Workers' Safety and Compensation Board Yukon

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

Surname	
First Name	
Address	
Telephone #	Date of Birth (d/m/y)
Has worker filed a claim? ☐ Yes ☐ No	Claim # or Part of body
Date of Injury (d/m/y)	
Family Doctor	
Employer	

PROVIDER'S INFORMATION

Name	
Address	
Telephone #	Fax#
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

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

***Please provide further details on these limitations** _____

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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) _____

This information is being collected under the authority of the *Workers' Safety and Compensation Act* for the purpose of determining eligibility for benefits. For further information, contact (867) 667-5645 or 1-800-661-0443.