

PHYSIOTHERAPY INITIAL ASSESSMENT

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)
Has worker filed a claim? Yes No	Claim no. (if known)
Date of injury (dd/mm/yyyy)	Body part injured
Family doctor	
Employer	

Provider's information
Clinic name
Address
Therapist's name
Therapist's email
Telephone no.
Fax no.
Date of visit (dd/mm/yyyy)

Subjective findings
Worker's description of injury
Has the worker had a similar problem in the past? No Yes - please explain:

Objective findings

Observations

ROM and biomechanical analysis

Strength

Neurological

Special test and results (ex: empty can test)

Test name	Result	
	Positive	Negative
	Positive	Negative
	Positive	Negative
	Positive	Negative
	Positive	Negative

What is your clinical impression?

Critical job demands

Worker's occupation

List the worker's five most critical job demands

Critical job demand <i>Ex: Lifting 20 lbs</i>	Current ability <i>Lift 5 lbs</i>	Job match <i>No</i>

Is the job demands analysis for this occupation needed?

Yes

No

Treatment plan

Treatment goals	Recommended treatment (methodology)	
Frequency and expected duration of treatment. Additional comments if needed.	Visits per week	Duration
	1 2 3 4 Other:	☐ 4 weeks ☐ 5 weeks ☐ 6 weeks Other:

Recommended or prescribed equipment or supplies

Return to work

Based on current functional abilities, can regular duties be performed?

Yes

No – Please list all they can do:

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

Severe injuries with likely long term or permanent work restrictions

Other health concerns affecting recovery. Explain:

Other (i.e., non-compensable conditions). Explain:

Has a FAF been provided to the worker?

Yes

No – Explain:

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	
Disability management guideline for injury	Injury _____ Length of disability _____		
Authorization	Initial assessment and 2 treatment sessions approved 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	DD/MM/YYYY		
Additional comments			
CM's signature			
Date of approval			