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

Physiotherapy Progress Report

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.

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			

CLIENT 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)	NUMBER OF TREATMENT SESSIONS TO DATE
DATE OF PREVIOUS ASSESSMENT (dd/mmm/yyyy)	DATE OF FIRST VISIT (dd/mmm/yyyy)

Work Status

	PRE-ACCIDENT EMPLOYMENT/TRAINING	PRE-ACCIDENT STATUS	CURRENT EMPLOYMENT/TRAINING	CURRENT STATUS
PRIMARY STATUS				
SECONDARY STATUS				
TERTIARY STATUS				

Comments

PROVIDE ADDITIONAL COMMENTS ON WORK STATUS, AS RELEVANT

Return to Work Planning

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

1. WHAT IS THE CLIENT'S CURRENTLY RECOMMENDED RETURN TO WORK STATUS?

○ Full work status ○ Modified work ○ Not recommended to return to work in any capacity

IF MODIFIED WORK, SPECIFY WHAT MODIFICATION:

☐ Modified hours ☐ Modified duties

If the client is not recommended to return to work in any capacity, fill out Questions 2 and 3.

2. WHEN CAN RETURN TO WORK COMMENCE? PLEASE PROVIDE DETAILS:

3. RECOMMENDATION(S) ON RETURN TO WORK

Activities of Daily Living (ADL)

REPORTS OF ISSUES RELATED TO ADLs

Assessment Findings

SIGNIFICANT 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:

SIGNIFICANT OBJECTIVE FINDINGS

OBSERVATIONS — PREVIOUS ASSESSMENT FINDINGS	OBSERVATIONS — CURRENT ASSESSMENT FINDINGS
AROM/PROM/BIOMECHANICAL ANALYSIS — PREVIOUS ASSESSMENT FINDINGS	AROM/PROM/BIOMECHANICAL ANALYSIS — CURRENT ASSESSMENT FINDINGS

RESISTED STRENGTH TESTING — PREVIOUS ASSESSMENT FINDINGS	RESISTED STRENGTH TESTING — CURRENT ASSESSMENT FINDINGS
NEUROVASCULAR STATUS — PREVIOUS ASSESSMENT FINDINGS	NEUROVASCULAR STATUS — CURRENT ASSESSMENT FINDINGS
CONCURRENT THERAPIES (Please include how often and/or how many visits.) — PREVIOUS ASSESSMENT FINDINGS	CONCURRENT THERAPIES (Please include how often and/or how many visits.) — CURRENT ASSESSMENT FINDINGS
SPECIAL TEST/OTHER — PREVIOUS ASSESSMENT FINDINGS	SPECIAL TEST/OTHER — CURRENT ASSESSMENT FINDINGS
MEDICAL INVESTIGATION(S)	

Objective Measures

OBJECTIVE MEASURE USED (e.g. NDI, Oswestry, DASH)	
PREVIOUS ASSESSMENT FINDINGS	CURRENT ASSESSMENT FINDINGS

Physiotherapy 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

TREATMENT PROGRESS
DESCRIBE TREATMENT PROGRESS TO DATE

TREATMENT GOALS (AT LEAST 1)
TREATMENT GOAL 1:
TREATMENT GOAL 2:
TREATMENT GOAL 3:

BARRIERS TO RECOVERY
BARRIER 1
BARRIER 2
BARRIER 3

UPDATED TREATMENT PLAN

Return to ADLs

4. HAS THE CLIENT RETURNED TO ADLs?

○ Yes ○ No

IF NO, SELECT ESTIMATED RETURN TO ADLs:

Communication Request

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

○ Yes ○ No

6. DO YOU WISH TO HAVE A PHONE CONSULT WITH OTHER CLINICIANS INVOLVED IN THIS CLIENT'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 client 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.