Workers' Safety and Compensation Board
Yukon

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Extension request **Discharge report**

PHYSIOTHERAPY REPORT

This information is being collected under the authority of the Workers' Safety and Compensation Act for the purpose of determining eligibility for benefits.
For further information, contact (867) 667-5645 or 1-800-661-0443. Please contact WSCB before providing care if you have not signed a service agreement: Work is Healthy

Worker's information	
Last name	
First name	
Address	
Telephone no.	Date of birth (dd/mm/yyyy)
Claim #	Body part injured
Date of injury (dd/mm/yyyy)	

Health care provider's information
Clinic name
Address
Therapist's name
Telephone no.
Fax no.
Reassessment date (dd/mm/yyyy)

Treatment summary		
Treatment dates	Number of missed appointments	Overall functional progress

Comments:

Objective findings (If you need to provide more information, please attach an additional document.)

Findings	**Initial assessment date:**	**Previous extension request date:**	**Current extension request date:**	**Discharge date:**
Observations				

Objective Findings				
Findings	**Initial assessment date:**	**Previous extension request date:**	**Current extension request date:**	**Discharge date:**
ROM and biomechanical analysis				
Strength				
Neurological				
Other				

Objective Findings

Additional comments

Treatment plan
(If this is a discharge report, you do not need to complete this section; please go directly to the RTW section below.)

Goals / Methodology	Progress related to goal	If further treatment is recommended, please provide the rational

Frequency and expected duration of treatment	Visits per week: 1 2 3 4 Other:	Duration: 4 weeks 5 weeks 6 weeks Other:

Explain any delay in recovery

Please provide an estimated discharge date

Return to work

Worker's critical job demands	Estimated % of current function at this task
1.	1.
2.	2.
3.	3.
4.	4.

If needed, what ongoing accommodation(s)/modification(s) would allow the worker to remain at work?

- N/A
- Workstation analysis
- Modified hours
- Modifies duties
- Gradual RTW
- Other - please describe:

Are there barriers to recovery and/or return to work?

- No
- Yes – please select all that apply:
  - Hesitancy to return to work
  - Not job attached or lack of appropriate modified work
  - Reported employee/employer issues
  - Pain/impairment barriers beyond expectation for injury
  - High perceived disability
  - Fear of movement of activity
  - Injured worker appears anxious
  - Worker is not engaged in treatment
  - Severe injuries with likely long term or permanent work restrictions
  - Other health concerns affecting recovery. Explain: ____________________
  - Other (i.e., non-compensable conditions). Explain: ____________________

Discharge instructions

- N/A
- Home exercise
- Other:

Signature ____________________ Date ____________________

WSCB Physiotherapy authorization for extension
** To be completed by WSCB and returned to the HCP**

Case manager		Case manager's phone number	
Worker's name		Claim number	
Health care provider		Fax number	

Assessment date which authorization is based.	
Disability management guideline for injury	Injury ____________ Length of disability ____________
Authorization	Treatment plan approved with modifications. Explain: ____________ Treatment plan approved as recommended with approximate end date: ____________ Treatment plan not approved Claim denied Call case manager to discuss
Next reporting date	
Additional comments	
CM’s signature	
Date of approval	