



Community Social Services Early Intervention Program (CSSEIP) AUTHORIZATION & OCCUPATIONAL FITNESS ASSESSMENT (OFA) FORM

PURPOSE

This confidential form will assist the CSSEIP Medical Case Manager to:

- 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 BE COMPLETED BY EMPLOYEE)

I authorize any physician or practitioner, healthcare or rehabilitation provider, or any other person who has examined, diagnosed or treated me (or who may do so), to release my personal information including full particulars of my medical history that are reasonably necessary to process my claim to the Community Social Services Early Intervention Program (CSSEIP) and the development of my return to work plan, to:

- The Trustees of the Healthcare Benefit Trust and their agents (Trustees) which includes Great-West Life and the Rehabilitation Services department at the Healthcare Benefit Trust; and
- Designated representative(s) of the Union Bargaining Association; and
- Designated representative(s) of the Community Social Services Employers' Association.

I authorize the Trustees to give my personal information to other medical providers for necessary treatment.

I authorize my employer to provide the Trustees with information regarding my employment, my date of disability related to my CSSEIP claim, and any other information reasonably necessary for the proper processing of my CSSEIP claim and the development of my return to work plan.

I authorize the Trustees to disclose any information collected to process my CSSEIP claim, to Great-West Life for the purposes of administering any Long Term Disability claim I may make.

I authorize the Trustees to use my Social Insurance Number as my identification number for this claim.

THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR 6 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: _(_____)_____

Please include a copy of this page with physician's statement

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 treating 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: <input type="checkbox"/> short distances only <input type="checkbox"/> medium distances <input type="checkbox"/> no restriction	_____
Standing: <input type="checkbox"/> less than 15 min. <input type="checkbox"/> less than 30 min <input type="checkbox"/> no restriction	_____
Sitting: <input type="checkbox"/> less than 30 min. <input type="checkbox"/> less than 1 hr. <input type="checkbox"/> no restriction	_____
Lifting floor to waist: <input type="checkbox"/> <10kg <input type="checkbox"/> <25 kg <input type="checkbox"/> no restriction	_____
Lifting waist to shoulder: <input type="checkbox"/> <10kg <input type="checkbox"/> <25 kg <input type="checkbox"/> no restriction	_____
Stair climbing: <input type="checkbox"/> none <input type="checkbox"/> 2-3 steps <input type="checkbox"/> short flight <input type="checkbox"/> no restriction	_____
Ladder climbing: <input type="checkbox"/> none <input type="checkbox"/> 2-3 steps <input type="checkbox"/> 4-6 steps <input type="checkbox"/> no restriction	_____
Hand/Wrist <input type="checkbox"/> grip <input type="checkbox"/> type <input type="checkbox"/> write <input type="checkbox"/> twist <input type="checkbox"/> no restriction	_____
Above shoulder activity: _____	_____
Below shoulder activity: _____	_____
Vision: <input type="checkbox"/> acuity _____ <input type="checkbox"/> depth _____ <input type="checkbox"/> perception _____	_____
Other: _____	_____

Cognitive/Mental Limitations:	Duration - Comments
Attention and Concentration: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	_____
Learning and Memory: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	_____
Decision-Making: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	_____
Judgement: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	_____
Organization and Planning: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	_____
Social interaction: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	_____
Communication: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	_____
Adaptation: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	_____
Other: _____	_____

PHYSICIAN INFORMATION

Name of Attending Physician *(please print)*

Specialty *(if applicable)*

Address

City

Province

Postal Code

(_____) _____
Phone Number

_(_____) _____
Fax Number

Physician's Signature

Date: _____
(month, day, year)

* Please fax or mail this form by: _____

To: Early Intervention Coordinator
Community Social Services Early Intervention Program
HEALTHCARE BENEFIT TRUST
#530 – 1285 West Broadway
Vancouver, B.C. V6H 3X8



Tel: 604-630-1458
Toll Free: 1-888-630-1456
Fax: 604-630-1475

**In accordance with the BCMA fee schedule A00032, Healthcare Benefit Trust will pay a form completion fee of \$37.50 for your assistance in this regard. Please mail your invoice to the address listed above. Please note we require original invoices (not faxes).*