

Physiotherapist Application for Additional Treatment

Claim Number

Worker Information

Last Name		First Name	
Address			City
Province	Postal Code	Phone Number	Date of Birth (dd/mm/yyyy)
Job Title		Name of Attending/Referring Physician	

Injury Details

Date of Incident	Area of Injury	Request for discussion with WCB Physiotherapy Consultants? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Assessment	Worker's Description of Incident or Injury	

Examination Findings and Diagnosis

Current Subjective Complaints																																
Self Assessment Tool (check tools used - minimum of 2)		Score	Score																													
<input type="checkbox"/> Numeric Pain Rating Scale (NPRS)	_____	<input type="checkbox"/> Lower Extremity Activity Profile (LEFS)	_____																													
<input type="checkbox"/> Roland Morris Back Pain Questionnaire (back)	_____	<input type="checkbox"/> Disabilities of the Arm, Shoulder and Hand (DASH)	_____																													
<input type="checkbox"/> Neck Disability Index (neck)	_____	<input type="checkbox"/> Health Status Disability	_____																													
Current Objective Findings (e.g., strength, mobility, neurological, etc.)																																
Therapist's Diagnosis on Completion of Assessment:		Change from initial report: <input type="checkbox"/> Yes <input type="checkbox"/> No																														
Is recovery satisfactory? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what are the complications/other factors impeding progress?																																
Dates of Treatment (place an X for dates attended):																																
Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List any dates of cancellations/no shows: _____																																
Treatment Plan: Anticipated treatment ___/week x ___ weeks		Rationale for further treatment:																														

Work Capabilities

Is worker disabled from work as a result of the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	When can worker return to regular duties? Date <input type="checkbox"/> Unknown at time of examination
Is worker capable of alternate or modified work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, outline restrictions:	Duration of restrictions _____ weeks

Therapist Information

Therapist Name		Phone Number	Fax Number
Facility Name		Email	Date
City	Province	Postal Code	Therapist Signature