

# PHYSIOTHERAPY PROGRESS REPORT

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, **Telephone:** (867) 667-5645, **Toll free:** 1-800-661-0443, **Fax:** (867) 667-8740, **Web:** www.wcb.yk.ca  
**Please contact WSCB before providing care if you have not signed a service agreement: Work is Healthy**

## WORKER'S INFORMATION

Surname	
First Name	
Address	
Telephone #	Date of Birth (d/m/y)
Has worker filed claim? Yes    No	Claim # or part of body
Date of Injury (d/m/y)	
Family Doctor	
Employer	

## PROVIDER'S INFORMATION

Name	
Address	
Telephone #	Fax #
Date of Visit (d/m/y)	

## TREATMENT

Treatment dates										
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Treatment goals and progress made towards goals										
If you recommend further treatment, please provide your rationale, frequency, focus of treatment, expected results and end date										
Has the worker's functioning changed significantly since the last report?    Yes    No If <b>Yes</b> , please attach a FAF										

**RETURN TO WORK**

Have you educated the worker about recovery while at work?    Yes    No  
 If **No**, explain

Worker's current occupation

Worker's critical job demands

Estimated % of current function at this task

Recommended modifications and/or accommodation that would allow the patient to remain at work

**RETURN TO WORK**

Are there barriers to return to work?    Yes    No  
 If there are barriers to return to work, complete and attach Appendix 1

**ADDITIONAL COMMENTS OR OBSERVATIONS**

Signature \_\_\_\_\_ Date (d/m/y) \_\_\_\_\_

**WSCB Physiotherapy Treatment Authorization**

Provider \_\_\_\_\_ Fax # \_\_\_\_\_  
 Proposed treatment end date (d/m/y) \_\_\_\_\_  
 Claim owner \_\_\_\_\_ Claim owner phone # \_\_\_\_\_  
 Treatment plan approved    Treatment not approved    Claim denied    Call to discuss

WSCB Signature \_\_\_\_\_ Date (d/m/y) \_\_\_\_\_