Saskatchewan Workers' Compensation Board
200 - 1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com
Phone: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free fax: 1.888.844.7773

Click on any field to start editing.

PTP

Reset Form

Physical Therapy Progress Report

WCB claim number: _____

Worker's name: _____

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

Request for extension ☐ Denied CES/CM _____ Date: _____ (MM/DD/YYYY)

CLINICAL

1. Date of this exam: _____ (MM/DD/YYYY)
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 ☐ No ☐ Yes. If Yes, date of discharge: _____ (MM/DD/YYYY)

Did the worker return to their regular duties? ☐ Yes ☐ No

MANAGEMENT

9. Results of diagnostics since previous report if applicable: _____
10. Management plan: ☐ Medication ☐ Chiropractor ☐ Physical therapist ☐ Massage ☐ Specialist ☐ Surgery ☐ Secondary/Tertiary treatment ☐ Other

Provide details _____

11. Treatment plan: ☐ Biomechanical ☐ Electro-physical agent ☐ Regional conditioning Supervised _____ Home _____ ☐ Supervised global conditioning ☐ Education ☐ Transitional RTW ☐ Other _____
12. Frequency of treatment: _____ per week, Other _____

Expected date of discharge from treatment _____. (MM/DD/YYYY)

13. Are you aware of other health or non-health factors affecting recovery: ☐ Yes ☐ No Explain: _____
14. Would you like WCB to arrange/expedite: ☐ Diagnostic ☐ Specialist ☐ Assessment team review ☐ Other

Details: _____

When writing to the WCB, please print name and claim or firm number.

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Physical Therapy Progress Report

WCB claim number: _____

Worker's name: _____

15. Have you contacted the employer regarding current restrictions? ☐ Yes Date of contact _____ MM/DD/YYYY

☐ No Please explain: _____

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: _____ MM/DD/YYYY

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: _____ MM/DD/YYYY

19. Estimated current restrictions? ☐ Subjective ☐ Objective

☐ Lifting _____ lbs ☐ Pushing/pulling _____ lbs ☐ 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: _____ MM/DD/YYYY

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