

PROFESSION

Part A: Patient Identification

Last Name

First Name

Initial

Date of Birth (dd/mm/yy)

HCS Number

Claim Number:

Part B: Practitioner's Statement

Diagnosis

Date of Examination on which this examination is based (dd/mm/yy)

Date of final treatment(dd/mm/yy)

Functional status on discharge (Related to work duties)

Outcome code:

- _____ Code 1 Discharged without restrictions - return to work
 - _____ Code 2 Discharged without restrictions - did not return to work
 - _____ Code 3 Returned to work on a graduated program
 - _____ Code 4 Discharged with restrictions - return to work
 - _____ Code 5 Discharged with restrictions - did not return to work
 - _____ Code 6 Did not complete program
- State reason did not complete program:

Total number of appointments attended and dates of appointments

Dates Absent

Part C: Practitioner Identification

Last Name

First Name

Signature

Date (dd/mm/yy)

Part D: Clinic Identification

Street Address

Clinic Name

Billing Number

City

Province

Postal Code

Phone

Fax