

Physiotherapy Progress/ Discharge Assessment

☐ Progress Report ☐ Discharge Form

Claim Number

PPDA

Worker Information

Last Name		First Name	
Address	City	Province	Postal Code
Date of Incident DD/MM/YYYY	Date of Birth DD/MM/YYYY	Job Title	Date of Examination/Treatment DD/MM/YYYY

Injury Details

Area of Injury	Request for discussion with WCB Physiotherapy Consultants? Yes <input type="checkbox"/> No <input type="checkbox"/>
Any changes in diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, state new diagnosis	

Examination Findings and Diagnosis

Current Subjective Complaints			
Self assessment tool (check tools used – minimum of 2)	Score:		Score:
<input type="checkbox"/> Numeric pain rating scale (NPRS)	_____	<input type="checkbox"/> Lower extremity profile (LEFS)	_____
<input type="checkbox"/> Roland Morris back pain questionnaire (back)	_____	<input type="checkbox"/> Disabilities of the arm, shoulder and hand (DASH)	_____
<input type="checkbox"/> Neck disability index (neck)	_____	<input type="checkbox"/> Health status disability	_____
Current objective findings – impairments			
Discharge - Status at discharge: - Reason for discharge:			
Is recovery satisfactory? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, what are the complications /other factors impeding progress?			
Were findings/recommendations discussed with worker? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was home program provided? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, specify:		

Work Capabilities

Will worker be disabled from work beyond the date of incident as a result of the injury? Yes <input type="checkbox"/> No <input type="checkbox"/>	When can worker return to regular duties? Date DD/MM/YYYY <input type="checkbox"/> Unknown at time of examination
Is worker capable of alternate or modified work? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, outline restrictions:	
Duration of restrictions: weeks	

Therapist Information

Therapist name		Phone Number	Fax Number
Facility name		Email	Date DD/MM/YYYY
City	Province	Postal Code	Therapist signature

Fax this form - in Winnipeg: 204-954-4999 | toll free: 1-877-872-3804