

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 initial treatment (dd/mm/yy)

History (Worker's history of injury including symptoms)

Clinical findings

Describe other conditions not related to the work injury which may affect recovery

Functional problems identified (Related to work duties)

Treatment goals (Functional abilities required to return to work)

Treatment Plan

Worker is currently working ___yes ___no If no, expected return to work date

Date of next appointment Frequency of appointments Expected discharge date

Part C: Practitioner Identification

Last Name (Please Print) First Name (Please Print) Signature _____ Date (dd/mm/yy)

Part D: Clinic Identification

Street Address **Clinic Name** **Billing Number**

City Province Postal Code Phone Fax