. representatives of the Nurses’ Bargaining Association, as appropriate, authorized to represent the unions in the Early Intervention Program,
3. representatives of the Health Employers Association of BC authorized to represent the employers in the Early Intervention Program,

to the extent that this disclosure is necessary for my ongoing treatment or the effective delivery of early intervention services to me.

If I make a claim for LTD benefits, I authorize the HBT to disclose to Great-West Life Assurance Co. the medical information collected in the EIP process that is necessary to process my LTD claim.

### THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR 5 MONTHS FROM THE DATE OF SIGNATURE

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Print Name: \_\_\_\_\_ Signature of Claimant: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

<sup>1</sup> Healthcare Benefit Trust (HBT) – the legal entity of the HBT is the Trustees of the HBT.

<sup>2</sup> “early intervention services” are customized services provided to ill or injured employees to facilitate their safe and timely recovery and return to work.

<sup>3</sup> “health care provider” means a physician (doctor), therapist, or other medical practitioner who has or will examine, diagnose or treat you with respect to the illness or injury for which early intervention services may be provided before or during your participation in the Early Intervention Program.

<sup>4</sup> “medical information” means information in the possession of a health care provider that relates to the diagnosis or treatment for the illness or injury for which early intervention services are to be provided.

<sup>5</sup> “personal information” means information about you, other than medical or employment information, that the early intervention service providers need to be able to provide early intervention services to you, including your home address and home telephone number.

<sup>6</sup> “employment information” means information in the possession of your employer that relates to your employment and is necessary to process your claim for early intervention services, including your job title, job description, date of disability and other information necessary for the development of a return to work plan.

**CONFIDENTIAL INFORMATION (To Be Completed By Attending Physician)**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_

Expected Date of Return to Work: \_\_\_\_\_

Reason for Absence:  Sickness     Injury     Occupational     Non-Occupational

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

If Psychiatric Diagnosis, DSM AXIS I: \_\_\_\_\_

Hospitalized:         No     Yes – If "Yes", date admitted: \_\_\_\_\_

Date Discharged: \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

Treatment: \_\_\_\_\_

\_\_\_\_\_

Date of First Visit: \_\_\_\_\_    Date of Most Recent Visit: \_\_\_\_\_

Date of Next Planned Visit: \_\_\_\_\_    Frequency of Visits: \_\_\_\_\_

When do you expect improvement? \_\_\_\_\_

Names of other treatment physicians: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Functional Limitations:**

Restrictions/limitations of function resulting from medications and/or treatment and approximate duration:

\_\_\_\_\_

\_\_\_\_\_

Are there any medical restrictions that limit your patient's functions or abilities?

No       Yes – please complete below.

**\* PLEASE NOTE THAT TRANSITIONAL WORK IS AVAILABLE**

**Physical Limitations:****Duration – Comments**

Walking:     short distances only     medium distances     no restriction    \_\_\_\_\_

Standing:    less than 15 min.     less than 30 min.     no restriction    \_\_\_\_\_

Sitting:      less than 30 min.     less than 1 hr.     no restriction    \_\_\_\_\_

Lifting Floor to Waist:     <10 kg     <25 kg     no restriction    \_\_\_\_\_

Lifting Waist to Shoulder:  <10 kg     <25 kg     no restriction    \_\_\_\_\_

Stair Climbing:     none     2-3 steps     short flight     no restriction    \_\_\_\_\_

Ladder Climbing:    none     2-3 steps     4-6 steps     no restriction    \_\_\_\_\_

Hand / Wrist:         grip     type     write     no restriction    \_\_\_\_\_

Above Shoulder Activity: \_\_\_\_\_

Below Shoulder Activity: \_\_\_\_\_

Vision:     acuity \_\_\_\_\_     depth \_\_\_\_\_     perception \_\_\_\_\_

Pushing / Pulling: \_\_\_\_\_

Other: \_\_\_\_\_

**Cognitive/Mental Limitations:****Duration – Comments**

Attention & Concentration:     mild     moderate     severe    \_\_\_\_\_

Learning & Memory:             mild     moderate     severe    \_\_\_\_\_

Decision-Making:                 mild     moderate     severe    \_\_\_\_\_

Judgment:                          mild     moderate     severe    \_\_\_\_\_

Organization & Planning:        mild     moderate     severe    \_\_\_\_\_

Social Interaction:                mild     moderate     severe    \_\_\_\_\_

Communication:                  mild     moderate     severe    \_\_\_\_\_

Adaptation:                         mild     moderate     severe    \_\_\_\_\_

Other: \_\_\_\_\_

