✓ To fill in and save this PDF, use Adobe Acrobat Reader XI or later.

GP Extended Medical Report

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

Lock

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? ☐ Yes ☐ 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?
☐ Yes ☐ 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)
☐ Full time ☐ Part time ☐ Self-employed ☐ Seasonal ☐ Training/Apprenticeship ☐ Student ☐ Retired ☐ Not employed

2. IS THE PATIENT ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?
Work: ☐ Yes ☐ No Training: ☐ Yes ☐ No School/Studies: ☐ Yes ☐ No

If the patient is continuing to work, study or train indicate their status, as applicable

3. STATUS OF DUTIES
Work: ☐ Full ☐ Modified Train: ☐ Full ☐ Modified Study: ☐ Full ☐ Modified

4. STATUS OF HOURS
Work: ☐ Full ☐ Modified Train: ☐ Full ☐ Modified Study: ☐ Full ☐ 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 ☐ Left ☐ Right ☐ Bilat. ☐ None
OTHER DIAGNOSIS — IDENTIFY ANY ADDITIONAL INJURIES THE PATIENT HAS SUSTAINED.			
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No
17. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES? ☐ Yes ☐ 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 manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.

Return To ICBC
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