Yukon Workers' Compensation Health and Safety Board

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Psychological Functional Abilities Form

Please contact YWCHSB before providing service if you have not signed a service agreement: Work is Healthy

Worker's Information

Surname

First name

Address

Telephone number | Date of birth (d/m/y)

Has worker filed a claim? ☐ yes ☐ no | Claim number or part of body

Date of injury (d/m/y) | Family Doctor

Employer

Provider's information

Name

Address

Telephone number | Fax number

Date of visit (d/m/y)

☐ Patient has no functional limitations

For patients exposed to a traumatic event at work:

- ☐ Allow temporarily leaving job site
- ☐ Reduce exposure to renders/triggers
- ☐ Time off for counseling appointments
- ☐ Change job environment/location
- ☐ Limitations due to environmental conditions
- ☐ 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

☐ Limitations due to medications (please provide details)

☐ Reduced hours (please provide details)

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.

Provider Signature: | Date (d/m/y)

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