



Chiropractic Reassessment Report



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 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	PRACTITIONER NUMBER

Assessment

DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)
----------------------------------	----------------------------------	----------------------------------	----------------------------------

Work Status

1. IS THE PATIENT STILL JOB ATTACHED? <input type="radio"/> Yes <input type="radio"/> No
2. 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
3. HAS THE PATIENT BEEN ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA? Work: <input type="radio"/> Yes <input type="radio"/> No Training: <input type="radio"/> Yes <input type="radio"/> No School/Studies: <input type="radio"/> Yes <input type="radio"/> No
If the patient is continuing to work, study or train indicate their status, as applicable
4. STATUS OF DUTIES Work: <input type="radio"/> Full <input type="radio"/> Modified Training: <input type="radio"/> Full <input type="radio"/> Modified Study: <input type="radio"/> Full <input type="radio"/> Modified
5. STATUS OF HOURS Work: <input type="radio"/> Full <input type="radio"/> Modified Training: <input type="radio"/> Full <input type="radio"/> Modified Study: <input type="radio"/> Full <input type="radio"/> Modified

Return to Work Planning

Only fill this section, "Return to Work Planning", if the patient was gainfully employed on the date of the accident and is not currently working, or working for modified hours/duties.

6. WHAT IS THE PATIENT'S CURRENTLY RECOMMENDED RETURN TO WORK STATUS? <input type="radio"/> Full work status <input type="radio"/> Modified work <input type="radio"/> Not recommended to return to work in any capacity
IF MODIFIED WORK, SPECIFY WHAT MODIFICATION: <input type="checkbox"/> Modified hours <input type="checkbox"/> Modified duties
If the patient is not recommended to return to work in any capacity, fill out Questions 7 and 8.
7. WHEN CAN RETURN TO WORK COMMENCE? PLEASE PROVIDE DETAILS:
8. ADDITIONAL RECOMMENDATION(S) ON RETURN TO WORK

Activities of Daily Living (ADL)

REPORTS OF ISSUES RELATED TO ADLs

Assessment Findings

SIGNIFICANT SUBJECTIVE FINDINGS

SIGNIFICANT OBJECTIVE FINDINGS

9. PALPATORY TENDERNESS

Yes No

If 'Yes' on Question 9 fill out at least one of the Questions 10, 11, or 12 .

10. CERVICAL SPINE Left Midline Right

11. THORACIC SPINE Left Midline Right

12. LUMBAR SPINE Left Midline Right

13. STRAIGHT LEG RAISE LIMITED

Yes No

IF YES, WHICH SIDE?

Left Right

AROM/PROM LIMITATIONS

14. CERVICAL

Yes No

IF YES, PROVIDE COMMENTS:

15. THORACIC

Yes No

IF YES, PROVIDE COMMENTS:

16. LUMBAR

Yes No

IF YES, PROVIDE COMMENTS:

NEUROLOGICAL EXAM	
17. SENSORY DEFICIT <input type="radio"/> Yes <input type="radio"/> No	IF YES, WHERE? <input type="checkbox"/> Left arm <input type="checkbox"/> Left leg <input type="checkbox"/> Right arm <input type="checkbox"/> Right leg
18. MOTOR WEAKNESS <input type="radio"/> Yes <input type="radio"/> No	IF YES, WHERE? <input type="checkbox"/> Left arm <input type="checkbox"/> Left leg <input type="checkbox"/> Right arm <input type="checkbox"/> Right leg
19. DEEP TENDON REFLEX DEFICITS <input type="radio"/> Yes <input type="radio"/> No	IF YES, WHERE? <input type="checkbox"/> Left arm <input type="checkbox"/> Left leg <input type="checkbox"/> Right arm <input type="checkbox"/> Right leg

20. DEGENERATIVE CHANGES <input type="radio"/> Yes <input type="radio"/> No
IF YES, SPECIFY LEVELS:

21. FRACTURE DISLOCATION <input type="radio"/> Yes <input type="radio"/> No
IF YES, SPECIFY LEVELS:

MEDICAL INVESTIGATION(S)

Objective Measures

OBJECTIVE MEASURE

Chiropractic Diagnosis

DIAGNOSIS 1		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

DIAGNOSIS 2		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

DIAGNOSIS 3		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

DIAGNOSIS 4		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

DIAGNOSIS 5		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

Treatment Progress

TREATMENT MODALITY

22. REFERRAL TO ADDITIONAL MEDICAL INVESTIGATION(S)

Yes No

IF YES, IDENTIFY:

Treatment

TREATMENT GOALS (AT LEAST 1)

TREATMENT GOAL 1

TREATMENT GOAL 2

TREATMENT GOAL 3

TREATMENT PLAN

Communication Request

23. DO YOU WISH TO HAVE A PHONE CONSULT WITH THE CLAIM FILE HANDLER?

Yes No

24. DO YOU WISH TO HAVE A PHONE CONSULT WITH OTHER CLINICIANS INVOLVED IN THIS PATIENT'S CARE?

Yes No

IF YES, SPECIFY WHICH ONES:

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.