



Saskatchewan
Workers'
Compensation
Board

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PTP

Click on any field to start editing.

Physical Therapy Progress Report

WCB Claim No: _____

Worker's Name: _____

Clinic Name: _____ Clinic Number: _____ Provider Number: _____ Phone: _____ Fax: _____ Care Provider Name, Address, Postal Code <div style="text-align: right; font-size: small;">Print/Stamp/Sticker</div>	Provincial Health Number: _____ Date of Birth: _____ Phone: _____ Employer Name: _____ Worker Name, Address, Postal Code <div style="text-align: right; font-size: small;">Print/Stamp/Sticker</div>
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Request for Extension Denied CES/CM _____ Date _____ d/m/y

CLINICAL

1. Date of this Exam: _____ d/m/y 2. Current Diagnosis: _____ 3. Body Areas currently being treated: _____ 4. Subjective complaints: _____ 5. Objective clinical findings: (including quantifiable measures such as ROM in degrees/percentage, manual muscle testing graded out of 5, SLR, DTR, sensation, limb girth) etc. _____ 6. Self Report(Initial/Current): Roland Morris ___ / ___ Quick Dash ___ / ___ QD Work module ___ / ___ NDI ___ / ___ LEFS ___ / ___ 7. Assessment of recovery status(0-10) _____ (0 = no recovery, 10 = recovered to preinjury) 8. Discharge from treatment <input type="checkbox"/> No <input type="checkbox"/> Yes. If Yes, Date of discharge: _____ d/m/y Did the worker return to their regular duties? <input type="checkbox"/> Yes <input type="checkbox"/> No.

MANAGEMENT

9. Results of diagnostics since previous report if applicable: _____ 10. Management Plan: <input type="checkbox"/> Medication <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Massage <input type="checkbox"/> Specialist <input type="checkbox"/> Surgery <input type="checkbox"/> Secondary/Tertiary Treatment <input type="checkbox"/> Other Provide Details _____ 11. Treatment plan: <input type="checkbox"/> Biomechanical <input type="checkbox"/> Electro-physical Agent <input type="checkbox"/> Regional Conditioning Supervised _____ Home _____ <input type="checkbox"/> Supervised global conditioning <input type="checkbox"/> Education <input type="checkbox"/> Transitional RTW <input type="checkbox"/> Other _____ 12. Frequency of treatment: _____ per week, Other _____ Expected date of discharge from treatment _____ d/m/y . 13. Are you aware of other health or non-health factors affecting recovery: <input type="checkbox"/> Yes <input type="checkbox"/> No. Explain: _____ 14. Would you like WCB to arrange/expedite <input type="checkbox"/> diagnostic <input type="checkbox"/> Specialist <input type="checkbox"/> assessment team review <input type="checkbox"/> Other. Details: _____ 15. Have you contacted the employer regarding current restrictions? <input type="checkbox"/> Yes. Date of Contact _____ d/m/y <input type="checkbox"/> No. Please Explain: _____
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Physical Therapy Progress Report

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Worker's Name: _____

RETURN TO WORK

16. Is the worker off work as a result of the work injury? Yes No
 Who advised the worker to be off work? Chiropractor Physical Therapist Medical Doctor Worker has taken themselves off work.
 If off of work how long do you anticipate the worker to be off work? _____ days Other.

 Has a return to work been arranged? Yes No. If yes who arranged the RTW? Chiropractor
 Physical Therapist Medical Doctor Employer. Name: _____
 If no, please explain: _____
 17. Return to work date: _____ d/m/y
 18. If worker is at work: Are they currently working with restrictions? No Yes
 How long are restrictions expected to remain? _____ days Unknown Other _____
 Anticipated date of full hours/duties: _____ d/m/y
 19. Estimated current restrictions? Subjective Objective
 lifting _____ pushing/pulling _____ reaching _____
 overhead reaching _____ turning _____ walking _____ stairs _____
 ladders _____ standing (hours) _____ sitting (hours) _____
 environment _____ No restrictions
 other _____
 Client and Practitioner agreed Yes No (explain in comments)
 20. Would you like to complete the Electronic Return to Work Form(PRTW) Yes No (RTW form needs to be completed 1 week before RTW).
 21. Comments RTW _____
 22. General Comments: _____

Signature: _____ **Please sign form before mailing/faxing.** Date: _____

