



Physiotherapy Progress Report



If applicable, please select the Lock button before submitting the form.

Please note: once the Lock button has been selected, the form will no longer be editable.

INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

CLIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER

Assessment

DATE OF ASSESSMENT (dd/mmm/yyyy)	NUMBER OF TREATMENT SESSIONS TO DATE
DATE OF PREVIOUS ASSESSMENT (dd/mmm/yyyy)	DATE OF FIRST VISIT (dd/mmm/yyyy)

RELEVANT PRE-ACCIDENT HISTORY
ARE YOU AWARE OF ANY PRIOR INJURIES OR MEDICAL CONDITIONS AT THE TIME OF THIS ACCIDENT? <input type="radio"/> Yes <input type="radio"/> No
IF YES, DESCRIBE CONDITIONS/TREATMENT AND POSSIBLE IMPACT, IF ANY, ON RECOVERY: <div style="text-align: center;"> Details: Details: Details: </div>

MEDICAL INVESTIGATION OR SPECIALIST
ARE YOU AWARE OF ANY MEDICAL INVESTIGATION OR SPECIALIST REFERRAL RELATING TO INJURIES FROM THIS ACCIDENT? <input type="radio"/> Yes <input type="radio"/> No
IF YES, LIST THE MEDICAL INVESTIGATION OR SPECIALIST REFERRAL (if known provide date, findings, etc) <div style="text-align: center;"> Details: Details: Details: </div>

WORK STATUS
WAS THE PATIENT EMPLOYED OR ENGAGED IN THESE ACTIVITIES ON THE DATE OF THE ACCIDENT? PLEASE INDICATE WHICH ONE(S) <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> Self-employed <input type="radio"/> Seasonal <input type="radio"/> Training <input type="radio"/> Student <input type="radio"/> Retired <input type="radio"/> Unemployed
PROVIDE JOB TITLE(S) FOR WORK:
CURRENT WORK STATUS AS A RESULT OF THIS ACCIDENT: Work: _____ Training: _____ School: _____ COMMENTS:

Assessment Findings

SUBJECTIVE FINDINGS - List relevant symptoms related to this accident (include location, frequency, duration, intensity, etc)
 - Relevant OUTCOME MEASURES may be included (optional)

INITIAL FINDINGS:

CURRENT FINDINGS:

OBJECTIVE FINDINGS - List relevant objective findings related to this accident (observation, range of motion, strength, neurological, special tests, palpation)

INITIAL FINDINGS:

CURRENT FINDINGS:

Diagnosis

PRIMARY DIAGNOSIS - Identify most serious or significant injury

NATURE OF INJURY

COMMENTS:

BODY PART

ORIENTATION

DIAGNOSIS 2 - Identify all other diagnosis caused by or related to this accident

NATURE OF INJURY

COMMENTS:

BODY PART

ORIENTATION

DIAGNOSIS 3

NATURE OF INJURY

COMMENTS:

BODY PART

ORIENTATION

DIAGNOSIS 4

NATURE OF INJURY

COMMENTS:

BODY PART

ORIENTATION

Recommended Physiotherapy Care Plan

PRIMARY BARRIERS TO RECOVERY (includes Functional, Physical, Psychosocial, Employer, Medical or Compliance)
BARRIER 1
BARRIER 2
BARRIER 3
PRIMARY GOAL OF PHYSIOTHERAPY TREATMENT (should be Specific, Measurable, Achievable, Relevant and Time-Bound)
PROGNOSIS AND RECOVERY TIMELINES
DO YOU EXPECT THE PATIENT TO RETURN TO PRE-ACCIDENT FUNCTION WITH CONTINUED PHYSIOTHERAPY TREATMENTS?
COMMENTS:
WOULD THE PATIENT BENEFIT FROM ACTIVE REHABILITATION NOW?
COMMENTS:
RECOMMENDED REASSESSMENT DATE FOR NEXT PROGRESS REPORT (IF APPLICABLE) (DD/MMM/YYYY):

Note: A TREATMENT PLAN must be submitted to ICBC when treatments are requested outside the early access period of Enhanced Care or when further treatment sessions are recommended beyond the current approved Treatment Plan. Therefore, Treatment Plans may be required concurrently with a requested PROGRESS REPORT.

I certify that the information provided is true and correct to the best of my knowledge and that this report has been completed by a treating therapist.

Select one of the following:

- I have obtained consent from the patient to share all information related to the history, examination, assessment and management of the injury to the motor vehicle accident with ICBC.
- This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.