



**ATTENDING PHYSICIAN'S ASSESSMENT AND RECOMMENDATIONS – STUDENT**

**Section A: Information (to be completed by Student)**

Student Name (Print):

Student ID number:

Email address:

Primary Phone Number:

Red Deer College Program:

Last Day of Lab and/or Clinical:

**Section B: Consent (to be completed by Student)**

I authorize the physician/medical health professional to disclose information to staff at the [Red Deer College \(RDC\) Health, Safety and Wellness Centre](#) regarding my medical condition as it relates to my current absence from lab and/or clinical by completing and submitting (by fax or email – see below for contact information) this completed form for the purposes of validating and managing my claim for medical leave as it relates to my fitness to practice for lab and/or clinical. I understand that staff at the RDC Health, Safety and Wellness Centre will keep my medical information confidential but for the purpose of facilitating my return to lab and/or clinical. I consent to allow staff at the RDC Health, Safety and Wellness Centre to review my claim status and to share information with my Associate Dean as it relates to my current absence for the purposes of facilitating my return to lab and/or clinical. The Associate Dean will review the summary from the assessment and make a decision about my potential return based on the outcomes of the course and seat availability.

A photocopy/faxed copy of this authorization is as valid as the original.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

[Red Deer College Health, Safety and Wellness Centre](#)

Phone: 403-342-3427

Fax: 403-342-3303

Email: [health.safety@rdc.ab.ca](mailto:health.safety@rdc.ab.ca)

**SECTIONS C – F TO BE COMPLETED BY A QUALIFIED MEDICAL DOCTOR OR QUALIFIED MENTAL HEALTH PROFESSIONAL**

**SECTION C: TREATMENT**

**Date of assessment:**

Please indicate the nature of the student's illness and/or injury:

Primary diagnosis:

Secondary Diagnosis:

(If diagnosis is a mental health disorder, please use DSM-V terminology)

Severity (circle one): Mild   Moderate   Severe   GAF Score

Date illness began or symptoms first appeared:

Date absence from lab and/or clinical began:

Date of first visit for this absence:

Date(s) of subsequent visit(s):

Objective findings and test results (attach copies of results):

Subjective symptoms:

Please describe the student's symptoms including severity:

Has the student experienced the same or similar medical problem in the past (circle one)? Yes   No

If yes, explain:

Factors contributing to the injury/illness:

Is the student following your treatment recommendations (circle one)? Yes   No

Treatment (drug, dosage, physiotherapy, other):

Is the student's condition: improving   unchanged   deteriorating (please circle one)

Student under active treatment (circle one)? Yes   No

If yes, provide the following:

Name of specialist:

Specialty:

Date(s) of visit(s):

Frequency of visits (weekly, monthly, other):

Name of other consulting or treating health care practitioners:

Other treatment (i.e. physiotherapy, group therapy):

Types and Name of facility:

Dates attended:

In-patient hospital admission (include name of institution, admission, discharge, name of admitting MD):

Is any surgery, investigative procedure, or other therapy scheduled for the future (circle one)? Yes   No

If yes, please outline date of scheduled surgery:

**Section D: At Red Deer College, we strive to assist students to continue or return to lab and/or clinical as soon as they are reasonably and safely able, without aggravating their injury or illness. Your recommendations below will assist us to work with our student to ensure these medical limitations are implemented with the goal of helping the student recover and return to their program.**

<b>Walking/Standing/Sitting</b>					
	Unable	< 15 minutes	15-30 minutes	30-60 minutes	Unlimited
Walking					
Sitting					
Standing					
Squatting/Kneeling					
Crouching					
Other:					
<b>Lifting/Pushing/Pulling: Please list any limitations and estimated duration of limitations</b>					

	Adequate	Poor	Not able	Comments
<b>Able to maintain Focus/Attention/Concentration</b>				
<b>Able to manage stressful situations</b>				
<b>Able to engage in decision making</b>				
<b>Able to engage in critical thinking</b>				
<b>Able to control emotions</b>				
<b>Able to relate and communicate appropriately with others</b>				
<b>Able to perform complex and varied tasks</b>				
<b>Able to maintain energy and pace required for the job</b>				
<b>Able to appropriately manage time</b>				
<b>Able to organize and prioritize workload</b>				
<b>Able to respond appropriately to supervision and management</b>				

**SECTION E: RECOMMENDATIONS**

Based on your assessment and medical judgement of the above factors, is this student (check all that apply):

- Fit to return to classroom
- Fit to return to lab
- Fit to return to clinical

- Student unfit to return.

Based on your clinical observations, please describe the student's current cognitive and or physical limitations impacting the student from performing any or all class, lab or clinical work:

Duration:

Reassessment date:

- Student fit for modified duties where possible within program of study.

Please indicate specific functional limitations:

Duration:

Reassessment date:

#### SECTION F: SIGNATURE

By affixing my signature below, I certify that I am a qualified medical doctor or a qualified mental health professional and that I have personally assessed and treated the above student. It is my opinion that the information is true and accurate.

NAME (please print):

ADDRESS:

TELEPHONE NUMBER:

FAX NUMBER:

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_