wcb Workers' Compensation Board – Alberta

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C534
PHYSICAL THERAPY SERVICES PROGRESS/DISCHARGE REPORT

WORKER DETAILS

			Gender ☐ Male ☐ Female	WCB Claim Number
Surname	First Name and Initial			Date of Birth *(yyyy/mm/dd)*
Address Street	City/Town	Province	Postal Code	Telephone Number

Worker's Job Title/Occupation:	Progressive Injury? ☐ Yes ☐ No	Date of Injury *(yyyy/mm/dd)*

Describe how and when the injury/condition occurred.

Examination
Symptoms:

Objective Findings:

Change in Diagnosis? If yes, describe

☐ Yes ☐ No

Diagnostic Code 1:	Diagnostic Code 2:	Diagnostic Code 3:

Part of body:	Side of Body:	Nature of Injury:

Affected Movements Patterns

Type	ROM left (degrees)	ROM right (degrees)	Strength

Pain Scale:	Type of Pain:

Reflex Normal? ☐ Yes ☐ No If no, describe

Sensation Normal? ☐ Yes ☐ No If no, describe

Myotomes Normal? ☐ Yes ☐ No If no, describe

Any other findings
(Including functional status)?

Are you aware of any prior conditions in the same anatomical area? ☐ Yes ☐ No If yes, describe

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Treatment Plan

Treatment Plan

Manual Therapy? ☐ Yes ☐ No Manual Therapy Description:

What interventions are you employing

Acupuncture:	☐ Yes	☐ No	Muscle Stimulation:	☐ Yes	☐ No	Exercise:	☐ Yes	☐ No
Interferential:	☐ Yes	☐ No	Tens:	☐ Yes	☐ No	Home Program:	☐ Yes	☐ No
Traction:	☐ Yes	☐ No	Ice:	☐ Yes	☐ No	Ultrasound:	☐ Yes	☐ No
Heat:	☐ Yes	☐ No	Education:	☐ Yes	☐ No			
Other:	☐ Yes	☐ No	If yes, describe: _____					

Patient engagement to therapy

Progressing as expected ☐ Yes ☐ No If no, describe:

Any complicating factors affecting recovery? ☐ Yes ☐ No If yes, describe:

Surgery? ☐ Yes ☐ No If yes, Actual or estimated date of surgery *(yyyy/mm/dd)*

Consultation(s)/Referral(s)/Investigation(s) ☐ Contact with WCB Case Manager ☐ Contact with PT Consultant ☐ Referral to Return to Work Provider

Treatment complete? ☐ Yes ☐ No If yes, discharge recommendations:

Is this a request for treatment extension beyond the current authorized time frame? ☐ Yes ☐ No

Number of weeks of additional therapy required?

Has the worker missed work beyond the date of accident? ☐ Yes ☐ No

Has the patient returned to work? ☐ Yes ☐ No If yes, Date Returned *(yyyy/mm/dd)*

If returned to work, what is the worker's current work status? ☐ Full duties and hours ☐ Modified Hours _____ ☐ Modified duties

Job Requirements?

If patient is currently not working or is working modified duties, complete the following.
Please make a selection below as they relate to the injury:

Sitting	☐ Able	☐ Unable	☐ Limited to ____ Hours
Standing	☐ Able	☐ Unable	☐ Limited to ____ Hours
Walking	☐ Able	☐ Unable	☐ Limited to ____ Hours
Bending	☐ Able	☐ Unable	☐ Limited
Twisting	☐ Able	☐ Unable	☐ Limited
Kneeling/squatting	☐ Able	☐ Unable	☐ Limited

Climbing	☐ Able	☐ Unable	☐ Limited
Lifting	☐ Able	☐ Unable	☐ Limited, Max of _____ (lbs/kg)
Pushing / pulling	☐ Able	☐ Unable	☐ Limited
Overhead reaching	☐ Able	☐ Unable	☐ Limited
Driving	☐ Able	☐ Unable	☐ Limited to ____ Hours

Other reasons why the patient cannot work:
☐ Hospitalized ☐ Self reported pain ☐ Opioids/Medication side effects

Other restrictions or additional comments/special considerations:

☐ Estimated Return to Work to pre-accident work date *(yyyy/mm/dd)* or ☐ permanent restrictions anticipated

Name and address to whom fee is payable:
(please print)

WCB Billing Number: _____

Signature

Printed Name

Telephone Number

Fax Number

Provider's Reference Number

Date *(yyyy/mm/dd)*