

Practitioner's Discharge Summary Report

Profession:

Part A: Patient Identification

WCB Claim Number:

Last Name	First Name	Initial	Date of Birth (DD/MM/YY)	Personal Health Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Part B: Practitioner's Statement

Diagnosis

Date of Examination (DD/MM/YY)

Date of final treatment (DD/MM/YY)

Functional status on discharge (Related to work duties)

Outcome code:

- Code 1- Discharged without restrictions - return to work
- Code 2- Discharged without restrictions - did not return to work
- Code 3- Returned to work on a graduated program
- Code 4- Discharged with restrictions - return to work
- Code 5- Discharged with restrictions - did not return to work
- Code 6- Did not complete program. State reason did not complete program:

Total number of appointments attended and dates of appointments

Dates Absent

Part C: Practitioner Identification

Last name:	First name:
Signature:	Date (DD/MM/YY)

Part D: Practitioner Information

Clinic name:		Clinic billing number:	
Clinic address:	City:	Province:	Postal code:
Phone:	Fax:		