TYLER LEIBACH
2469 CHANCELLOR BLVD
PRINCE GEORGE
V2N 0E6

June 04, 2025

Dear Health Care Provider,

Our HA is committed to assisting its employees in recovering from illness or injury and offers a comprehensive Enhanced Disability Management Program (EDMP). This program is designed to assist your patient in accessing medical and rehabilitation services that may be required to stay at work or successfully return to work. We are committed to working with you to assist your patient and to that end we request that you complete the following Medical Questionnaire no later than June 18, 2025 so that we better understand your patient's condition.

The purpose of these questions is NOT to inquire into illnesses/injuries or restrictions/limitations that are unrelated to this patient's current absence from work.

In completing the questions below, please note that our EDMP services may include:

1) Facilitating Access To Medical And/or Rehabilitative Assessments And/or Services

We may be able to facilitate expedited access to diagnostic services, or access to additional treatment recommendations which may not be covered under your patient's MSP or extended health plans. If rehabilitation services are appropriate, please provide recommendations.

2) Providing Transitional Work/stay At Work Arrangements

We are committed to accommodating employees with temporary limitations or restrictions in our transitional work program. We do not require our employees to be fully recovered in order to remain at work or return to work quickly. Temporary work assignments include flexible work, days, hours and modifications to current duties or even assignment of alternate/sedentary work. Please consider this information when completing the questions.

Thank you, in advance, for your assistance. Please contact me at 250 613-9427 with any questions.
Yours truly,

Ella Dreyshner, CDMP
Lead, Disability Management Professional

MEDICAL QUESTIONNAIRE

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1. Please indicate patient's nature of illness:

Mental health.

2. Please indicate patient's current diagnosis:

Major Depressive Disorder
Generalized anxiety disorder
ADHD
PTSD, BPD

3. Please indicate your patient's prognosis for recovery and return to work:

Hopeful

4. Please describe your patient's specific treatment plan:

Medication management
Regular Counselling & DBT.

5. Please indicate your patient's recommendations for treatment:

- As above.
- Stress reduction to achieve above which can require reduced work hours

6. Is your patient following the recommended course of treatment for their injury/illness? If no why

yes.

not?

7. Is your patient's recovery progressing as expected?

yes.

8. If no, are additional assessments/treatments required? Explain.

N/A

9. Has your patient been referred to a specialist in relation to their illness/injury causing this absence from work? yes.

10. Outline specific psychosocial or cognitive limitations/restrictions to consider in planning for a RTW:

a. Attention And Concentration

Can be impaired, worse with evening/night shift.

b. Learning And Memory

N/A

c. Decision Making

N/A

d. Judgment

N/A

e. Organization And Planning

f. Social Interaction

Requiring work on psych ward can be triggering.

g. Communication

h. Adaptation

i. Other (please explain)

j. Anticipated duration of cognitive/psychosocial limitation:

____ # of weeks

2 # of months

Other:

Comments

11. Please indicate if the limitations/restrictions are expected to be temporary or permanent?

Hopefully with stress reduction from decreased work load, will be able to focus on recovery and fully recover.

12. Are there any other factors which present as a barrier to your patient's return to work? If so, please describe:

Work on Psych ward as above.

Patient Authorization:

I, TYLER LEIBACH (please print) have authorized you, as my Health Care Provider, to complete this medical questionnaire. In addition, I authorize you to submit this form to my Disability Management Professional (DMP).

I understand that my DMP will only use the information in this form for the purpose of delivering disability management services to me under the EDMP in relation to my current absence from work.

Patient Signature: _____ **Date:** June 5th 2025

Health Care Provider's Signature: K. Geddes Date: 5/6/2025

Patient Authorization:

I, Tyler Zubach (please print) have authorized you, as my Health Care Provider, to complete this medical questionnaire. In addition, I authorize you to submit this form to my Disability Management Professional (DMP).

I understand that my DMP will only use the information in this form for the purpose of delivering disability management services to me under the EDMP in relation to my current absence from work.

Patient Signature: _____ **Date:** June 5th 2025

GRTW Plan

If there are recommendations for a transitional or gradual return to work, please outline the limitations and/or schedule required to support this employee in returning to or remaining at work. Please use the chart below:

WEEK OF	HOURS OF WORK					TASK LIMITATIONS/RESTRICTIONS
	M	T	W	Th	F	
	M	T	W	Th	F	
	M	T	W	Th	F	
	M	T	W	Th	F	

2 day shifts/wk x 2 Months. [Aug 2/2025]
*[0500 - 1300]

GEDDES.