



# PSYCHOLOGICAL FUNCTIONAL ABILITIES FORM

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, Telephone: (867) 667-5645, Toll free: 1-800-661-0443, Fax: (867) 667-8740, Web: www.wcb.yk.ca

WORKER'S INFORMATION		PROVIDER'S INFORMATION	
Surname		Name	
First Name			
Address		Address	
Telephone #	Date of Birth (d/m/y)		
Has worker filed a claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	Claim # or Part of body	Telephone #	
Date of Injury (d/m/y)			
Family Doctor		Fax#	
Employer		Date of Visit (d/m/y)	

**PART A**

Patient has no functional limitations

**PART B**

For Patients Exposed to a Traumatic Event at Work

Patient has functional limitations and can return to work providing the following limitations can be appropriately accommodated

<input type="checkbox"/> Allow temporarily leaving job site	<input type="checkbox"/> Gradual re-exposure to feared situations
<input type="checkbox"/> Limitations due to environmental conditions	<input type="checkbox"/> Reduce exposure to dangerous situations
<input type="checkbox"/> Time off for counselling appointments	<input type="checkbox"/> Have another employee as backup
<input type="checkbox"/> Change job environment/location	<input type="checkbox"/> Arrange transportation to work
<input type="checkbox"/> Reduce exposure to reminders/triggers*	<input type="checkbox"/> Reduce cognitive demands
<input type="checkbox"/> Limitations due to medications*	<input type="checkbox"/> Attend work ASAP without working
<input type="checkbox"/> Reduced hours*	

\*Please provide further details on these limitations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Estimated duration of functional limitations (in days) \_\_\_\_\_

I have reviewed the details of this report with client and have provided him/her with a copy of the report.

I certify that this is a complete and accurate report. The fees charged are in accordance with the fee schedule and I have received no prior payment.

Signature \_\_\_\_\_ Date (d/m/y) \_\_\_\_\_