Trillium Health Partners
Better Together

Attending Practitioner Report (APR) | People Safety & Support
All sections of the form must be completed in full in order to be processed

****If this is a workplace injury/illness, do not complete this APR. Please have your attending practitioner complete a WSIB Form 8: Health Professional's Report.**

CONFIDENTIAL

Section A: Employee Information (to be completed by the Employee)

THP is committed to protecting your privacy. The personal information in this form is collected in accordance with the Personal Health Information Protection Act ("PHIPA"). It will be used and maintained in the strictest confidence by THP for the intended purpose of determining your eligibility for sick leave benefits due to illness and/or injury, and/or return to work information. If you have any questions about the collection, use and disclosure of the personal information provided on this form, please contact Privacy ext.7548 or privacy@thp.ca

Employee Full Name: ______________________ Date of Birth: ______________________
Personal E-mail: ______________________ Employee ID: ______________________
Department: ______________________ Employee Phone: ______________________
Position: ______________________ Manager/Supervisor: ______________________

Date of First Shift Absent: ______________________ Status: ☐ FT ☐ PT ☐ CAS

I hereby authorize the practitioner, who, by completing and signing this form, may release medical or functional information pertaining to my current medical absence to People Safety & Support and allow them to determine sick leave benefits and/or provide return to work information to my Manager/ Supervisor to facilitate a safe return to work.

Employee Signature: ______________________ Date (mm/dd/yy): ______________________

Section B: Medical Assessment (to be completed by the Practitioner)

In accordance with the Ontario Medical Association (OMA) position paper, which supports the timely return to work programs and the role of the primary care physician, please provide objective reports on impairment, prognosis, treatment, medical restrictions and/or limitations, and other supporting documentation. Please note that we are not asking for a diagnosis.

1. **Nature of Illness/Injury** (we require this information for the purpose of adjudicating sick benefits): Please describe the illness/injury and the functional impairment that is preventing the employee from performing their regular duties.

   ____

   ____

   If the patient has a secondary medical condition that may prolong the length of absence, please explain: ____

2. **Absence Information:**
   i. Date illness/injury began: ______________
   ii. Date of first visit for current illness/injury: ______________
   iii. Date of planned follow-up: ______________
   iv. Planned frequency of follow-up visits: ______________
   v. Is absence due to a chronic illness/injury? ☐ Yes ☐ No

Absence Information (continued):

Motor Vehicle Accident: ☐ Yes ☐ No

Surgery or Procedure as treatment? If yes, date of surgery (mm/dd/yy): ________________

If yes, is it covered by OHIP? ☐ Yes ☐ No

Hospitalized? If yes, from: _______________ to _______________

Pregnancy related? If yes, please confirm estimated date of confinement (EDC): __________

3. **Is there an active treatment plan currently in place?** ☐ Yes ☐ No
   If yes, please describe treatment provided and the treatment plan:

   ____

   ____

4. **Is the patient presently under the care of a medical specialist?** ☐ Yes ☐ No
   If no, has a referral occurred? ☐ Yes ☐ No ☐ N/A

5. **By signing below, I verify that, based on my assessment and objective medical evidence, the patient is totally disabled** (unable to perform *the regular job duties or hours*) from (date): _______________ with an expected return to:

   Modified duties on (date): _______________ or

   Regular duties (no restrictions) on (date): _______________

   Are there any restrictions to maximum hours of work per day/shift?

   ☐ 4 hours ☐ 8 hours ☐ 12 hours ☐ No restrictions

Trillium Health Partners offers modified work for employees who are able to work but may not be able to perform their full duties. It is the Hospital's expectation that employees will return to modified duties if capable and duties are available

Section C: Recommended Physical Abilities (to be completed by the Practitioner)

1. Please indicate patient's current functional abilities as of today's assessment, regardless of return to work status. Check all that apply.

Walking	0 – 15 min		15 – 30 min		30 – 60 min	
Sitting	0 – 15 min		15 – 30 min		30 – 60 min	
Standing	0 – 15 min		15 – 30 min		30 – 60 min	
Stair Climbing	Full Abilities		Limited Abilities		Cannot Perform	
Ladder Climbing	Full Abilities		Limited Abilities		Cannot Perform	
Bending	Full Abilities		Limited Abilities		Cannot Perform	
Crouching/Kneeling	Full Abilities		Limited Abilities		Cannot Perform	
Repetitive Motion	Full Abilities		Limited Abilities		Cannot Perform	
Pushing/Pulling	Sed. (0 – 10 lb)		Light (11 – 20 lb)		Med. (21 – 50 lb)	
Lifting/Lowering	Sed. (0 – 10 lb)		Light (11 – 20 lb)		Med. (21 – 50 lb)	
Carrying	Both Hands	Left Hand	Right Hand	Limited	Max. Weight (lb):	
Fine Finger	Both Hands	Left Hand	Right Hand	Limited		
Gripping/Grasping	Both Hands	Left Hand	Right Hand	Limited	Max. Weight (lb):	

2. **Please add any other functional abilities not listed above:**

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3. **Cognitive Capabilities – Please indicate any limitations. Please indicate PHQ-9 or GAD-7 score, if relevant:**

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Section D: Attending Practitioner Contact Information & Fees

Fees for Completion of Medical Certificate: It is the responsibility of the patient/employee to pay for completion of the form, and submit the original receipt for reimbursement. Fees will be reimbursed in accordance with OMA guidelines or union collective agreement.

I have personally assessed and treated the above patient/employee. It is my opinion that the above information is true and accurate.

Practitioner's Name:______________________ **Professional Designation/Specialty (e.g. MD, NP, Specialist):** _________________________ **CPSO#/License #/Registration #:** __________ **Phone:** ______________ **Fax:**______________ **Signature:** ______________________________ **Date:** __________________________________	Practitioner's Stamp
PLEASE RETURN COMPELETED FORM WITHIN **5 BUSINESS DAYS** TO PEOPLE SAFETY & SUPPORT by **FAX: 416-521-4160 or E-MAIL: employeemedical@thp.ca**	