Kinesiology Reassessment 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)	DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)

Work Status

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

Comments

PROVIDE ADDITIONAL COMMENTS ON WORK STATUS, AS RELEVANT

Assessment Findings

SIGNIFICANT SUBJECTIVE FINDINGS

SIGNIFICANT OBJECTIVE FINDINGS

JOINT RANGE OF MOTION SCREEN/STRENGTH (complete only relevant sections)

JOINT / MOVEMENT		CHANGED MOTION (+/-) FROM INTAKE	CHANGED STRENGTH AT PROGRESS
-- please select --			
-- please select --			
-- please select --			
-- please select --			

FUNCTIONAL ABILITIES RELATED TO JOB DEMANDS AND/OR ACTIVITIES OF DAILY LIVING			
FUNCTIONAL ABILITY	**REPORTED JOB DEMANDS (weights, heights, distances, frequencies)**	**CURRENT ABILITY**	**DEMANDS MET**
-- Please Select --			○ Yes ○ No
-- Please Select --			○ Yes ○ No
-- Please Select --			○ Yes ○ No
-- Please Select --			○ Yes ○ No
-- Please Select --			○ Yes ○ No
-- Please Select --			○ Yes ○ No

Activity Tolerance and Functional Mobility

SUBJECTIVE REPORTS OF FUNCTIONAL MOBILITY AND ACTIVITY TOLERANCE:
OBSERVED FUNCTIONAL MOBILITY AND ACTIVITY TOLERANCE:

Treatment

UPDATED CLIENT SPECIFIC GOALS
GOAL 1
GOAL 2
GOAL 3

UPDATED CLINICAL/REHAB SPECIFIC GOALS
GOAL 1
GOAL 2
GOAL 3

BARRIERS TO RECOVERY
BARRIER 1
BARRIER 2
BARRIER 3

UPDATED TREATMENT PLAN			
NUMBER OF TREATMENT SESSIONS BEING RECOMMENDED	LENGTH OF TREATMENT SESSIONS IN MINUTES	FREQUENCY OF TREATMENT SESSIONS	ANTICIPATED DISCHARGE DATE (ddmmmyyyy)
ADDITIONAL INFORMATION			

REPORT DISTRIBUTION — REPORT DISTRIBUTED TO THE FOLLOWING:

Communication Request

6. DO YOU WISH TO HAVE A PHONE CONSULT WITH THE CLAIM FILE HANDLER?
○ Yes ○ No
7. 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 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.