



3. HAS THE PATIENT HAD ANY MEDICAL INVESTIGATIONS AND/OR REFERRALS TO PHYSICIANS PROVIDING SPECIALIZED SERVICES FOR INJURIES SUSTAINED AS A RESULT OF THE CRASH?  
 Yes  No

IF YES, PROVIDE DETAILS:

**VOCATIONAL STATUS**

4. IS THE PATIENT EMPLOYED OR ENGAGED IN TRAINING ACTIVITIES? PLEASE INDICATE WHICH ONE(S)  
 Full time  Part time  Self-employed  Seasonal  Training/Apprenticeship  Student  Retired  Homemaker/caregiver  Not employed

PATIENT'S JOB POSITION, AS APPLICABLE

5. IS THE PATIENT ABSENT FROM THE FOLLOWING AS A RESULT OF THE CRASH?  
 Work:  Yes  No Training:  Yes  No School/Studies:  Yes  No Homemaking/caregiving:  Yes  No

**If the patient is continuing to work, study, train, or provide homemaking/caregiving, indicate their status, as applicable**

6. STATUS OF DUTIES  
 Work:  Full  Modified Train:  Full  Modified Study:  Full  Modified Homemaking/caregiving:  Full  Modified

7. STATUS OF HOURS  
 Work:  Full  Modified Train:  Full  Modified Study:  Full  Modified Homemaking/caregiving:  Full  Modified

**If the patient is currently off work or working modified hours/duties, complete the following section**

8. CAN THE PATIENT PERFORM ALL REGULAR DUTIES AND REGULAR HOURS?  
 Yes  No

**If patient cannot perform all regular duties at regular hours**

9. WHAT ARE THE PATIENT'S SPECIFIC DUTIES OR PHYSICAL DEMANDS THAT CANNOT BE PERFORMED? PLEASE SPECIFY THE DEGREE OF IMPACT

10. DISABILITY START DATE (dd/mmm/yyyy)	11. ANTICIPATED DISABILITY END DATE (dd/mmm/yyyy)
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12. DO YOU SUPPORT A GRADUATED RETURN TO WORK PROGRAM?  
 Yes  No

IF YES, WHEN IS THE EARLIEST ANTICIPATED START DATE? (dd/mmm/yyyy)	DURATION (indicate the number of weeks) Weeks
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13. DOES THE PATIENT REQUIRE ANY SPECIALIZED SERVICES OR ADAPTIVE EQUIPMENT TO FACILITATE RETURN TO WORK?  
 Yes  No

IF YES, WHAT TYPE OF SPECIALIZED SERVICE(S) OR ADAPTIVE EQUIPMENT IS REQUIRED?

**AVOCATIONAL STATUS**

14. AVOCATIONAL STATUS (e.g. activities of daily living)

15. IS THE PATIENT CURRENTLY UNABLE TO ENGAGE IN THEIR PRE-CRASH AVOCATIONAL ACTIVITIES?  
 Yes  No

IF YES, WHAT IS THE EARLIEST DATE THE PATIENT COULD RETURN TO THEIR AVOCATIONAL ACTIVITIES?

16. IF THE PATIENT IS CONTINUING TO ENGAGE IN THEIR AVOCATIONAL ACTIVITIES, INDICATE THEIR STATUS, AS APPLICABLE  
**Duties:**  Regular  Modified **Hours:**  Regular  Modified

If modified, provide additional details explaining reasoning and recommendations



## Recommended Care Management Plan

19. PROVIDE MANAGEMENT RECOMMENDATIONS INCLUDING WHICH TREATMENT(S), MEDICAL INVESTIGATION(S), OR REFERRAL(S) ARE APPROPRIATE TO ADDRESS THE PATIENT'S INJURY/ INJURIES, AS APPLICABLE	
20. DO YOU EXPECT THE PATIENT TO RETURN TO PRE-CRASH FUNCTION WITH THE ABOVE RECOMMENDED CARE MANAGEMENT PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to determine If "No" or "Unable to determine", provide comments:	
21. WILL THE PATIENT LIKELY REQUIRE ADDITIONAL THERAPY BEYOND THE ABOVE RECOMMENDED CARE MANAGEMENT PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", indicate:	
<b>PROGNOSIS AND RECOVERY TIMELINES</b>	
22. PROVIDE DETAILS ON PROGNOSIS:	
23. PROVIDE DETAILS ON ANTICIPATED RECOVERY TIMELINES:	
<b>TREATMENT NOTES</b>	
24. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate:	
25. ANTICIPATED DATE OF FULL RECOVERY (dd/mmm/yyyy)	26. ANTICIPATED TREATMENT REASSESSMENT DATE (dd/mmm/yyyy)
<b>ADDITIONAL COMMENTS</b>	

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 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.

**Return To** ICBC  
PO BOX 2121, STN TERMINAL  
VANCOUVER BC V6B 0L6  
**Fax** 1-877-686-4222

## Appendix – Common ICD 9 Codes

INJURY TYPE	ICD 9 CODE(S)
<b>Mental disorders</b>	<ul style="list-style-type: none"> <li>• 300 Neurotic disorders</li> <li>• 309 Adjustment reaction</li> </ul>
<b>Symptoms, Signs, And Ill-Defined Conditions</b>	<ul style="list-style-type: none"> <li>• 781 symptoms involving nervous and musculoskeletal systems</li> </ul>
<b>Fractures</b>	<ul style="list-style-type: none"> <li>• 800 Fracture of vault of skull</li> <li>• 801 Fracture of base of skull</li> <li>• 802 Fracture of face bones</li> <li>• 803 Other and unqualified skull fractures</li> <li>• 804 Multiple fractures involving skull or face with other bones</li> <li>• 805 Fracture of vertebral column without mention of spinal cord injury</li> <li>• 806 Fracture of vertebral column with spinal cord injury</li> <li>• 807 Fracture of rib(s) sternum larynx and trachea</li> <li>• 808 Fracture of pelvis</li> <li>• 809 Ill-defined fractures of bones of trunk</li> <li>• 810 Fracture of clavicle</li> <li>• 811 Fracture of scapula</li> <li>• 812 Fracture of humerus</li> <li>• 813 Fracture of radius and ulna</li> <li>• 814 Fracture of carpal bone(s)</li> <li>• 815 Fracture of metacarpal bone(s)</li> <li>• 816 Fracture of one or more phalanges of hand</li> <li>• 817 multiple fractures of hand bones</li> <li>• 818 ill-defined fractures of upper limb</li> <li>• 819 multiple fractures involving both upper limbs, and upper limb with rib(s) and sternum</li> <li>• 820 fracture of neck of femur</li> <li>• 821 fracture of other and unspecified parts of femur</li> <li>• 822 fracture of patella</li> <li>• 823 fracture of tibia and fibula</li> <li>• 824 fracture of ankle</li> <li>• 825 fracture of one or more tarsal and metatarsal bones</li> <li>• 826 fracture of one or more phalanges of foot</li> <li>• 827 other, multiple and ill-defined fractures of lower limb</li> <li>• 828 multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum</li> </ul>
<b>Sprain/strains</b>	<ul style="list-style-type: none"> <li>• 840 Sprains and strains of shoulder and upper arm</li> <li>• 841 Sprains and strains of elbow and forearm</li> <li>• 842 Sprains and strains of wrist and hand</li> <li>• 843 Sprains and strains of hip and thigh</li> <li>• 844 Sprains and strains of knee and leg</li> <li>• 845 Sprains and strains of ankle and foot</li> <li>• 846 Sprains and strains of sacroiliac region</li> <li>• 847 Sprains and strains of other and unspecified parts of back</li> <li>• 848 Other and ill-defined sprains and strains</li> </ul>
<b>Concussion</b>	<ul style="list-style-type: none"> <li>• 850 Concussion</li> </ul>
<b>Contusion</b>	<ul style="list-style-type: none"> <li>• 920 Contusion of face, scalp, and neck except eye(s)</li> <li>• 921 Contusion of eye and adnexa</li> <li>• 922 Contusion of trunk</li> <li>• 923 Contusion of upper limb</li> <li>• 924 Contusion of lower limb and of other and unspecified sites</li> </ul>