Hamilton Health Sciences
HEALTH, SAFETY AND WELLNESS

Chronic Condition Exclusion Form

Employee Information:		
Last Name:	First Name:	Employee ID #:
Street Address:	City:	Postal Code:
Home Phone Number:	Job Description/Title:	Department:

Dear Doctor:

Hamilton Health Sciences (HHS) has an Attendance Support and Management Program. Entry into the program is based on an employee missing 150 hours of work and / or having six (6) or more occurrences in the past calendar year. Medically established serious chronic conditions are excluded from the program and your patient has indicated that their sick-related absences may qualify as such exclusion. **In order to assess whether an exclusion applies, we require further information as outlined on the following page.**

As per our policy, a **medically established serious chronic condition** – is defined as a disease:

- Of long duration; and
- Generally slow progression; and
- Having a dangerous possible result; and
- Having had a specialist involved in consultation and / or management.

Send completed form marked "confidential" **and your invoice** to:

Health, Safety and Wellness
Hamilton Health Sciences – King West
P.O. Box 2000, Hamilton, ON L8N 3Z5
OR: Fax: 905-577-8379 Email: ability@hhsc.ca

Section A - Consent Information (To be completed by employee)

I authorize my treating, medically qualified health care professional _____
(Name)
to provide Health, Safety and Wellness with information **relative to my illnesses and inability to work** by completing Section B. I understand that **this is a voluntary employee process to apply for an exclusion** and that the Hospital will use this information to determine eligibility for exclusion from the Attendance Management and Support Program. I accept a photocopy or other reproduction of this authorization is as valid as the original.

Employee's Signature: _____ Date: ____/____/____
DD MM YY

Section B

TREATING PRACTITIONER RESPONSE

1. Does your patient have a **medically established serious chronic condition based on the above definition**?
   ☐ Yes ☐ No If yes, please respond to the following:
   a. What is the nature of the condition? _____

2. Has the employee been seen by a specialist? ☐ Yes ☐ No

3. What is the current status of the medical condition?
   a. ☐ Condition is stable and no further improvement expected
   b. ☐ Condition is stable and expected to improve
   c. ☐ Condition is stable and expected to deteriorate
   d. ☐ Condition is unstable and further treatment is required

4. *If the condition is expected* to deteriorate, what is the contributing factor?
   ☐ Natural progression of conditions
   ☐ Comorbid medical conditions
   ☐ Comorbid psychosocial reasons
   ☐ Failure to engage in recommended treatments
   ☐ Other:_____

5. When was this chronic condition diagnosed? _____

6. Please provide dates of disability in which the employee was unable to attend work related to this diagnosis:
   _____

7. What restrictions and limitations can be put in place to assist the employee in attending work either during a flare up of the illness or in the natural progression of the condition? If work accommodation is required, complete the attached Work Accommdation Request Form and Functional Abilities Form (as appropriate).
   _____

8. How frequent are the episodes that would impact attendance at work in any capacity?_____

9. What is the approximate duration of an absence related to an episode? _____

10. Is the prognosis for attendance at work:
    a. Expected to improve? ☐ Yes ☐ No When? _____
    b. Remain the same? ☐ Yes ☐ No
    c. Deteriorate? Please explain: _____

11. Additional comments that may assist the employee to attend work in a regular and predictable manner:

_____

_____

Section C

Notice to physician and/or other qualified medical health care professional: Any information provided by you to Hamilton Health Sciences may be disclosed to the patient and/or those authorized by him/her to receive such disclosure.

Physician's Signature: _____ Date: ___/___/___
DD MM YY

Print name: _____ Phone number: ( ) _____