Workers' Safety and Compensation Board Yukon

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Clear Form

PHYSIOTHERAPY INITIAL ASSESSMENT

This information is being collected under the authority of the Workers' Safety and Compensation Act for the purpose of determining eligibility for benefits.
For further information, contact (867) 667-5645 or 1-800-661-0443. Please contact WSCB before providing care if you have not signed a service agreement: Work is Healthy

Worker's information

Last name	
First name	
Address	
Telephone no.	Date of birth (dd/mm/yyyy)
Has worker filed a claim? ☐ Yes ☐ No	Claim no. (if known)
Date of injury (dd/mm/yyyy)	Body part injured
Family doctor	
Employer	

Provider's information

Clinic name
Address
Therapist's name
Therapist's email
Telephone no.
Fax no.
Date of visit (dd/mm/yyyy)

Subjective findings

Worker's description of injury

Has the worker had a similar problem in the past?

☐ No
☐ Yes - please explain:

Objective findings

Observations
ROM and biomechanical analysis
Strength
Neurological

Special test and results (ex: empty can test)

Test name	Result
	☐ Positive ☐ Negative
	☐ Positive ☐ Negative
	☐ Positive ☐ Negative
	☐ Positive ☐ Negative
	☐ Positive ☐ Negative

What is your clinical impression?

Critical job demands | Worker's occupation

List the worker's five most critical job demands

Critical job demand *Ex: Lifting 20 lbs*	Current ability *Lift 5 lbs*	Job match *No*

Is the job demands analysis for this occupation needed? ☐ Yes ☐ No

Treatment plan

Treatment goals	Recommended treatment (methodology)

Frequency and expected duration of treatment. Additional comments if needed.	Visits per week ☐ 1 ☐ 2 ☐ 3 ☐ 4 Other:	Duration ☐ 4 weeks ☐ 5 weeks ☐ 6 weeks Other:

Recommended or prescribed equipment or supplies

Return to work

Based on current functional abilities, can regular duties be performed?

- ☐ Yes
- ☐ No – Please list all they can do:

Are there barriers to recovery and/or return to work?

- ☐ No
- ☐ Yes – Please select all that apply:

- ☐ Hesitancy to return to work
- ☐ Not job attached or lack of appropriate modified work
- ☐ Reported employee/employer issues
- ☐ Pain/impairment barriers beyond expectation for injury
- ☐ High perceived disability
- ☐ Fear of movement of activity
- ☐ Injured worker appears anxious
- ☐ Severe injuries with likely long term or permanent work restrictions
- ☐ Other health concerns affecting recovery. Explain:

- ☐ Other (i.e., non-compensable conditions). Explain:

Has a FAF been provided to the worker?

- ☐ Yes
- ☐ No – Explain:

Signature _____ Date _____

WSCB Physiotherapy authorization for extension
**** To be completed by WSCB and returned to the HCP****

Case manager		Case manager's phone number	
Worker's name		Claim number	
Health care provider		Fax number	

Disability management guideline for injury	Injury _____ Length of disability _____
Authorization	☐ Initial assessment and 2 treatment sessions approved ☐ Treatment plan approved with modifications Explain: _____ ☐ Treatment plan approved as recommended with approximate end date: _____ ☐ Treatment plan not approved ☐ Claim denied ☐ Call case manager to discuss
Next reporting date	
Additional comments	
CM's signature	
Date of approval	