



## Nurse Practitioner 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.



CLAIM INFORMATION		
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF NP REPORT (dd/mmm/yyyy)

PATIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER
ARE YOU THE PATIENT'S REGULAR PRACTITIONER? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SUBJECTIVE
KEY 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, DESCRIBE CONDITIONS/TREATMENT AND POSSIBLE IMPACT, IF ANY, ON RECOVERY:

OBJECTIVE
KEY OBJECTIVE FINDINGS:

## Diagnosis

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
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WORK STATUS
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
HAS THE PATIENT BEEN 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
STATUS OF DUTIES Work: <input type="checkbox"/> Full <input type="checkbox"/> Modified    Training: <input type="checkbox"/> Full <input type="checkbox"/> Modified    Study: <input type="checkbox"/> Full <input type="checkbox"/> Modified
STATUS OF HOURS Work: <input type="checkbox"/> Full <input type="checkbox"/> Modified    Training: <input type="checkbox"/> Full <input type="checkbox"/> Modified    Study: <input type="checkbox"/> Full <input type="checkbox"/> Modified
PROVIDE REASONS WHY THE PATIENT IS NOT WORKING, TRAINING OR STUDYING IF APPLICABLE

## Recommended Care Plan Treatment

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

TREATMENT NOTES
DO YOU EXPECT THE PATIENT TO RETURN TO NORMAL FUNCTION WITH THE ABOVE RECOMMENDED TREATMENT PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to determine
IF "NO" OR "UNABLE TO DETERMINE", PROVIDE COMMENTS:
7. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, INDICATE:
ANTICIPATED DATE OF FULL RECOVERY (dd/mm/yyyy)

## Patient Education – check any/all that have been communicated to the patient

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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