



GP Extended Medical Report

This form is to be completed by the primary care provider, whenever possible.

If applicable, please select the Lock button before submitting the form.

Please note: once the Lock button has been selected, the form will no longer be editable.



Complete this form if the patient is **NOT ABLE** to complete work, training or studying activities.

INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF GP REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

PATIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	MSP/PRACTITIONER NUMBER
ARE YOU THE PATIENT'S REGULAR PRACTITIONER?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

SUBJECTIVE
KEY SUBJECTIVE FINDINGS:

RELEVANT PRE-ACCIDENT HISTORY
HAS YOUR PATIENT EVER HAD SYMPTOMS AND/OR RECEIVED TREATMENT/MEDICATIONS FOR THE AREA(S) INJURED IN THIS ACCIDENT?
<input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, DESCRIBE CONDITIONS/TREATMENT AND POSSIBLE IMPACT, IF ANY, ON RECOVERY:

WORK STATUS
1. IS THE PATIENT EMPLOYED OR ENGAGED IN TRAINING ACTIVITIES? PLEASE INDICATE WHICH ONE(S)
<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Self-employed <input type="checkbox"/> Seasonal <input type="checkbox"/> Training/Apprenticeship <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Not employed
2. IS THE PATIENT ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?
Work: <input type="checkbox"/> Yes <input type="checkbox"/> No Training: <input type="checkbox"/> Yes <input type="checkbox"/> No School/Studies: <input type="checkbox"/> Yes <input type="checkbox"/> No
If the patient is continuing to work, study or train indicate their status, as applicable
3. STATUS OF DUTIES
Work: <input type="checkbox"/> Full <input type="checkbox"/> Modified Train: <input type="checkbox"/> Full <input type="checkbox"/> Modified Study: <input type="checkbox"/> Full <input type="checkbox"/> Modified
4. STATUS OF HOURS
Work: <input type="checkbox"/> Full <input type="checkbox"/> Modified Train: <input type="checkbox"/> Full <input type="checkbox"/> Modified Study: <input type="checkbox"/> Full <input type="checkbox"/> Modified

Objective

PHYSICAL EXAM

KEY OBJECTIVE FINDINGS:

Diagnosis

PRIMARY DIAGNOSIS – IDENTIFY THE MOST SERIOUS OR SIGNIFICANT INJURY.

DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat. <input type="checkbox"/> None
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OTHER DIAGNOSIS – IDENTIFY ANY ADDITIONAL INJURIES THE PATIENT HAS SUSTAINED.

DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat. <input type="checkbox"/> None
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat. <input type="checkbox"/> None
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat. <input type="checkbox"/> None
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat. <input type="checkbox"/> None

Off Work/Modified Work Details

Please only complete this section if the patient is currently off work or working modified hours/duties.

5. HAVE YOU DISCUSSED WITH YOUR PATIENT THEIR SPECIFIC WORK DUTIES?

Yes No

6. CAN THE PATIENT PERFORM ALL REGULAR DUTIES?

Yes No

If Patient cannot perform all regular duties

7. WHAT ARE THE PATIENT'S SPECIFIC DUTIES OR PHYSICAL DEMANDS THAT CANNOT BE PERFORMED?

8. DISABILITY START DATE (dd/mmm/yyyy)

9. ANTICIPATED DISABILITY END DATE (dd/mmm/yyyy)

10. ARE THERE OTHER MEDICAL CONDITIONS (non-accident related) THAT ARE CONTRIBUTING TO THE CURRENT DIAGNOSIS OR SYMPTOMS?

Yes No

IF YES, PROVIDE COMMENTS:

11. DO YOU SUPPORT A GRADUATED RETURN TO WORK PROGRAM?

Yes No

IF YES, WHEN IS THE EARLIEST ANTICIPATED START DATE? (dd/mmm/yyyy)

DURATION (Indicate the number of weeks)

Weeks

12. DOES THE PATIENT REQUIRE ANY SPECIALIZED SERVICES OR ADAPTIVE EQUIPMENT TO FACILITATE RETURN TO WORK?

Yes No

IF YES, WHAT TYPE OF SPECIALIZED SERVICE(S) OR ADAPTIVE EQUIPMENT IS REQUIRED?

13. IS THE PATIENT CAPABLE OF CARRYING OUT HIS/HER **NON-WORK** ACTIVITIES?

Yes No

IF NO, DESCRIBE SPECIFIC ACTIVITIES THE PATIENT IS NOT ABLE TO DO AND ESTIMATE NUMBER OF WEEKS UNTIL THEY ARE ABLE TO DO THESE ACTIVITIES:

14. ADDITIONAL COMMENTS:

Recommended Care Plan Treatment

RECOMMENDED PRE-APPROVED TREATMENT(S) – INDICATE WHICH TREATMENT(S) ARE APPROPRIATE TO ADDRESS THE PATIENT'S INJURY/INJURIES

TREATMENT TYPE

TREATMENT TYPE

TREATMENT TYPE

ADDITIONAL TREATMENT RECOMMENDATION INCLUDING TYPE, FREQUENCY AND DURATION IF APPLICABLE:

ANTICIPATED FUNCTIONAL OUTCOMES FROM THE CUSTOMIZED TREATMENT PLAN

OUTCOME 1

OUTCOME 2

OUTCOME 3

ADDITIONAL COMMENTS:

TREATMENT NOTES
PROTOCOLS AND GUIDELINES (e.g. OPTIMA, ODG, etc.) Are you using an established protocol to inform your treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If applicable, please indicate the protocol for treatment:
15. DO YOU EXPECT THE PATIENT TO RETURN TO NORMAL FUNCTION WITH THE ABOVE RECOMMENDED TREATMENT PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to determine
IF "NO" OR "UNABLE TO DETERMINE", PROVIDE COMMENTS:
16. WILL THE PATIENT LIKELY REQUIRE ADDITIONAL THERAPY BEYOND THE ABOVE RECOMMENDED TREATMENT PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No
17. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, INDICATE:
18. ANTICIPATED DATE OF FULL RECOVERY (dd/mmm/yyyy)
19. ANTICIPATED TREATMENT REASSESSMENT DATE (dd/mmm/yyyy)

Patient Education – check any/all that have been communicated to the patient

In accordance with evidence informed best practice, and as applicable to the injuries sustained by the patient, the patient has received education with respect to:

- the desirability of an early return, without limitation, to being able to perform the activities the patient could perform before the injury and if applicable, to the patient's employment, training or study
- an estimate of the probable length of time that symptoms will last
- the usual course of recovery
- the probable factors that are responsible for the symptoms the patient may be experiencing
- appropriate self-management and pain management strategies

By checking this box, I certify that the information provided is true and correct to the best of my knowledge.

Select one of the following:

- I have obtained consent from the patient to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.
- This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

Personal information on this form is being collected under Section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and Section 28 or 28.1 of the *Insurance (Vehicle) Act (BC)* for the purpose of obtaining a health care report in order to investigate, manage or settle a claim. Questions about the collection of this information may be directed to the adjuster, or call 604-661-2800 or contact the Privacy & Freedom of Information (FOI) Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.

Return To ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6
Fax 1-877-686-4222