

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)

Worker's current complaints

Clinical findings

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

Progress towards treatment goals (Functional abilities required for return to work)

Identify any impediments to recovery

Treatment Plan

Worker is currently working ___yes___no

If no, expected return to work date

If yes, has worker returned on a graduated return to work plan ___yes___no

Expected length of program

Total number of appointments attended and dates of appointments

Dates Absent

Dates of treatment since last report:

Date of next appointment

Frequency of appointments

Expected discharge date

Part C: Practitioner Identification

Last Name

First Name

Signature

Date (dd/mm/yy)

Part D: Clinic Identification

Clinic Name

Billing Number

Street Address

City

Province

Postal Code

Phone

Fax