CHP USER MANUAL

Chiropractor's Progress/Discharge **Report WCB Claim No.** _____

Clinic No.: _____ **Doc No.:** _____ **Personal Health No.:** _____

Phone No.: _____ **Fax No.:** _____ **Date of Birth** _____ **Phone No:** _____

Chiropractor's Name, Address, Postal code

Employer Name _____

Worker Name, Address, Postal Code

Print/stamp/sticker

Print/stamp/sticker

Clinic Name _____

(Please note: All sections need to be filled out to insure reimbursement.)

REQUEST FOR EXTENSION ☐ **DENIED CES/CM** _____ **Date** _____ *(Note that case management in consultation with the Chiropractic Consultant when appropriate will be considering assessment of recovery and duration, frequency of treatments as well as other clinical features in approving further treatment at a primary level or if a decision will be made to proceed with a multi-disciplinary assessment.)*

1. Examination date: dd/mm/yy____ **2. Current Diagnosis:** _____ *(Be as specific as possible)*

3. Body areas currently being treated *(List body areas presently under treatment and related to the compensable injuries)*

4. Subjective Complaints*: (Use quantifiable measures where possible i.e. Numeric pain scale rating)*

5. Objective Findings: *(Use quantifiable measures where possible (i.e. Range of motion, straight leg raise testing, manual muscle testing, deep tendon reflex testing.)*

_____

_____

_____

_____

6. Results of diagnostics since previous report: *(Please attach all pertinent diagnostic reports to the form if not already done)*

7. Assessment of recovery (0-10): initial_____**current**_____ 0 = No recovery, 10 = recovered to preinjury

Explain any delay in recovery:

(The assessment of recovery is a measure that asks the provider to summarize available information to provide an estimate of the expectation of recovery within typical primary timelines. The clinician is asked to incorporate clinical findings, self-report measure change, objective functional change where testing is appropriate as well as possible psychosocial issues. A score between 0 and 10 representing no recovery and 10 representing recovery to pre-injury status is established. This score will represent the practitioners' assessment of the complexity of this primary patient's presentation and potential for recovery.)

8. Have you advised the patient to be off work due to the injury: ☐ **yes** ☐ **no (if yes, complete #10 – 21)**

If no, is the patient to be working with restrictions ☐ **yes** ☐ **no (if yes, complete #10 – 21)**

9. Discharged: ☐ **Yes** DD MM YY ***(Include the date of discharge)*** ☐ **no, requires a Request for Extension of Treatment (complete #10 – 21).**

10. Self-Report (initial/current) **Roland Morris / Quick Dash / QD Work module / NDI / LEFS /_____**

(The self-report measures have been developed based on instruments that were established at the Outcome Measures Workshop. The instruments chosen are based on body parts involved i.e. Roland Morris for thoracic and lumbar spine, Quick Dash for upper quadrant, and NDI for cervical spine and LEFS for lower quadrant injuries. It is mandatory to use the instruments described above. Please include the raw score for the initial and the current measure when providing the information about the self-report measure.)

11. Treatment Plan: ☐physical Therapist* ☐massage* ☐specialist* ☐hospitalized* ☐education ☐biomechanical ☐electrophysical ☐regional conditioning, supervised____home ____ ☐supervised global conditioning ☐transitional RTW *Please name(med., caregiver)_____

(This section is meant to communicate services that you have included in your treatment plan. Also, please identify if you are aware of other caregivers who are involved in the care of the worker even if you didn't refer to these practitioners.)

12. Frequency of treatment:_____per week 13. Expected number of weeks to discharge:_____

14. Would you like WCB to arrange/expedite ☐diagnostic ☐specialist ☐assessment type/name_____ *(In the comments section specify type of diagnostic or specialist that you are requesting. Also secondary or tertiary assessment.)*

15. Are you aware of other health or non-health factors affecting recovery ☐no ☐yes (if yes, add to comments)

(Are there any red flags - diabetes, arthritis, cardiovascular disease or yellow flags - depression, family issues, monetary which may affect recovery.)

16. Estimated restrictions include ☐lifting (# of lbs.) _____ ☐pushing/pulling (# of lbs)_____☐reaching ☐overhead reaching ☐turning ☐walking_____☐stairs_____ ☐ladders_____ ☐standing (# of hrs) ____ ☐sitting (# of hrs) ____ ☐environment _____ ☐other_____

(Provide the restrictions based on best clinical judgment and available information i.e. functional testing where appropriate. It does not ask for confirmed capacities but asks the practitioner to provide functional levels based on available information so that return to work parameters can be established.)

17. The effects of the injury may affect activity for: # of days if < 8 days_____☐8–14 ☐15-21 RTW Date _____
(Based on your examination and management/treatment plan when the worker would be capable of Transitional or RTW.)

18. Has transitional RTW been discussed with the worker: ☐Yes ☐No the employer ☐Yes ☐No

19. Has a transitional RTW been arranged: ☐Yes RTW start date _____ ☐No *(Explain barriers as to why the worker could not start transitional work in comments section.)*

20. Are there any specific safety or medication concerns in a TRTW ☐No ☐Yes (If yes, explain in comments)

21. Comments*: (Please use the comments section to include any concerns with the severity of injury, treatment, psychosocial or work issues which may delay recovery.)*

_____

_____

_____

Signature:_____Date_____Copy to _____