



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.

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		

REGISTERED CARE ADVISOR (RCA) REFERRAL
1. IS A REGISTERED CARE ADVISOR (RCA) REFERRAL RECOMMENDED AT THIS TIME? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No			
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
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
COMMENT:			

WORK STATUS
3. 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
4. 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
5. 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
6. PROVIDE REASONS WHY THE PATIENT IS NOT WORKING, TRAINING OR STUDYING:
7. DO YOU SUPPORT ANY CONTINUED RESTRICTIONS ON REGULAR DUTIES OR HOURS? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, PROVIDE COMMENTS:

TREATMENT ACCESSED
<input type="checkbox"/> Physiotherapy <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Psychology <input type="checkbox"/> Chiropractic <input type="checkbox"/> Kinesiology <input type="checkbox"/> Counselling <input type="checkbox"/> Acupuncture <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF NO, PROVIDE COMMENTS:
9. HAS THE PATIENT RETURNED TO FULL FUNCTIONAL STATUS? <input type="checkbox"/> Yes <input type="checkbox"/> 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
TREATMENT TYPE
TREATMENT TYPE

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