

Extension request

Discharge report

PHYSIOTHERAPY REPORT

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		Health care provider's information	
Last name		Clinic name	
First name		Address	
Address		Therapist's name	
Telephone no.	Date of birth (dd/mm/yyyy)	Telephone no.	
Claim #	Body part injured	Fax no.	
Date of injury (dd/mm/yyyy)		Reassessment date (dd/mm/yyyy)	

Treatment summary									
Treatment dates		Number of missed appointments				Overall functional progress			
Comments:									

Objective findings (If you need to provide more information, please attach an additional document.)				
Findings	Initial assessment date:	Previous extension request date:	Current extension request date:	Discharge date:
Observations				

Objective Findings

Findings	Initial assessment date:	Previous extension request date:	Current extension request date:	Discharge date:
ROM and biomechanical analysis				
Strength				
Neurological				
Other				

Objective Findings**Additional comments****Treatment plan** (If this is a discharge report, you do not need to complete this section; please go directly to the RTW section below.)

Goals / Methodology	Progress related to goal	If further treatment is recommended, please provide the rationale
Frequency and expected duration of treatment	Visits per week: 1 2 3 4 Other:	Duration: 4 weeks 5 weeks 6 weeks Other:

Explain any delay in recovery

Please provide an estimated discharge date

Return to work	
Worker's critical job demands 1. 2. 3. 4.	Estimated % of current function at this task 1. 2. 3. 4.

If needed, what ongoing accommodation(s)/modification(s) would allow the worker to remain at work?

N/A
 Workstation analysis
 Modified hours
 Modifies duties
 Gradual RTW
 Other - please describe:

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
 Worker is not engaged in treatment
 Severe injuries with likely long term or permanent work restrictions
 Other health concerns affecting recovery. Explain:

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

Discharge instructions

N/A
 Home exercise
 Other:

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	
Assessment date which authorization is based.			
Disability management guideline for injury	Injury _____		
	Length of disability _____		
Authorization	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			