

Physical Therapy Initial Report

WCB claim number: _____

Worker's name: _____

Clinic name: _____	Provincial Health Number: _____
Clinic number: _____	Provider number: _____
Phone: _____	Date of birth: _____ Phone: _____
Fax: _____	MM/DD/YYYY
Care provider's name, address, postal code Print/Stamp/Sticker	Employer name: _____ Worker's name, address, postal Code Print/Stamp/Sticker

Recurrent treatment? No Yes. If yes, approx. last treatment date _____ (If a WCB client requests further (recurrent) treatment but has not attended treatment for more than 30 days at the clinic or if the worker has approached a different clinic for treatment, the WCB will fund an initial assessment and recurrent initial assessment report only, with WCB notifying the clinic if funding for more treatment will be provided.)

MM/DD/YYYY

CLINICAL

- Date of injury: _____ 2. Date of this exam: _____
MM/DD/YYYY MM/DD/YYYY
- Part of body injured: _____
- Diagnosis: _____
- Mechanism of injury: _____
- Subjective complaints: _____
- 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. _____
- Functional outcome measure: Roland Morris _____ Quick Dash _____ QD work module _____ NDI _____ LEFS _____
(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 measure when providing the information about the self-report measure)
- Assessment of recovery (0-10) status _____ (0 = no recovery, 10 = recovered to preinjury)
(The assessment of recovery is a measure that asks the provider to summarize available information and provide an estimate of the worker's current status of recovery. 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 where 0 represents no recovery and 10 represents recovery to pre-injury status.)
- Intensity score 0 1
(0= An injured worker who displays medical and psychological factors that will allow successful outcome.
1= An injured worker who requires a high level of complex treatment programming to achieve a successful outcome.)
- Are you aware of previous injury/treatment for this area? No Yes Date: _____
MM/DD/YYYY

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Explain _____

(This is dependent on the worker's recall of previous injuries. Therefore, the year of injury is satisfactory)

MANAGEMENT

12. Investigations ordered: if applicable x-ray CT MRI Other: _____

13. Management plan: Medication Chiropractor Physical therapist Massage Specialist Surgery
 Secondary/Tertiary treatment Other

Provide details _____

14. Treatment plan: Biomechanical Electro-physical agent

Conditioning Supervised _____

Transitional RTW Other _____

15. Frequency of treatment: _____ per week, Other _____

Expected date of discharge from treatment _____
MM/DD/YYYY

(This should represent the total expected number of treatments to discharge)

16. Have you contacted the employer regarding current restrictions?

Yes Date of contact _____ Name: _____
MM/DD/YYYY

No

RETURN TO WORK

17. 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 or Nurse Practitioner

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: _____

18. Return to work date: _____
MM/DD/YYYY

19. If worker is at work: Are they currently working with restrictions? No Yes

How long are restrictions expected to remain? _____ days Unknown Other _____

20. Estimated current restrictions? Subjective Objective

Lifting _____ lbs Pushing/pulling _____ lbs Reaching _____

Overhead reaching _____ Turning _____ Walking _____ Stairs _____

Ladders _____ Standing (hours) _____ Sitting (hours) _____

Environment _____ Other _____

Client and practitioner agreed: Yes No (explain in comments)

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(Use the boxes above to indicate if the restrictions that are provided are based on functional testing (where appropriate as defined in the soft tissue guidelines) or by client perception of function in combination with clinical judgment. If you have already advised that the worker is not suitable for work of any kind at this time (question 14), then the restriction sections should be left blank. Your rationale for indicating the worker's inappropriateness for return to work of any kind should be included in the comments section.)

21. Would you like to complete the Electronic Return to Work Form(PRTW)?

Yes No (RTW form needs to be completed 1 week before RTW).

(If No, explain in the comments section. If there are concerns expressed by the physical therapist regarding medication, a discussion between the physical therapist and physician regarding return-to-work issues should be initiated and should be commented on in the comments section below)

22. Comments RTW _____

23. General comments: _____

(Summarize any clinical findings or concerns that are not reflected in the report.)

Signature: _____ Date: _____
MM/DD/YYYY