

## User Manual for Practitioner's Return to Work Report (PRTW)

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Return to work (RTW) is a documented plan/strategy to accommodate an injured worker with temporary restrictions while receiving treatment or rehabilitation.

The return-to-work plan is a collaboration between the worker, the employer, the care provider and the WCB. The return to work will be monitored and progressed by the care providers based on objective clinical findings. It should have a defined start and end point that may include a combination of a gradual increase in hours of work and/or work activities designed to return the injured worker to the pre-injury job.

It is expected that the majority of RTW programs will be less than four weeks in duration, unless there are unusual circumstances such as unusual shift length, heavy to very heavy industrial DOT, a highly repetitive job or a post-surgical worker

A RTW Plan should include:

- The week it should start, the total hours of work, the days, and a list of restrictions to job duties; and
- Any comments or concerns regarding job duties in the comments section.

A RTW may exceed four weeks on occasion. After the four weeks have been completed, the practitioner should:

- Submit the remainder of the RTW for the final stages;
- If a graduated RTW of greater than 4 weeks is required, provide a rationale in the restrictions section below; and
- Provide an anticipated end date. When a RTW plan exceeds 4 weeks, please indicate the actual week when the worker can be expected to return to work, i.e., week 5, 6, 7. This is particularly important when the return to work is exceeding 4 weeks because the worker's case manager uses this information for payment of wage loss.

**Practitioner's Return to Work Report**

**WCB Claim No.:** \_\_\_\_\_

<b>Clinic #</b> _____	<b>Billing #</b> _____	<b>Personal Health #</b> _____	
<b>Phone #</b> _____	<b>Fax #</b> _____	<b>Date of Birth</b> _____	<b>Phone #</b> _____
Practitioner's Name, Address, Postal code		<b>Employer Name</b> _____	
		Worker Name, Address, Postal Code	
<b>Clinic Name</b> _____			

**Memo to:** \_\_\_\_\_ **(employer/primary practitioner/WCB)**

*Please forward any requests for changes to the RTW plan to the therapist, who will monitor the worker's progress, evaluate any suggested changes, adjust the RTW plan if required, and forward amendments to all parties. The WCB will also adjust the level of income replacement as the worker's duties and hours of work change.*

**Return to Work Start Date:** \_\_\_\_\_ **DD/MM/YY**      **Anticipated End Date:** \_\_\_\_\_ **DD/MM/YY**

**Employer Contact Name:** \_\_\_\_\_ **Contact Phone #** \_\_\_\_\_

**Calendar of Hours and Restrictions**

Month		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>Week One</b>	Date	21/10/07						
	Hrs		4		4		4	
<p><b>Restrictions:</b> Mr. Smith should avoid lifting greater than 25 lbs. and above shoulder activity.</p> <p><b>Comments:</b> Mr. Smith requires alternate modified work than his construction job as a framer. He should be accommodated in the shop until he begins his GRTW.</p>								
<b>Week Two</b>	Date	28/10/07						
	Hrs		4	4	4	4	4	
<p><b>Restrictions:</b> Mr. Smith can begin lifting above shoulder while under treatment.</p> <p><b>Comments:</b> Continue accommodation in the shop while under treatment.</p>								
<b>Week Three</b>	Date							
	Hrs							
<p><b>Restrictions:</b></p> <p><b>Comments:</b> Please explain need for RTW longer than 2 weeks</p>								
<b>Week Four</b>	Date							
	Hrs							
<p><b>Restrictions:</b></p> <p><b>Comments:</b> Please explain need for RTW longer than 2 weeks</p>								

**Signatures:** Care provider may sign all three as verification that all parties are aware of, and have agreed to, the RTW plan.