



**MEDICAL REPORT TO BE COMPLETED
BY THE TREATING PHYSICIAN**

IMPORTANT INFORMATION:

The primary goal of our Return To Work Program is to assist employees who have temporary or permanent impairment due to medical reasons to return to work and/or remain at work. This program includes modified or alternate duties for employees with temporary or permanent restrictions. Many positions occupied by Canadian Pacific Railway employees are critical to safe railway operations and impact on the safety of the public and/or other employees. Therefore, it is important that this detailed medical report is completed by the employee's treating physician, and returned to the company in a timely manner. Failure to complete this report may delay or prevent employees from returning to work.

PART 1 – To Be Completed by Employee

NAME OF EMPLOYEE:
EMPLOYEE NUMBER:
POSITION:
TELEPHONE NUMBER:
SUPERVISOR'S NAME:

This injury is covered under: WCB ____ WIB ____ LTD ____ Other ____

Patient/Employee Consent

I, the undersigned, hereby authorize Dr. _____ to release to and discuss information concerning my present medical condition with the office of the Chief Medical Officer, CPR. I also authorize representatives from the office of the Chief Medical Officer, CPR to discuss my present medical condition with Dr. _____. I understand that only information relating to my work restrictions will be transmitted to my supervisor. I also authorize CPR to release all or a portion of the medical information that is relevant to the adjudication of any benefit claim related to my present medical condition to the applicable Workers' Compensation Board (WCB) and/or Benefit Carrier. Any use and disclosure of my medical information will be in accordance with legal requirements and CPR Policy 1804, Privacy of Information. This consent is valid for six months from date of signing.

Signature of Patient/Employee

Signature of Witness

Date

Date

PART 2 – To Be Completed by Physician

Dear Physician:

**Please complete Part 2 of this form and fax ALL pages to:
Occupational Health Services, Canadian Pacific Railway at (403) 319-6803
or mail, allowing for 10 days of mail delivery, to:
Suite 345, Gulf Canada Square, 401 – 9th Avenue S.W., Calgary, Alberta T2P 4Z4
Please see back page for information on payment for completing this form.**

MEDICAL INFORMATION

1. DATE OF INJURY/ONSET OF ILLNESS: _____
2. FIRST DAY OF ABSENCE: _____
3. DIAGNOSIS: A) _____ B) _____
C) _____ D) _____

4. TREATMENT – Completed and Current: (indicate dates)

Surgery _____	Date(s) _____
Hospitalization _____	Date(s) _____
Rehabilitation Program _____	Date(s) _____
Referrals _____	Date(s) _____
Investigations _____	Date(s) _____
Other _____	Date(s) _____

5. Current Medications: (name, dosage, and expected duration of use)

Name _____	Dosage _____	Duration _____
Name _____	Dosage _____	Duration _____
Name _____	Dosage _____	Duration _____
Other _____		

6. If your patient must take any form of medication or suffers from a medical condition that may affect his/her coordination, judgment and alertness or impact on safe performance in any way, please advise, according to your observation, if the medication or medical condition has any effect on his/her:

	NO	YES		NO	YES
Alertness	<input type="checkbox"/>	<input type="checkbox"/>	Memory	<input type="checkbox"/>	<input type="checkbox"/>
Attention	<input type="checkbox"/>	<input type="checkbox"/>	Mood (i.e. manic behaviour)	<input type="checkbox"/>	<input type="checkbox"/>
Orientation	<input type="checkbox"/>	<input type="checkbox"/>	Psychomotor functions	<input type="checkbox"/>	<input type="checkbox"/>
Judgment	<input type="checkbox"/>	<input type="checkbox"/>			

7. To the best of your knowledge, does your patient suffer from any illness that can result in sudden impairment?

NO YES

If yes, please explain: _____

8. In your opinion, is your patient capable of performing duties that are critical to his/her own safety or to the safety of others?

NO YES

PLEASE APPEND REPORTS FROM SPECIALISTS, LABORATORY, PHYSIOTHERAPY, X-RAYS, etc.

9. Is your patient fit to return to pre-accident/illness duties? YES Date: _____
 NO
10. Is your patient fit to return to modified duties/hours? YES Date: _____
 NO

If yes, please specify:

- Sedentary** Primarily sitting, with occasional walking/standing. Able to occasionally lift up to 10 lbs.
- Light** Can occasionally lift up to 20 lbs, with frequent lifting and/or carrying up to 10 lbs. Can perform work that entails walking and standing.
- Medium** Can occasionally lift up to 50 lbs, with frequent lifting and/or carrying up to 20 lbs. Can perform work that entails walking and standing.
- Heavy** Can occasionally lift up to 100 lbs. Frequent lifting and/or carrying up to 50 lbs.

Limitations/Restrictions are: Temporary Duration _____ Permanent

Additional Limitations/Restrictions

	NO	If YES ⇒	Please specify Limitation/Restriction
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting and Carrying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Repetitive Use of Upper Limbs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Above Shoulder Work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending	<input type="checkbox"/>	<input type="checkbox"/>	_____
Working at Heights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking on Uneven Ground	<input type="checkbox"/>	<input type="checkbox"/>	_____
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Graduated Return to Work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Modified hours, please specify: _____

11. If your patient is unfit for work at this time, when is the next Re-assessment Date? _____

Estimated Return to Work Date _____

Prognosis for Return to Work _____

12. Additional Comments: _____

13. Do you wish to discuss your patient's condition with the Company's Regional Physician? NO YES

 SIGNATURE OF TREATING PHYSICIAN

 DATE

 TREATING PHYSICIAN'S NAME (PRINT)

INVOICE

INFORMATION REGARDING PAYMENT OF MEDICAL REPORT

On receipt of the completed report, Canadian Pacific Railway agrees to pay to the treating physician a fee of \$90.00. This fee is used as a guide. It is appreciated that in some circumstances a greater fee may be appropriate commensurate with the physician's time and the detail of the information provided. In such circumstances, a fee in accordance with the current provincial guidelines for uninsured services would be appropriate. In the area provided below, please **CLEARLY PRINT** to whom the cheque should be made payable and the address. Send completed medical report and invoice to:

**ATTENTION: OHS DEPARTMENT, FAX: (403) 319-6803, or mailing address:
CANADIAN PACIFIC RAILWAY, SUITE 345, 401 – 9th AVENUE S.W.,
GULF CANADA SQUARE, CALGARY, ALBERTA T2P 4Z4**

**PLEASE NOTE: IF NOT WRITTEN LEGIBLY, IT WILL NOT BE
POSSIBLE TO PROCESS YOUR PAYMENT.**

TO BE COMPLETED BY PHYSICIAN:

Name of Patient: _____

**NAME AND ADDRESS OF PERSON AND/OR COMPANY TO WHOM CHEQUE
SHOULD BE MADE PAYABLE TO:**

Name of TREATING PHYSICIAN IN PRINT: _____

TREATING PHYSICIAN'S ADDRESS: _____

TELEPHONE: () _____ FAX: () _____

Date Medical was Completed: _____

FOR CANADIAN PACIFIC RAILWAY USE ONLY:

AMOUNT: \$ 90.00 Canadian ACCOUNT: 65802 INVOICE# _____

CoCode: 1000 Order #: 7005727 Order: Yes

SIGNATURE: _____ EMPLOYEE NUMBER: 689619