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

Physiotherapy Initial 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

1. IS THE CLIENT STILL JOB ATTACHED?
○ Yes ○ No

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

3. HAS THE CLIENT BEEN ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?
Work: ○ Yes ○ No Training: ○ Yes ○ No School/Studies: ○ Yes ○ No

If the client is continuing to work, study or train indicate their status, as applicable

4. STATUS OF DUTIES
Work: ○ Full ○ Modified Training: ○ Full ○ Modified Study: ○ Full ○ Modified

5. STATUS OF HOURS
Work: ○ Full ○ Modified Training: ○ Full ○ Modified Study: ○ Full ○ Modified

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.

6. 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 7 and 8.

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

8. ADDITIONAL RECOMMENDATION(S) ON RETURN TO WORK

Activities of Daily Living (ADL)

REPORTS OF ISSUES RELATED TO ADLs

Assessment Findings

SIGNIFICANT SUBJECTIVE FINDINGS

SIGNIFICANT OBJECTIVE FINDINGS

OBSERVATIONS

AROM/PROM/BIOMECHANICAL ANALYSIS

RESISTED STRENGTH TESTING

NEUROVASCULAR STATUS

CONCURRENT THERAPIES (Please include how often and/or how many visits.)

SPECIAL TEST/OTHER

MEDICAL INVESTIGATION(S)

Objective Measures

OBJECTIVE MEASURE USED (e.g. NDI, Oswestry DASH)

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

First Treatment

TREATMENT MODALITY (If applicable)

9. REFERRAL TO ADDITIONAL MEDICAL INVESTIGATION(S)

○ Yes ○ No

IF YES, IDENTIFY:

Treatment

TREATMENT GOALS (AT LEAST 1)

TREATMENT GOAL 1

TREATMENT GOAL 2

TREATMENT GOAL 3

TREATMENT PLAN

Return to ADLs

10. HAS THE CLIENT RETURNED TO ADLs?

○ Yes ○ No

IF NO, SELECT ESTIMATED RETURN TO ADLs:

Communication Request

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

○ Yes ○ No

12. 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.