Kinesiology 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)

RELEVANT PRE-ACCIDENT HISTORY

ARE YOU AWARE OF ANY **PRIOR INJURIES** OR **MEDICAL CONDITIONS** AT THE TIME OF THIS ACCIDENT?

○ Yes ○ No

IF YES, DESCRIBE CONDITIONS/TREATMENT AND POSSIBLE IMPACT, IF ANY, ON RECOVERY:

Choose an item. Details:
Choose an item. Details:
Choose an item. Details:

MEDICAL INVESTIGATION OR SPECIALIST

ARE YOU AWARE OF ANY **MEDICAL INVESTIGATION** OR **SPECIALIST** REFERRAL RELATING TO INJURIES FROM THIS ACCIDENT?

○ Yes ○ No

IF YES, LIST THE MEDICAL INVESTIGATION OR SPECIALIST REFERRAL (if known provide date, findings, etc)

Choose an item. Details:
Choose an item. Details:
Choose an item. Details:

WORK STATUS

WAS THE PATIENT EMPLOYED OR ENGAGED IN THESE ACTIVITIES ON THE DATE OF THE ACCIDENT? PLEASE INDICATE WHICH ONE(s)

○ Full time ○ Part time ○ Self-employed ○ Seasonal ○ Training ○ Student ○ Retired ○ Unemployed

PROVIDE JOB TITLE(s) FOR WORK:

CURRENT WORK STATUS AS A RESULT OF THIS ACCIDENT:

Work: **Choose an item.** Training: **Choose an item.** School: **Choose an item.**

COMMENTS:

V1 (012023)

RETURN TO WORK PLANNING

Only fill in this section if the patient has not yet returned or is on a graduated return to work as a result of this accident.

IS THE PATIENT NOW ABLE TO RETURN TO PRE-ACCIDENT DUTIES AND HOURS FOR WORK?

○ Yes ○ No

IF NO, LIST THE PRIMARY WORK-RELATED FUNCTIONAL LIMITATION(S) THAT RESULTED FROM THIS ACCIDENT. PLEASE USE THE TESTING RESULTS FROM FUNCTIONAL ABILITIES TABLE IN THE APPENDIX.

1)

2)

3)

ACTIVITIES OF DAILY LIVING (ADL)

IS THE PATIENT ABLE TO PERFORM THE FOLLOWING **ACTIVITES OF DAILY LIVING** (indicate only tasks that were performed prior to this accident)?

? Self-care: **Choose an item.**
Sport: **Choose an item.**

? Homemaking: **Choose an item.**
Leisure: **Choose an item.**

? Caregiving: **Choose an item.**

COMMENTS:

IF NO, LIST THE PRIMARY ACTIVITIES OF DAILY LIVING THAT CANNOT BE PERFORMED AS A RESULT OF THIS ACCIDENT. PLEASE USE THE TESTING RESULTS FROM FUNCTIONAL ABILITIES TABLE IN THE APPENDIX.

1)

2)

3)

Assessment Findings

SUBJECTIVE FINDINGS - List relevant symptoms related to this accident (include location, frequency, duration, intensity, etc)
- Relevant OUTCOME MEASURES may be included (optional)

INITIAL FINDINGS:	CURRENT FINDINGS:

OBJECTIVE FINDINGS - List relevant objective findings related to this accident (observation, range of motion, strength, neurological, special tests, palpation)

INITIAL FINDINGS:	CURRENT FINDINGS:

FUNCTIONAL TESTING FOR JOB DEMANDS (AND/OR ACTIVITIES OF DAILY LIVING)
COMPLETE FUNCTIONAL ABILITIES TABLE IN APPENDIX

Recommended Kinesiology Care Plan

PRIMARY BARRIERS TO RECOVERY (includes Functional, Physical, Psychosocial, Employer, Medical or Compliance)
BARRIER 1
BARRIER 2
BARRIER 3

PRIMARY GOAL OF KINESIOLOGY TREATMENT (should be Specific, Measurable, Achievable, Relevant and Time-Bound)

PROGNOSIS AND RECOVERY TIMELINES
PLEASE PROVIDE THE NAME AND PROFESSION OF THE REGULATED PRIMARY HEALTH CARE PROVIDER(S) FOR THE PATIENT
Name: Healthcare profession: **Choose an item.**
Name: Healthcare profession: **Choose an item.**
DO YOU EXPECT THE PATIENT TO **RETURN TO PRE-ACCIDENT FUNCTION** WITH CONTINUED KINESIOLOGY TREATMENTS?
Choose an item.
COMMENTS:

RECOMMENDED **REASSESSMENT** DATE FOR NEXT PROGRESS REPORT (if applicable) (DD/MMM/YYYY):

Note: A TREATMENT PLAN must be submitted to ICBC when treatments are requested outside the early access period of Enhanced Care or when further treatment sessions are recommended beyond the current approved Treatment Plan. Therefore, Treatment Plans may be required concurrently with a requested PROGRESS REPORT.

☐ I certify that the information provided is true and correct to the best of my knowledge and that this report has been completed by a treating therapist.

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 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.

APPENDIX – Functional Abilities Table

IS THE PATIENT MEDICALLY APPROPRIATE FOR FUNCTIONAL TESTING AT THIS TIME?

○ Yes ○ No

IF NO, PLEASE EXPLAIN:

If the patient is absent from work or on a GRTW plan, focus **FUNCTIONAL TESTING** on work-related functional limitations. However, if the patient has returned to pre-accident work status (or is unable to return to pre-accident work status, such as a catastrophic injury), then focus FUNCTIONAL TESTING on limitations in Activities of Daily Living (ADL).

Demands for Functional Testing table below based on:

☐ Reported Job Demands ☐ Reported ADL Demands

☐ Confirmed Job Demands ☐ Confirmed ADL Demands

Note: Ensure Job/ADL Demands provide **specific weights/loads, heights, distances, length of time and/or frequencies**

Functional Abilities — Describe all accident-related functional limitations related to job demands and/or activities of daily living

Functional Ability	Job/ADL Demands	Initial Findings DATE:	Current Findings DATE:	Comments	Job/ADL Demands Met
Choose an item.					○ Yes ○ No
Choose an item.					○ Yes ○ No
Choose an item.					○ Yes ○ No
Choose an item.					○ Yes ○ No
Choose an item.					○ Yes ○ No
Choose an item.					○ Yes ○ No
Choose an item.					○ Yes ○ No
Choose an item.					○ Yes ○ No