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GP Reassessment 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.

Lock

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

REGISTERED CARE ADVISOR (RCA) REFERRAL

1. IS A REGISTERED CARE ADVISOR (RCA) REFERRAL RECOMMENDED AT THIS TIME?
☐ Yes ☐ No

IF YES, REFERRAL REQUESTED FOR:

SUBJECTIVE

KEY SUBJECTIVE FINDINGS:

OBJECTIVE

KEY OBJECTIVE FINDINGS:

DIAGNOSIS

2. HAS THE DIAGNOSIS OF THE INJURIES CHANGED SINCE THE LAST REPORT? (IF NO, SKIP TO WORK STATUS SECTION)
☐ Yes ☐ No

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

COMMENT:

WORK STATUS

3. 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

4. STATUS OF DUTIES

Work: ☐ Full ☐ Modified Train: ☐ Full ☐ Modified Study: ☐ Full ☐ Modified

5. STATUS OF HOURS

Work: ☐ Full ☐ Modified Train: ☐ Full ☐ Modified Study: ☐ Full ☐ Modified

6. PROVIDE REASONS WHY THE PATIENT IS NOT WORKING, TRAINING OR STUDYING:

7. DO YOU SUPPORT ANY CONTINUED RESTRICTIONS ON REGULAR DUTIES OR HOURS?

☐ Yes ☐ No

IF YES, PROVIDE COMMENTS:

TREATMENT ACCESSED

☐ Physiotherapy ☐ Massage Therapy ☐ Psychology ☐ Chiropractic ☐ Kinesiology ☐ Counselling
☐ Acupuncture ☐ Other Specify:

FUNCTIONAL GOALS (OUTCOMES TO BE MEASURED)

FUNCTIONAL GOAL 1

FUNCTIONAL GOAL 2

FUNCTIONAL GOAL 3

COMMENTS ON FUNCTIONAL GOALS (including progress made towards goals, limitations on progress as appropriate):

8. HAS THE PATIENT RETURNED TO A PRE-ACCIDENT LEVEL OF ACTIVITY OUTSIDE OF WORK?

☐ Yes ☐ No

IF NO, PROVIDE COMMENTS:

9. HAS THE PATIENT RETURNED TO FULL FUNCTIONAL STATUS?

☐ Yes ☐ No

IF NO, PROVIDE PRACTITIONER'S OPINION ON WHAT BARRIERS EXIST:

Recommended Care Plan Treatment

RECOMMENDED TREATMENT(S) — INDICATE WHICH TREATMENT(S) ARE APPROPRIATE TO CONTINUE TO ADDRESS THE PATIENT'S INJURY/INJURIES

TREATMENT TYPE

TREATMENT TYPE

TREATMENT TYPE

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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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