Workers' Compensation Board

Alberta

Physical Therapy
Reporting Guide

For use with:

Physical Therapy Assessment Report (C-533)

Physical Therapy Status/Discharge Report (C-534)

Physical Therapy Invoice (C-019)

C-510 Rev Mar 2009

APPENDIX “D”
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General Instructions

This reporting guide was developed to assist you, the treating Physical Therapist, in completing the documentation required to fulfill the contractual obligations identified in the agreement with the WCB. The agreement should always be used as the first priority in clarifying documentation expectations. This tool is to be used to clarify any remaining questions you may have.

Reporting Fees

The WCB will pay a report fee of $20.00 for the following reports:
Physical Therapy Assessment Report
Physical Therapy Status/Discharge Report

This agreement is based on the understanding reports will be:
Legible
Complete
Of adequate quality
Received within 2 business days of completion of service (assessment and discharge reports)

Incomplete/Illegible Reports may be returned unpaid.

Form Completion

Fax or mail to meet WCB requirements.

Type or Print	Legibility is important as all forms are electronically scanned.
Black Ink	Use **black ink only** to ensure a quality image is used for scanning into electronic files.
Billing Information	Provide the clinic's WCB billing number (e.g. X999).

Form Distribution

Fax or mail to the Workers' Compensation Board.

Workers' Compensation Board
PO Box 2415
Edmonton, Alberta
T5J 2S5

Fax within Edmonton	(780) 427-5863
Fax outside Edmonton	1-800-661-1993

EXTENSION REQUESTS FAX REPORT TO (780) 498-3226

Send a copy to the referring physician.

Retain a copy for your files.

We will accept PART 1 faxed as original, provided it meets reporting requirements, is legible and of adequate quality. **If faxed, please do not submit the original.**

Ordering Information

Physical Therapy Forms	
C-533	Physical Therapy Assessment Report
C-534	Physical Therapy Status/Discharge Report
C-019	Physical Therapy Invoice
C-510	Physical Therapy Reporting Guide

Questions/Contacts

Fees Payment	(780) 498-4229	Medical Aid, Financial Services (Please do not contact Claim Owners or Medical Services staff)
Claim Number	(780) 498-3999 (Edmonton) (403) 517-6000 (Calgary)	Claims Contact Centre Claims Contact Centre
Discuss clinical aspects of the case. Assistance in completing reports.	(780) 498-3899	WCB Physical Therapy Consultants

*NOTE: To ensure faster service when sending information to the Workers' Compensation Board, please indicate the claim number on all correspondence.

2. Physical Therapy Assessment Report

C-533

General Instructions Physical Therapy Assessment Report (C-533)

A Physical Therapy Assessment Report must be submitted to WCB within 2 business days of the initial visit.

Provide legible and complete information to ensure proper handling of the case.

This will enable the WCB to deal more effectively with your worker, and to ensure you receive proper payment for the report.

It is important that all sections of the report be filled out.

*** Additional or sensitive information may be provided by attaching a separate sheet to the report.**

Physical Therapy Assessment Report (C-533) Completion Guide

We have provided brief instructions and relevant information on how to complete the Assessment Report.

TRIAGE

The Physical Therapist shall use professional judgment in planning the most appropriate form of Service delivery by using the clinical details gathered from the Assessment. In initial treatment planning, the Physical Therapist is required to identify one of the following forms of Triage

Please check the appropriate Box:

TRIAGE 4 – PHYSICAL THERAPY TREATMENT
TRIAGE 5 – SURGICAL/FRACTURE PROTOCOL

1. **Date of Accident.**

   Provide the specific date the accident occurred.
   If it is a progressive injury, use the date that the worker first sought medical treatment.

2. **Is the worker working?**

   Indicate whether the worker is missing time from work due to the injury.

3. **Job title - Occupation.**

   Provide a job title which best describes the worker's job and the appropriate code from the National Occupation Classification (NOC). Example: Clerical Supervisor is more descriptive than Supervisor. Construction Foreman is more descriptive than Foreman.
   The NOC may be ordered from: Canada Communication Group Publishing
   Ottawa, Ontario K1A 0S9
   Telephone: 1-800-661-2868
   Fax: 1-800-565-7757
   An NOC search can also be conducted online by logging on to **http://www23.hrdc-drhc.gc.ca/2001/e/generic/nocsearch.shtml.**

4. **Which Practitioner or facility rendered first treatment?**

   Indicate where the worker first sought treatment or medical attention.
   Your response could be any of the following:
   Name of physician.
   Name of other physical therapist.
   Yourself.
   Name of medical facility.
   Name of hospital emergency.
   In Addition: In some cases the worker may have been sent to your clinic by:
   WCB ,
   WCB Physical Therapy Consultant,
   Return to Work Assessment Centre (RTWAC).
   You **MUST** provide that information in this section.
   If a physician or another physical therapist rendered the first treatment and the client does not know the exact date of the first treatment, record "approximately" before the date boxes and record the approximate date in the boxes. If you provided the first treatment, record that date.

5. **Worker's work-related injury/illness.**

   Describe the worker's explanation of events leading up to the signs/symptoms or injury.
   Include location, mechanism of injury, materials and tools or equipment involved.
   If there was no specific incident, but symptoms are attributed to occupational activities, describe activities involved and duration of signs/symptoms prior to the worker seeking treatment.
   Accident date refers to the date that the accident occurred or the onset of symptoms.

6. **Worker's complaints.**

   Describe nature and site(s) of symptoms according to the worker.
   Include pain, numbness, tingling, etc.
   Document local, regional and/or referred symptoms.

7. **Has the worker had a similar problem previously?**

   In discussion with the worker or based on past history:
   - Describe the extent and nature of any similar problems the worker may have had prior to the most recent injury.
   - Provide an approximate time frame, if known.

8. **Diagnosis.**

   Please provide <u>**your**</u> Physical Therapy Diagnosis, which may be different from the physician's or any other practitioner's diagnosis, unless you concur.
   A ***written*** diagnosis is required in addition to the Diagnostic Code(s) to facilitate reference for the case worker. Provision is made for up to three (3) Diagnostic Codes for cases of multiple injury or secondary causes of injury.
   Provide a clear diagnosis.
   Provide a provisional diagnosis, if a clear diagnosis cannot be given.
   Please include the applicable ICD-9 Diagnostic Codes.
   Changes in the diagnosis should be reported on the Physical Therapy Status Report.

9. **Date of referral.**

   Indicate the date the physician completed the referral slip.
   If the worker attended your clinic prior to attending the physician, indicate the date the worker first contacted your clinic.

10. **Date of assessment.**

    Provide the date of your assessment/initial visit.

11. **Assessment findings.**

    List the worker's current functional abilities as they relate to specific job demands.
    Comment on limiting factors such as range, strength and pain and how they affect the job demands.
    Comment on other contributing factors (compensable and non-compensable) which may impede or delay the worker's return to work. Please include any prior history of treatment for a similar injury or condition.
    You must be as specific as possible, including:
    - ROM (degrees of movement).
    - Amount (scale of 1-10) and degree (mild, moderate, severe) of pain.
    - Muscle grading for strength.
    - Presence or absence of neurological signs.

***Note: Follow-up reports must relate back to your initial Assessment report. You must be able to support how "the worker feels better".**

12. Goals and treatment, methodology, time frames.

Please list your expected outcomes of treatment. Based on assessment findings, the goals must be objective and measurable, and must include specific expectations for ROM, strength, function, relative to critical job demands, etc.
Briefly identify treatment methods and time frames to achieve the goals.
You must use your best judgment to identify the number of weeks required.
Workers, except in specific circumstances (e.g. tenolysis) should not be treated daily.

Example:

Goals and Treatment Plan	Methodology	Time Frames
To improve lifting to 50 lbs floor to waist occasionally	Manual therapy, hot packs, stretching exercises. Initial home program and active exercise regimen	0 - 2 weeks
To improve sitting tolerance.	Introduce activities in sitting to simulate job requirements.	2 - 3 weeks
To increase endurance and functional strength.	Cardiovascular training and progressive resistive exercise.	3 - 5 weeks *

The highest number of weeks indicated (5*) will be the total time considered for the claim, not a total of all the time frames you record.

13. Any complicating factors/Barriers to Return to Work affecting recovery?

Identify any Barriers to Return to Work, APPENDIX "B".
Document any conditions or circumstances, compensable and noncompensable, which may delay recovery.
May include psychological and/or behavioral aspects.
This information will help us determine the extent of the injury attributable to the workplace and if there is a need for additional resources.

14. Surgery

Indicate (by checking "Yes" or "No") whether the worker has had surgery or if the worker is scheduled for surgery in the future.
State the actual date of the past surgery or the estimated date of the impending surgery.

***Note: If you have treated a worker prior to his/her surgery, and will begin treating again after the surgery, you must complete a Physical Therapy Discharge Report at the end of treatment prior to surgery and a new Physical Therapy Assessment Report post-surgery.**

***Note: In the event that the surgeon's protocol is different from the WCB's, you must provide the WCB with a copy (APPENDIX "A").**

15. Is the injury preventing the worker from performing date of accident work?

Indicate (by checking "Yes" or "No") whether the worker is capable of performing his usual work duties.

This question is asking if the injury is preventing the worker from working. The answer must only relate to the work-related injury, not other physical problems or availability of work.

16. Does the worker have a job to return to?

Indicate whether or not the worker has a job to return to with either his date of accident employer or with another employer immediately following discharge from treatment.

If "no", then your discharge outcomes should focus on "fitness to work" (FTW).

"Fitness to work" means that the worker is capable of performing:

Employment at the pre-accident level.
Employment at a modified or alternative level.
Not employed, but capable of pre-accident level.
Not employed, but capable of modified or alternative level.

17. Estimated date of return to pre-accident work.

The date you record here must match your Treatment Goals and should reflect your best professional opinion. It should ***not*** be an automatic or routine 6 weeks from the date of the first treatment.

If the worker can go back to work in 4 weeks but you want 1-2 treatments to monitor the response to treatment and return to work (RTW), include this in your goals.

Regardless of how you answer this question, you must always answer questions 18 and 19 regarding "modified or alternative" work and work restrictions.

18. Can "modified or alternate" work be performed?

- Indicate (by checking "Yes" or "No") whether the worker is capable of performing alternate or modified duties, regardless of whether the modified work is available or not.
- Check only one of: sedentary, light, medium, heavy or very heavy. (Definitions are on the back of form.)
- If the worker is not capable of any work, complete by indicating not applicable (NA).
- Often employers can provide alternate or modified duties during the period of recovery.
- If the worker is able to perform modified duties during treatment or rehabilitation it may enhance their recovery.
- This will aid in the development of a suitable rehabilitation plan.
- WCB requires the physical therapist's professional judgment to determine what is appropriate for the worker.
- It is important to record the worker's **potential** for "modified or alternate" work even if they are unable to use the injured body part.
- Remember, the overall goal of physical therapy for injured workers is return to work (RTW). If your treatment results in a worker returning to "modified or alternate" work then you have achieved a positive outcome for:
  - the worker
  - the employer, and
  - WCB.

19. Any work restrictions?

Document activities which should be avoided to prevent re-injury or aggravation of the condition.

Indicate whether the work restrictions are permanent or temporary.

Indicate the duration of any temporary work restrictions (e.g. two weeks or one month).

Example:

- The maximum amount of time the worker can stand or sit.
- The worker's ability or inability to lift, and the maximum weight that can be lifted.
- The number of weeks for temporary work restrictions.

20. Billing.

- Please provide your clinic's WCB billing number (e.g. X999)
- Ensure that your clinic name and address are complete and legible.
- All fees will be paid directly to the clinic, not to individual therapists.

3. Physical Therapy Status/Discharge Report

C-534

General Instructions Physical Therapy Status/Discharge Report (C-534)

The Contractor shall submit a Status Report to the WCB within 2 business days of the conclusion of the third week of Treatment or at the end of each 4-week period of treatment for surgical protocols. If no further treatment occurs after the completion of the last Status Report, that Status Report shall serve as the Discharge Report. Please check the appropriate box whether the form is being submitted as a Status Report or as a Discharge Report.

Provide legible and complete information to ensure proper handling of the case.

This will enable the WCB to deal more effectively with your worker, and to ensure you receive proper payment for the report.

It is important that *all sections* of the report be *filled out.*

***Additional or sensitive information may be provided by attaching a separate sheet to the report.**

Physical Therapy Status/Discharge Report (C-534) Completion Guide

We have provided brief instructions and relevant information for some of the questions where we felt further clarification would be helpful.

*Please check the appropriate box to indicate whether the report is being used as a Status Report or as a Discharge Report.

TRIAGE
The Physical Therapist shall use professional judgment in planning the most appropriate form of Service delivery by using the clinical details gathered from the Assessment. In initial treatment planning, the Physical Therapist is required to identify one of the following forms of Triage:
TRIAGE 4 – PHYSICAL THERAPY TREATMENT
TRIAGE 5 – SURGICAL/FRACTURE PROTOCOL

1. **Date of Accident.**
   - Provide the specific date the accident occurred.
   - If it is a progressive injury, use the date that the worker first sought medical treatment.

2. **Is the worker working?**
   - Indicate whether the worker is missing time from work due to the injury.

3. **Treatments.**
   - Please indicate the manual therapy, modalities, education, exercises and home program provided.

4. **Treatment Dates (month/day).**

   Provide all dates of treatment by month and date (e.g. March 26 would be recorded as 3/26).
   Normally, no more than 21 treatments over 6 consecutive weeks will be funded by WCB.
   Indicate “no shows” by **NS** in the appropriate box; and **C** for “cancelled appointment”.

5. **Describe changes in diagnoses and/or status.**

   Provide your physical therapy diagnosis or any changes in your diagnosis from that which was recorded on the Assessment Report.
   Please indicate whether the worker’s condition (status) has changed from the time of the last report.
   Please indicate the applicable ICD-9 CM Diagnostic Codes.

6. **Treatment completed.**

   If “Yes”, this report will serve as your discharge report.
   “No“ should be checked if worker requires further treatment, referral to a RTWAC, referral to another program.

7. **Does the worker have a job to return to?**

   Indicate whether the worker has a job to return to with **either his date of accident employer, or with another employer** immediately following discharge from treatment. This should be completed whether the worker is being discharged or continuing with treatment.

8. Functional status/Objective measures.

Provide current functional and objective measures, as related to the Assessment.
Comment on range of motion, strength, pain rating scale, weight bearing status, swelling, neurological/dural findings.
Functional status should clearly indicate the worker's current functional abilities as they relate to specific job demands, including any limiting factors.
Report range of motion status in degrees, **consistent** with assessment findings on the Assessment Report.

9. Critical job demands met?

- If "No", please comment on why the critical job demands have not been met.
- Comment as to any changes in the goals or treatment plan that will assist the worker to meet the critical job demands.

10. Current status.

Please check the **one** box that best describes the worker's **present level of employability**.
Indicate the worker's current employment status and work capability level.
If the worker is unable to perform **any** level of work, and is going to continue on with any type of treatment or any other medical intervention (e.g. surgery), please check Further Medical Investigation or Further Treatment.
If "other" is checked, please provide an explanation in the space available and as part of your functional status goals achieved and/or not met.

Employment Pre-accident Level (Return to Work):
Worker has returned to a job, either with their pre-accident employer or another employer, at the pre-accident functional level.

Employment Modified Level (Return to Work):
Worker has returned to a job, either with their pre-accident employer or another employer, at a modified level relative to the pre-accident functional level.

Not Employed, Capable of Pre-accident Level (Fit to Work):
Worker is capable of returning to a pre-accident level job, either with their pre-accident employer or another employer, but a job is not immediately available.

Not Employed, Capable of Modified Level (Fit to Work):
Worker is capable of modified or alternative level employment but not employed. Outcome measurement for modified level will be based on the worker advancing at least one functional level.

Further Medical Investigation:
- Worker was referred back to physician, or for diagnostic testing, or surgery.

Further Treatment:
- Worker requires further physical therapy treatment at your facility.

Non-compliance/Non-attendance:
- Worker stopped attending treatment.
- Treatment was stopped because the worker was non-compliant (refused to do specific things or follow clinic regulations/rules).
- Treatment was stopped for other reasons related to the worker's actions in the clinic.
- Worker transferred to another facility.

Return to Work Assessment Centre (RTWAC):
- Has the worker been referred to an RTWAC?

Other:

- If in using these categories, a circumstance arises which does not fit any of the above, attach a written note explaining the circumstances. In this way, the WCB will be able to take this into account. Example: Worker is retired.

11. Further therapy.

Requests for Extensions of treatment for exceptional circumstances must be approved by a WCB Physical Therapy Consultant. Fax the completed Status Report to the Physical Therapy Consultants at 780-498-3226. Failure to obtain the required approval for an extension could result in WCB and the injured worker not paying for the additional treatment.

12. Any complicating factors/Barriers to Return to Work affecting recovery?

- Include any Barrier to Return to Work, APPENDIX "B".
- Document any other conditions or circumstances, compensable and noncompensable, which may delay recovery.
- May include psychological and/or behavioral aspects.
- This information will help us to determine the extent of the injury attributable to this workplace and if there is a need for additional resources.

13. Surgery:

- Please indicate (by checking "Yes" or "No") whether the worker has had surgery or if the worker is scheduled for surgery in the future.
- State the actual date of the past surgery or the estimated date of the pending surgery.

*__Note: If you have treated a worker prior to his/her surgery, and you will begin treating again after the surgery, you must complete a new Physical Therapy Assessment Report.__

***Note: In the event that the surgeon's protocol is different from the WCB's, you must provide the WCB with a copy, (APPENDIX "A").**

14. Is the injury preventing the worker from performing date of accident work?

- Indicate (by checking "Yes" or "No") whether the worker is capable of performing his usual work duties.
- This question is asking if the injury is preventing the worker from working. The answer must only relate to the work-related injury, not other physical problems or availability of work.
- **Regardless of how you answer this question, you must always answer questions 15 and 16 regarding "modified or alternate" work and work restrictions.**

15. Can "modified or alternate" work be performed?

Indicate (by checking "Yes" or "No") whether or not the worker is capable of performing alternative duties, regardless of whether modified work is available or not.

Check only one: sedentary, light, medium, heavy or very heavy. (Definitions are on the back of form).

Often employers can provide alternate or modified duties during the period of recovery. If the worker is not capable of any work, complete by indicating "not applicable" (NA).

If the worker is able to perform modified duties during convalescence, it may enhance their recovery.

This will aid in the development of a suitable rehabilitation plan.

WCB requires the physical therapist's professional judgment to determine what is appropriate for the worker.
It is important to record the worker's **potential** for "modified or alternate" work even if they are unable to use the injured body part.
Remember, the overall goal of physical therapy for injured workers is return to work (RTW). If your treatment results in a worker returning to "modified or alternate" work then you have achieved a positive outcome for:

- the worker,
- the employer, and
- WCB.

16. Any work restrictions.

- Document activities that should be avoided to prevent re-injury or aggravation of the condition.
- Indicate whether the work restrictions are permanent or temporary.
- Indicate the duration of any temporary work restrictions (e.g. two weeks or one month).

Example:

- The maximum amount of time the worker can stand or sit.
- The worker's ability or inability to lift and the maximum weight that can be lifted.
- The number of weeks for temporary work restrictions.

17. Billing.

Please provide your clinic's WCB billing number (e.g. X999).
Ensure that your clinic name and address are complete and legible.
All fees will be paid directly to the clinic, not to individual therapists.

4. Physical Therapy Invoice

C-019-

General Instructions Physical Therapy Invoice (C-019)

1. The Physical Therapy Invoice is designed to allow you to bill for a number of visits or treatments.

2. An invoice must be accompanied by either an Assessment, Status or Discharge Report. In the event that the worker will be provided with Transitional Return to Work Treatments after Discharge, a final invoice should be provided to include all the transitional visits.

3. The first invoice sent with the Status Report should include a charge for the assessment and treatment provided on the first visit, and all treatments or sessions provided within the first three weeks.

4. If the worker continues on with treatment, the second invoice should accompany the Discharge Report and should include all treatments provided in the last three weeks of treatment.

5. The following Health Services Codes must be used when submitting your invoice(s):

   - **07.38AA - Physical Therapy Assessment**
   - **07.38AB - Physical Therapy Treatment**
   - **07.38AF - Transitional Return to Work Treatment**

6. The Contractor may prescribe sundry items on the list provided in your contract, where appropriate (if warranted by the compensable injury), without authorization from the for up to a total of $100.00. Sundry items exceeding $100.00 require PT Consultant approval prior to provision to the worker.

7. In the event that more than one meter or more than one roll of a particular sundry item is provided to the worker, the item must be listed on the invoice more than once (e.g. 2 meters of Theraband, must be entered on the invoice as:

   97/06/16 TB01 $ 2.84
   97/06/16 TB01 $ 2.84

8. Ensure that you quote the WCB claim number, and complete all worker identification information.

9. Please ensure the clinic name and address are legible and complete, and you have provided the clinic WCB billing number (e.g. X999).

10. WCB shall make payment only in the clinic name.

11. **<u>DO NOT</u> bill WCB for report fees on the Physical Therapy Invoice. Report fees are automatically paid upon receipt of complete and legible reports.**

12. **Reports that are not legible or complete will be returned unpaid.**

APPENDIX “A”

WCB SURGICAL PROTOCOL – TIMEFRAMES

SEE CURRENT CONTRACT FOR DETAILS.

Appropriate strengthening and conditioning should be incorporated into the documented timeframes such that the Worker will be fit for suitable employment (within restrictions) on completion.

Fracture protocols begin after the Worker has been given medical clearance to start mobilizing the facture area. Approval for treatment to mobilize the joints above and below the fracture, while the facture is immobilized, must be obtained in advance from the Physical Therapy Consultant.

Transitional Return to Work

Transitional return to work may be provided on the same basis as under TRIAGE 4: PHYSICAL THERAPY TREATMENT in SCHEDULE “A”.

APPENDIX "B"

BARRIERS FOR RETURN TO WORK

GUIDE TO IDENTIFYING BARRIERS TO RETURN TO WORK

Injury Related: **This refers to issues related to the nature and severity of the injury.**

Severity

Severe injuries that will likely result in objective clinical impairment and work restrictions

Concurrent Conditions

- The presence of pre-existing or other conditions that impact the recovery of the work related injury (e.g. rheumatoid arthritis, diabetes)

Multiple Prior Injuries

- History of multiple recurrent injuries with extended time off work.

Diagnosis and Treatment

- Health professional sanctioning disability, not providing interventions that will improve function.
- Experience of conflicting diagnoses or explanations, resulting in confusion.
- Diagnostic language leading to catastrophizing and fear (e.g. fear of ending up in a wheelchair).
- Dramatization of pain by health professional producing dependency on treatments and continuation of passive treatment.
- Advise of extended rest or to withdraw from job.

Injury Other

- Please provide an explanation for any other barriers that are related to the injury.

Pain Related: **This refers to maladaptive attitudes, beliefs and behaviours in relation to pain.**

Attitudes and Beliefs

- Belief that pain is harmful or disabling resulting in fear-avoidance behaviour, e.g. the development of guarding and fear of movement.
- Belief that all pain must be abolished before attempting to return to work or normal activity.
- Belief that pain is uncontrollable.
- Passive attitude to rehabilitation.

Pain Behaviours

Use of extended rest, disproportionate "downtime".

Reduced activity level with significant withdrawal from activities of daily living.

Avoidance of normal activity and progressive substitution of lifestyle away from productive activity.

Report of extremely high intensity of pain, e.g. above 10 on a 0 to 10 Visual Analogue Scale.

Report of pain not consistent with physical presentation.

Excessive reliance on use of aids or appliances.

Level of disability that is disproportionate with the severity of injury (e.g. minor sprains that result in total work loss).

Use of Pain Medications

High intake of medication (possibly as self-medication), with an increase since onset of pain.

High intake of alcohol or other substances, with an increase since onset of pain.

Visits to emergency rooms for pain medications.

Emotions

Fear of increased pain with activity or work.

Depression (especially long-term low mood), loss of sense of enjoyment related to the injury.

More irritable than usual.

Anxiety about and heightened awareness of body sensations (includes sympathetic nervous system arousal).

Catastrophizing

Catastrophizing, thinking the worst, misinterpreting bodily symptoms.

Belief that pain is uncontrollable.

Pain Other

Please provide an explanation for any other barriers that are related to pain.

Work Related: **This refers to issues related to the ergonomic or psychosocial aspects of work.**

Not Job Attached

The Worker is not job attached (e.g. does not have a job to return to).

Lack of Suitable Modified Work

- Minimal availability of selected duties and graduated return to work pathways, with unsatisfactory implementation of these.
- Negative experience of workplace management of injuries (e.g. absence of a reporting system, discouragement to report, punitive response form supervisors and managers).
- Absence of interest from employer.

Low Job Satisfaction/Poor Work Relationships

Work history, including patterns of frequent job changes, experiencing stress at work, job dissatisfaction, poor relationships with peers or supervisors, lack of vocational direction.

Unsupportive or unhappy current work environment.

Low educational background, low socioeconomic status.

Work Demands

History of heavy manual work, notably from the following occupational groups: fishing, forestry and farming Workers, construction, including carpenters and builders; nurses; truck drivers, labourers.

Job involves significant bio-mechanical demands, such as lifting, manual handling heavy items, extended sitting, extended standing, driving, vibration, maintenance of constrained or sustained postures, inflexible work schedule preventing appropriate breaks.

Fear that work will cause further harm

- Belief that work is harmful; that it will do damage or be dangerous.
- Expectation of increased pain with activity or work, lack of ability to predict capability.

Work Other

- Please provide an explanation for any other barriers that are related to work.

WCB Related: These refer to issues related to Workers' Compensation and case management.

History of Multiple Claims

- History of claim(s) due to other injuries or pain problems.
- History of a previous claim(s) for the same problem.

History of Extended time off work

- History of extended time off work due to injury or other pain problem (e.g. more than 12 weeks).

Conflict towards WCB

- Blame WCB for all issues relating to injury.

Poor Attendance/Compliance

- Irregular participation or poor compliance with physical exercise, tendency for activities to be in a "boom-bust" cycle.

WCB Other

- Please provide an explanation for any other barriers that are related to the WCB.

Appendix “I” – Physical Activity Readiness Questionnaire (PAR Q)

- This form is to be completed by all workers who will be involved in an active exercise program while receiving treatment.
- The purpose is to ensure that any cardiovascular risks associated with participation in an active exercise program are identified.
- The PAR Q is a worker self-administered questionnaire. Physical Therapists should ask the worker to complete the form, explaining that its purpose is to ensure that the worker can safely perform and active exercise program.
- Question number 5 of Part 1 is expected to elicit a “yes” answer in many cases. Yes to this answer **does not** indicate a positive PAR Q. The physical therapist may wish to discuss the worker’s condition with the referring physician.
- “Yes” to other questions **does** indicate a positive PAR Q. The therapist should then discuss the positive response(s) with the worker. In the event that cardiovascular risk factors are present, the physical therapist should refer the worker back to the referring physician for a cardiovascular review. In this manner, safe parameters for the worker’s participation in an active exercise program can be determined.
- If the physical therapist or physician feels that the worker cannot safely participate, please contact the immediately.
- Retain the PAR Q form for your records. Do not send it to the WCB.

PHYSICAL ACTIVITY READINESS QUESTIONNNAIRE (PAR Q)
WORK CONDITIONING

PATIENT SURNAME ______ GIVEN NAME ______ INITIAL ______ DATE DD MM YY ______

PART I

		YES	NO
1.	Has your doctor ever said you have heart trouble? If yes, What? ______ When? ______	_____	_____
2.	Do you frequently have pains in your heart and chest? If yes, How often? ______ When? ______	_____	_____
3.	Do you often feel faint or have spells of severe dizziness? If yes, How often? ______	_____	_____
4.	Has a doctor ever said your blood pressure was too high? If yes, Present for how long? ______ When? ______ Precautions given? ______	_____	_____
5.	Has your doctor ever told you that you have a bone or joint problem, such as arthritis that has been aggravated by exercise, or might be made worse with exercise? If yes, Specify: ______	_____	_____
6.	Is there a good physical reason why you should not follow an activity program even if you wanted to? If yes, Specify: ______	_____	_____

PART II: ADDITIONAL

		YES	NO
1.	If you are female, are you pregnant?	_____	_____
2.	Do you experience difficulty breathing at rest?	_____	_____
3.	Do you have a history of asthma or emphysema?	_____	_____
4.	Do you have a persistent cough?	_____	_____
5.	Have you had a recent viral infection?	_____	_____
6.	Do you have problems with swelling of the lower extremities?	_____	_____
7.	Are you currently on any medications? If yes, Name(s) and dosage(s): ______ ______	_____	_____

______ PATIENT SIGNATURE

______ THERAPIST SIGNATURE

Appendix "II" – Return to Work Assessment Centres (RTWAC)

Note: Referrals to Return to Work Assessment Centres are not limited to soft tissue injuries and can be made at any time during a claim, following discussion and approval with the .

With a combination of medical management and active, job-focused physical therapy or chiropractic intervention, the majority of workers with soft tissue injuries are able to return to work within 6 weeks of injury. For those workers who are unable to successfully return to work within this time frame, referral to an RTWAC is recommended. Most should be referred within 4 weeks of the initial treatment.

RTWACs provide objective standardized information to:

- Evaluate the worker's functional status relative to critical job demands and determine fitness to work.
- Make recommendations regarding further treatment and determine if further medical rehabilitation (e.g. medical investigations, acute treatment, substance abuse treatment, surgical consultation, community services, etc.) is required.
- Determine if occupational rehabilitation is required.
- Assist in providing a plan of action for those workers who:
  - Do not return to work following treatment,
  - have serious injuries, and/or
  - have been on benefits long-term.

RTWAC evaluations include:

- Medical Status Exam (1 hour, with Physician).
- Functional Capacity Evaluation:
  - Basic (½ day)
  - Comprehensive (2 day)
  - On-site (½ - 2 day)

To make a referral to an RTWAC:

- Indicate on your Status Report, that RTWAC is recommended. Communicate recommendation to the Case Worker.
- As a courtesy to the RTWAC facility, please fax a copy of your most recent report to expedite the process.

Primary Assessment Service Definitions

MEDICAL STATUS EXAMINATION (MSE)

Objectives:
- clarify medical fitness to work
- confirm diagnosis
- identify medical RTW barriers
- identify work restrictions and their duration
- determine the need for further medical investigation
- identify further assessment precautions or contraindications
- educate the worker regarding the RTW process

Components:
- one day assessment performed by a physician
- complete history
- review of relevant past medical assessments/interventions
- physical assessment

BASIC FUNCTIONAL CAPACITY EVALUATION (BFCE)

Objectives:
- assess injury related critical job demands
- provides a snapshot of a worker's functional status
- provides a baseline/identifies the need for further rehabilitation
- identify functional RTW barriers
- educate the worker regarding the RTW process

Components:
- one day assessment performed by a Physical Therapist/Occupational Therapist/ Kinesiologist
- worker interview
- musculoskeletal assessment
- functional test items

COMPREHENSIVE FUNCTIONAL CAPACITY EVALUATION (CFCE)

Objectives:
- standardized objective test of a worker's overall physical functioning in work related tasks
- determines worker's general <u>work abilities and/or limitations</u>
- provides a baseline/identifies the need for further rehabilitation
- identifies functional RTW barriers
- educate the worker regarding the RTW process

Components:
- two day assessment performed by a Physical Therapist/Occupational Therapist/Kinesiologist
- Day 1
  - worker interview
  - musculoskeletal assessment
  - testing of functional items
- Day 2
  - re-testing of functional items

WORK SITE VISIT (WSV)

Objectives:
- clarify pre-accident job demands/job tasks
- explore modified/alternate RTW options
- identify work site RTW barriers
- re-establish worker/employer relationship
- initiate RTW negotiation
- educate the worker and employer regarding the RTW process

Components:
- one day assessment performed by a Physical Therapist/Occupational Therapist/Kinesiologist
- intake stakeholder conference
- worker interview
- supervisor interview
- workstation analysis
- job analysis
- RTW stakeholder conference