ALBERTA BLUE CROSS®

EARLY RETURN TO WORK FORM
FOR WEEKLY INDEMNITY/LONG-TERM DISABILITY BENEFITS

Name: **Occupation:** (Job description attached)

Date of birth: (YYYY/MM/DD) **ID number:** **Group number:**

An early return to work after an illness or injury benefits a patient socially and financially. To assist us in coordinating a safe and successful return to work, please fully complete the form below. We would be willing to pay a fee of up to $50.00 for this information. Enclosed is a copy of your patient's authorization to release this information to us.

TASK LIMITATIONS (please indicate what activities are restricted and provide details such as frequency, maximums, etc.)

Physical

- ☐ Lifting - from floor _____ (max. weight/frequency)
- ☐ Lifting – from waist _____ (max. weight/frequency)
- ☐ Lifting – from shoulder _____ (max. weight/frequency)
- ☐ Pulling _____ (max. weight/frequency)
- ☐ Pushing _____ (max. weight/frequency)
- ☐ Reaching – from shoulder _____ (max. frequency)
- ☐ Reaching – at shoulder _____ (max. frequency)
- ☐ Reaching – above shoulder _____ (max. frequency)
- ☐ Sitting _____ (how long/frequency)
- ☐ Walking _____ (distance/frequency)
- ☐ Standing _____ (how long/frequency)
- ☐ Climbing _____ (max. distance)
- ☐ Manual dexterity _____ (e.g., typing, grip, etc.)
- ☐ Driving _____ (license restrictions, how long)
- ☐ Kneeling _____ (how long/frequency)
- ☐ Crouching _____ (how long/frequency)

Cognitive

- ☐ Time deadlines
- ☐ Concentration
- ☐ Working alone
- ☐ Working in group
- ☐ Interacting with public

Work environment

- ☐ Temperature
- ☐ Dust/vapor/fumes
- ☐ Noise
- ☐ Tools/machinery
- ☐ Moving objects

Other: _____

Has medication been prescribed that would prohibit return to work activities? Yes ☐ No ☐

If yes, indicate type and duration and whether an alternate non-narcotic medication could be used. _____

Medical aids or personal equipment required: _____

Expected duration of above restrictions/limitations: _____

SCHEDULE MODIFICATIONS:

Are modifications required to work schedule (e.g., reduced hours, no night shift, etc.) and why? _____

Please review the proposed gradual return to work schedule below and indicate and explain necessary modifications.

Week	*1*	*2*	*3*	*4*
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Comments: _____

Re-assessment date: _____

Physician's name (please print) Telephone Date (YYYY/MM/DD)

Signature Fax

Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.

PLEASE RETURN COMPLETED FORM TO:

Alberta Blue Cross, Group Case Management Services,
10009 108 Street, Edmonton AB T5J 3C5 **FAX: (780) 498-5991**