

f 1.866.553.5119

CONTACT US AT: t 709.778.1000 t 1.800.563.9000 VISIT US AT: workplacenl.ca

Instructions for Completing Physiotherapist's Report PR

This is a multipurpose form which is used for Initial, Progress, and Discharge Reports. Report type is identified by ticking the appropriate box in the top right hand corner of the form.

A physiotherapist would complete this report for:

- 1. New injuries The physiotherapist or worker believes the injury is work-related.
- 2. Recurrences The injury may be a recurrence of a previous work-related injury.
- 3. Progress reporting When there is a significant change in the worker's: (1) condition; (2) treatment; or (3) return-to-work status.
- Extension requests The physiotherapist is requesting an extension of treatments.
- 5. Discharge reports The worker is being discharged.

On the day of the visit:

Provide the employer's copy of the form PR to the injured worker, who will then give it to the employer. Only sections outlined in red are visible on the employer's copy.

Complete and legible reporting:

- Reporting fees will not be paid for incomplete or illegible reports.
- Please do not use a stamp for any information including physiotherapist's name, contact information or billing number. Stamps are not permitted as this is a triplicate form. Information provided by stamp will not be visible on the worker and employer copies of the form. Forms using stamps will be considered illegible.

Section B - Specific Information for Parts of Body Injured:

- It is not necessary to provide the Mechanism of Injury information on reports subsequent to the initial report unless there is a change in the information provided or additional information is available.
- Coding is used in this section as outlined on the reverse of this sheet. Only one code box should be used for each code entered, regardless if the code has one or two digits (see example below).
- First, enter codes for Part(s) of Body and whether the injury pertains to the Left, Right or Center of the specified body part(s), if applicable. If the code for the Part of Body is not on the code sheet, enter the code for Other and identify the specific body part in the space below the code.
- If you are the primary health care provider, you must provide documentation of all injured parts of body, even if you are not providing physiotherapy treatment for all injured parts of body.
- For each Part of Body, enter coding, as applicable, for: Subjective Reports, Objective Findings, Diagnoses, Treatments and Assistive Devices*. When outlining the Examination findings and Treatment Plan, including all applicable codes is important.
- If the Subjective Report, Objective Finding, Diagnosis, Treatment, and/or Assistive Device is not included on the code sheet, enter the code for Other. When using Other codes, also enter the Other code number and provide details for that code in the Additional Comments box (box 11).
- The Update Status boxes are used when completing progress, and discharge reports. They are intended to provide updates on Subjective Reports and Objective Findings from the previous visit. The Update Status is not required for initial reports of injury.

*Note: The Assistive Devices category is only intended for devices which are being recommended at this time. Recommendations for assistive devices may also require completion of a Health Care Devices and Supplies Prescription form.

Section D - Return-to-Work Status:

The completion of current functional abilities information is based upon your professional judgement following examination and assessment of this patient. It is not intended to be a formalized functional capacity evaluation.

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SECTION B -	SPECI	FIC INFORMATION	ON FO	OR PA	RTS	OF B	ODY I	NJUR	ED													
7 Mechanis	sm of in	jury / incident:																				
Same	as pre	eviously reporte	d on	the ir	nitial	repo	rt.															
		code sheet ode where necessary						Е	xamir	nation							Tre	atmei	nt pla	n		
F Code	Part of E	Body	Su	bjective	e Repo	rts	1	Ok	jective	Findin	gs 5	6	Diagn	oses	1	2	Treat	ments	5	6	Assist. D	Devices
i. 20	_eft 🚺	Right Centre	10	14	9	4	1	24	39	42	45		26	-	4	22	27	10			96	
Other:		Update Status	С	D	A	C	С	D	D	В			'									
ii. 28	_eft 🚺	Right Centre	14	11	91		25	39					33		14	22	23					
Other:		Update Status	D	D	D		D	C														
iii.	eft	Right Centre																				
Other:		Update Status											'									
9 Pain NPF	RS over	the last 24 hours	7	-	0 no p	ain to	10 the \	vorst pa	ain ima	ginable)											
Did this in			S If ye.	s, pleas Don't		cify in E	Box 11.				issues				ker's		Yes If		ease s _i i't kno	-	n Box 11	1.
		ents - or - If you				r" code	es abov	ve (exc	ept Pa	rt of B	odv). in	dicate	the co	de # a	and pro			_ DOI	I KIIO	vv		
		Neoprene knee						`			• , .				•							
Points to																						

- Under the Subjective Reports category, code 91 is entered for Other and 91 Worker complaining of restricted shoulder movement is written in the Additional Comments box to specify the details of the Other code.
- Under the Assistive Devices category, code 96 is entered for Other and 96 Neoprene knee brace is written in the Additional Comments box to specify the details of the Other code.
- No Update Status is provided for objective finding 45 (wasting) as this finding had not been previously reported.

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MD, 8/10c and PR Code Sheet

Effective Date: September 2023

Blood tests / U/A **Assistive Devices** Provide details in Cervical pillow Arch supports Cervical collar Investigations Back support Walking boot CT scan EMS / NCS Ankle brace Heating pad Strap, band Comments box Back brace Wheelchair Bone scan Ultrasound **Prosthesis** Cold pack Bandage Crutches Dressing Orthotics Walker Corset Other* Other* X-ray Cane Cast 95 Occupational rehabilitation Range of motion exercises Proprioception exercises Strengthening exercises Core stability exercises Conditioning exercises Additional Comments box Soft tissue techniques Traction (mechanical) Stretching exercises Muscle stimulation Myofascial release Provide details in the SMT / adjustment Fraction (manual) Steroid injections Home exercises **Physiotherapy** Motion control Manipulations Mobilizations Acupuncture Chiropractic Ultrasound Education Massage Casting **Treatments** Suturing Oxygen Laser 22 22 22 22 23 24 25 26 26 30 30 31 33 33 8 9 Chronic obstructive pulmonary disease Traumatic spondylolisthesis / lysis Ligament tear (3rd degree sprain) Rotator cuff impingement Carpal tunnel syndrome Additional Comments box Ligament sprain (2nd) Ligament sprain (1st) Mechanical back pain Provide details in the Rotator cuff injury Spondylolisthesis Spinal cord injury Frozen shoulder Repetitive strain Rotator cuff tear Allergic reaction Plantar fasciitis Spinal stenosis Herniated disc Radiculopathy **Tenosynovitis** Meniscal tear Muscle strain Inflammation Epicondylitis Amputation Dislocation Laceration Disc injury **Fendonitis** Dermatitis Contusion Puncture Fracture Infection Abrasion Diagnosis Asthma Bursitis Hernia Crush Burn 9 5 5 Upper limb neural tension test (-ve) Provide details in the Additional Decreased range of motion (Physician use only) (Provide details in box 8) No objective findings Update status to be added for follow up on Subjective Reports and Objective Findings. Comments box Weakness Wheezing Wasting Mild improvement 89 Chiropractic use only Physiotherapy and **Objective Findings** No change Worsening Abnormal sensation (non-dermatomal) Upper limb neural tension test (+ve) Abnormal sensation (dermatomal) -evel of conditioning (good) Straight leg raise (Negative) -evel of conditioning (poor) Level of conditioning (fair) Straight leg raise (30-60) Range of motion (100%) Range of motion (≥50%) Range of motion (<25%) Range of motion (≥25%) Range of motion (≥75%) -eg length discrepancy Straight leg raise (0-30) Redness / discoloration Straight leg raise (60+) Significant improvement Moderate improvement Decreased air entry Abnormal reflexes Strength (4/5) Strength (2/5) Abnormal gait Strength (5/5) Strength (3/5) Strength (1/5) Joint effusion **Hypermobility Hypertonicity** Sensory loss **Hypomobility Hypotonicity** -aceration Deformity **Sleeding** Crepitus Bruising Atrophy Spasm CBA _imited weight bearing No subjective reports * Provide details in the Additional Comments Subjective Reports Difficulty standing Difficulty walking nterrupted sleep Pain (moderate) Difficulty sitting Pain radiating Pain (severe) **Tenderness Numbness** Headache Pain (mild) Dizziness Weakness Stiffness Fingling 2 2 4 5 5 7 10 88 Thoracolumbar region Lumbrosacral region * Provide details in the Sacroiliac region Other box located under Part of Body Cervical region Thoracic region -umbar region ung, airways **Part of Body** Lower leg Abdomen Shoulder -orearm Coccyx Finger Chest Elbow Pelvis Thigh Brain Face Hand Head Knee Groin Wrist Foot Heel Loe 20 22 22 22 22 24 25 26 26 27 28 33 33 33 33 33 33 33

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SE	CTION A - GEN	NERAL INFOR	MATIO	N (pl	ease p	orint	clearly	/)		Claim	#						PO #					
1	Worker's last n	ame		First	name			In	itial	Clinic	nam	е				Therap	oist's l	ast nan	ne	First n	ame	
2	Mailing address	S			Contact telephone						Mailing address								Wo	rkplacel	NL billing #	
	Province																				ee requested?	
	Postal code				Date of birth yyyy/mm/dd						Postal code								Yes No Applicable reporting			
3	MCP		ı		Gend	er [Тм Г	—⊢ TF		Teleph	none			1	Fax				_	ee paid a	as per MOA.	
4	Occupation		E	Employ	er					Date	/ time	of vis	sit yy	yy/mm/d	d I	hh:mm		AM		Initial		
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5	Date of injury /	I	Did this			ор	Y	'es		Are yo	ou the	lth [Ye:	s ca	d anoth re prov	rider		Yes	3		arge date /mm/dd	
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6	Date of referral		Date re	ferral r		d	Re	eferra		rce: [n, <i>spe</i>	☐ Wo							Da		nitial as	ssessment /dd	
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SEC	TION B - SPECI	FIC INFORMAT	TION F	OR PA	RTS	OF BO	DDY IN	JURI	ED													
7	Mechanism of in	njury / incident:																				
	Use codes from	rode sheet													_							
8	use more than one co	ode where necessary	_							nation								reatm		lan		
	Part of E		Sı 1	ubjective	e Repor	ts 4	1	Ob ₂	jective 3	e Findino	g s	6	Dia ₁	gnoses	1	2	Tre	atments	5 5	6	Assist. Devices	
i. Other	Left	Right Centre	╀			\dashv		-					+		╀							
ii.	Left	Update Status Right Centre	╫			\dashv		-					+		┢	T						
Other		Update Status	+			\dashv		_					+		╁							
iii.	Left	Right Centre	+			\dashv							╁		\vdash	Τ						
Other	:	Update Status				\dashv									\vdash							
9	Pain NPRS over	r the last 24 hours			0 no pa	ain to 1	0 the wo	orst pa	nin ima	aginable					•						<u> </u>	
10	Did this injury a		es If ye	es, pleas	se speci	ify in B	ox 11.			e other					rker's		Yes	If yes, _I	please	specify	in Box 11.	
	a prior health is:			Don't				,		covery							No		on't kn	now		
11	Additional Comm	nents - or - If you	u use an	y of the	e "other	" code	s above	e (exce	ept Pa	art of Bo	ody), ii	ndicat	e the	code #	and pr	rovide	detail	S.				
	TION C - SPEC							•														
	Do you suggest \ arrange any spec		_ =	Yes No	If yes, indica		se			disciplin /NCS	ary pi	rograi	m [=	irosurg nopaed		geon			ase prov nale in		
SEC.	TION D - RETU	JRN-TO-WOR	STAT	US															-			
13	Explanation of o	current functional	abilities	S check	all that a	pply and	d specify (details i	in the s	space pro	vided											
		as full functional					•			,												
	_	trictions, specify	_		_		_		_													
	_	twisting restrictions, spec			_		_		_						-	ions. s	speci	fv				
		crouching restri																				
		estrictions, speci																				
	Restriction	ns due to medica	ations, s	pecify_					_ [Limi	tation	s due	e to er	nvironn	nent, s	specify	<i>'</i>					
	Other limit	tations, specify_																				
14	What are the re	commended wor	k hours	?	Pre-ii	njury /	incider	nt [Otl	her:		;	Shoul	d the h	nours b	oe gra	duate	ed? [Yes	s	No	
15	Estimate duration	on of current fund	ctional a	bilities	: 🔲 1	1 to 2	days	3	to 7	days	8	to 14	days		15+ da	ıys						
SEC	TION E - TREA	ATMENT SUM	IARY																			
16	Number of treatments		nber of sed					Numb reatm						eatme					stima reatme			
	to date:		ointmer	nts:			_ r	eque	sted:					er wee	. •			_ W	veeks:			
m	TION F - FOLL									7	ı									\ \ \		
17	Have you review of this report with		Yes No				vided a to the v	vorkei	r? [Yes No				u provi orker to				s repor loyer?	t \square	Yes No		
18	Will you be reas	ssessing the worl	ker's	Yes		If yes			o 7 da			5 to 2 2+ da	1 day		o you v call yo		Vorkp	laceNl	-	Yes No		
19		complete and a	ccurate																	Date //mm/dd		
Γ	Signature	-		-					•									1 ,	уууу	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

W	orkplaceNL	SEND BY FAX ONLY f 709.738.1479 f 1.866.553.5119	CONTACT US AT: t 709.778.1000 t 1.800.563.9000		IT US AT: orkplacenl.ca	Physiotherap Report	oist's		PR
SEC	TION A - GENERAL INFORMA	TION (please pri	nt clearly)		Claim #				
1	Worker's last name	First name	In	itial	Clinic name		Therapist's last nar	me First na	me
2	Mailing address Province	Conta	ct telephone		Mailing addres	ss			
	Postal code	Date o	of birth yyyy/mm/dd		Postal code				
•					Talanhana	Fax		_	
3		Gende	r M F		Telephone	Fax			
4	Occupation	Employer			Date / time of	visit yyyy/mm/dd	hh:mm AM		
5	Date of injury / incident D	id this injury develo	p \(\text{Yes}	\dashv					
		ver time without a pecific injury / incide	=						
SEC	TION B - SPECIFIC INFORMATION	ON FOR PARTS O	F BODY INJURE	ED					
8	Use codes from code sheet use more than one code where necessary								
	Part of Body								
i.	Left Right Centre		Carla data	:la					
Other	Update Status		Code deta	iis p	oroviaea or	1 reverse.			
ii.	Left Right Centre								
Other	Update Status								
iii.	Left Right Centre								
Other	Update Status								
SEC.	TION D - RETURN-TO-WORK	CTATUC							
13	Explanation of current functional a		unly and enocify datails i	in the s	naco providod				
.0	☐ Worker has full functional ab	·			•				
	☐ Lifting restrictions, specify	< 10 lbs < 20) lbs	O A	void repetitive li	ifting O No lifting			
	☐ Bending / twisting restrictions	s, specify O No b	ending / twisting	\bigcirc	Avoid repetitive	bending / twisting			
	☐ Standing restrictions, specify	/		_ [Climbing (sta	airs / ladders) restric	ctions, specify		
	☐ Kneeling / crouching restricti								
	☐ Walking restrictions, specify				_				
	Restrictions due to medication	ons, specify		_ [Limitations d	ue to environment,	specify		
1/1	Other limitations, specify	. O Drain	:	7 04		Charlet than harring	h = ====d::=t==d0		
14	What are the recommended work						•	Yes N	10
15	Estimate duration of current function	onal abilities: 1	to 2 days 3	to 7 c	days	14 days 15+ d	ays		
a= -									
	FION F - FOLLOW-UP	7./			7 v. T .	Laurence and the Control		4	
17	Have you reviewed the details of this report with the worker?		u provided a copy port to the worker		_ Yes H _ No t	Have you provided a o the worker to give	a copy of this report to the employer?	rt	
18	Will you be reassessing the worke return-to-work capability?			7 da 5 14 d		21 days days			
19	I certify this is a complete and accomplete					orkplaceNL for this v	visit.	Date yyyy/mm/dd	
	Signature								



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Supporting Information

Employers and workers are obligated under the Workplace Health, Safety and Compensation Act, 2022 to co-operate in the worker's early and safe return to suitable and available employment with the injury employer. This may involve modified work, ease back to regular work, transfer to an alternate job, or trial work to assess the worker's capability.

The worker is responsible for providing the employer's copy of the physiotherapists' (PR) report, to the employer by the next working day following the physiotherapist's visit. If a worker cannot provide the form in person, he/she must contact the employer and provide the information by telephone. e-mail or fax.

Worker co-operation:

- contact the injury employer as soon as possible after the injury occurs and maintain effective communication throughout the period of recovery or impairment;
- (ii) assist the employer, as may be required or requested, to identify suitable and available employment;
- (iii) accept suitable employment when identified; and
- (iv) give WorkplaceNL any information requested concerning the return-to-work plan, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

Employer co-operation:

- contact the worker as soon as possible after the injury occurs and maintain effective communication throughout the period of the worker's recovery or impairment;
- (ii) provide suitable and available employment. The employer is responsible to pay the worker's salary earned during the early and safe return-to-work plan. WorkplaceNL will pay the differential, if any, between the salary earned during the early and safe return-to-work plan and 85% of the worker's net pre-injury earnings subject to the maximum compensable ceiling; and
- (iii) give WorkplaceNL any information requested concerning the worker's return to work, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

Part of Body												
1	Abdomen		Face		Lower leg	1	Thoracolumbar region					
2	Ankle Arm	1	Finger Foot		Lumbar region Lumbrosacral region	1	Toe Wrist					
4	Brain	'-	Forearm		Lung, airways		Other					
5	Cervical region	15	Groin	25	Pelvis							
6	Chest	16	Hand	26	Ribs							
7	Соссух	17	Head	27	Sacroiliac region							
8	Ear	18	Heel	28	Shoulder							
9	Elbow	19	Hip	29	Thigh							
10	Eye	20	Knee	30	Thoracic region							

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Physiotherapist's Report



SECTION B - SEPECIFIC INFORMATION FOR PARTS OF BODY INJURED Discretion injury incident Discretion injury injury incident Discretion injury incident Discretion injury injury incident Discretion injury inciden			f 1.866.	553.5119	t 1.80	00.563.900	00			'	rcpoi					41811811		_	
Mailing address	SEC	TION A - GENERAL INFOR	MATION	(please	print cle	early)		Clain	n #										
Prestor Pres	1	Worker's last name		First nar	ne		Initial	Clini	c nam	е			Thera	pist's las	st name) F	First na	me	
Presidence Pre	2	_		Co	ntact tele	ephone			0	dress									
More Center M P Eletabrine Fix A Cocupation Employer Date of Injury / Incident Date of Injury / Inj		Province						Province											
Conception Cender Int r		Postal code		Da	ite of birt	:h yyyy/mm.	/dd I	Posta	l code										
Date of Injury / Incident	3	MCP						Telep	hone			Fax			-				
Date of Injury / Incident Does his injury develop Yes Are you be Are you			<u> </u>		nder _	M	F	Data	/ 4:		:4 .000//	nm/dd	hh:mm						
Section C - SPECIFIC INFORMATION FOR PARTS OF BODY NJURED Stammation West of the provider of the provide	4	<u> </u>		mployer				Date	e / time	of VIS	sit yyyy/ii	nim/dd	nn:mm						
Physicians, specify	5		over tim	e without	a ·	=	3	prima	ary hea		=	care p	rovider s this wor		≒ 				
Section B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED	6				ved		Physicia	an, <i>sp</i> e	cify_						Date				nent
Part of Body	SEC	TION P. SPECIFIC INFORMA	ATION EC	D DADT	S OF PC			зреспу											
Use codes from code sheet				KFAKI	3 OF BC	ונאוו זעכ	JKED												
Part of Body Subjective Reports Update Status		wechanism of injury / incluent.																	
Part of Body Subjective Reports Objective Findings Diagnoses Treatments Nests. Device	8											\neg							
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Coher: Update Status		Code	1	bjective Re	ports 4	1 2	Objectiv	e Findin	igs I	6	Diagno	oses 2	1 2	1 reat	tments	5	6	Assist.	Devices
In Lest Right Ceres												\dashv							
Coher: Update Status		Opuate Statt										\dashv							
Collect Coll					+ -							\dashv							
Pain NPRS over the last 24 hours		Update Statt										\dashv							
Pain NPRS over the tast 24 hours On opain to 10 the worst pain imaginable 10 Did this injury aggravate Yes if yes, please specify in Box 11. Are there other issues affecting the worker's Yes if yes, please specify in Box 11. And there other issues affecting the worker's Yes if yes, please specify in Box 11. And there other issues affecting the worker's Yes if yes, please specify in Box 11. Additional Comments - or - If you use any of the "other" codes above (except Part of Body), indicate the code # and provide details. SECTION C - SPECIFIC INFORMATION FOR ALL DIAGNOSES (PERTAINING TO SECTION B) 12 Do you suggest WorkplacaNL Yes if yes, please Interdisciplinary program Neurosurgeon Please provide Arrange any specialty appointments? No indicate: EMG/NCS Orthopaedic surgeon Please provide Yes If yes, please Interdisciplinary program Neurosurgeon Please provide Arrange any specialty appointments? No indicate: EMG/NCS Orthopaedic surgeon Please provide Yes If yes, please Yes please provide Yes If yes yes If yes yes provide Yes If yes Yes If yes Yes If yes Yes If yes If yes If yes Yes If yes Yes If yes If yes												_							\perp
Did this injury aggravate Yes f yes, please specify in Box 11. Are there other issues affecting the worker's Yes f yes, please specify in Box 11. a prior health issue? No Don't know		Update Statu	JS																
SECTION C - SPECIFIC INFORMATION FOR ALL DIAGNOSES (PERTAINING TO SECTION B) 12 Do you suggest WorkplaceNL	9	Pain NPRS over the last 24 hours	s	0 no	pain to 1	0 the wors	t pain im	aginable	9										
SECTION C - SPECIFIC INFORMATION FOR ALL DIAGNOSES (PERTAINING TO SECTION B) 12 Do you suggest WorkplaceNL	10					ox 11.						e worke	er's	_		,	,	n Box 1	11.
12 Do you suggest WorkplaceNL arrange any specialty appointments? Yes If yes, please arrange any specialty appointments? No indicate: EMG/NCS Orthopaedic surgeon Please provide nationale in Box 11.	11	Additional Comments - or - If y	ou use any	of the "ot	her" code	s above (except P	art of B	ody), i	ndicate	e the cod	de # and	d provide	details.					
12 Do you suggest WorkplaceNL arrange any specialty appointments? Yes If yes, please arrange any specialty appointments? No indicate: EMG/NCS Orthopaedic surgeon Please provide nationale in Box 11.																			
12 Do you suggest WorkplaceNL arrange any specialty appointments? Yes If yes, please arrange any specialty appointments? No indicate: EMG/NCS Orthopaedic surgeon Please provide nationale in Box 11.																			
12 Do you suggest WorkplaceNL arrange any specialty appointments? Yes If yes, please arrange any specialty appointments? No indicate: EMG/NCS Orthopaedic surgeon Please provide nationale in Box 11.	050	TION O OPEOIFIO INFOR	MATION	50D AL	DIAGN	10050	(DEDT	A IN IIN I	0. TO	050	TION								
arrange any specialty appointments? No indicate: EMG/NCS Orthopaedic surgeon rationale in Box 11. SECTION D - RETURN-TO-WORK STATUS Seplanation of current functional abilities check all that apply and specify details in the space provided Worker has full functional abilities to return to work (please go to Section E) Liftling restrictions, specify <10 lbs <20 lbs <50 lbs Avoid repetitive bending / Ivisiting Bending / Ivisiting restrictions, specify No bending / Ivisiting Standing restrictions, specify Climbing (stairs / ladders) restrictions, specify Walking restrictions, specify Upper extremity restrictions, specify Upper extremity restrictions, specify Upper extremity restrictions, specify Other limitations, specify Itimitations due to environment, specify Other limitations, specify Itimitations due to environment, specify Itimit																			
Explanation of current functional abilities check all that apply and specify details in the space provided Worker has full functional abilities to return to work (please go to Section E) Lifting restrictions, specify	12			No ind	es, pieas icate:	se [_		nary p	rogran			0	rgeon					
Explanation of current functional abilities check all that apply and specify details in the space provided Worker has full functional abilities to return to work (please go to Section E) Lifting restrictions, specify	SEC.	TION D - RETURN-TO-WOR	RK STAT	US															
Worker has full functional abilities to return to work (please go to Section E) Lifting restrictions, specify					at annly and	d specify det	ails in the	snace pro	ovided										
Bending / twisting restrictions, specify No bending / twisting Avoid repetitive bending / twisting Standing restrictions, specify Climbing (stairs / ladders) restrictions, specify Sitting restrictions, setting sitting restrictions, setting sitting restrictions, setting sitting sitting sitting sitting sit		<u> </u>																	
Standing restrictions, specify Climbing (stairs / ladders) restrictions, specify Sitting restric		Lifting restrictions, specif	fy	10 lbs 🔘	< 20 lbs	◯ < 50 I	bs O	Avoid re	epetitiv	/e liftir	ng 🔘 l	No liftin	g						
Kneeling / crouching restrictions, specify Sitting restrictions, specify Upper extremity restrictions, specify Upper extremity, specify Upper extremity specify Upper extremity, specify Upper extremity, specify Upper extremity, specify Upper extremity, specify Upper		☐ Bending / twisting restric	tions, spe	cify \bigcirc N	No bendir	ng / twisti	ng 🔘	Avoid	repeti	tive be	ending /	twisting	9						
Walking restrictions, specify Upper extremity restrictions, specify Limitations due to environment, specify Limitations due to environment, specify Limitations due to environment, specify Dther limitations, specify Limitations due to environment, specify Limitations due to environment, specify Dther limitations, specify Limitations due to environment, specify No Number of Limitations due to environment, specify No Limitations due to environment, specify Limitations due to environment, specify Limitations due to environment, specify No Number of Limitations due to environment, specify No Number of Limitations due to environment, specify No Limitations due to environment, specify No Limitations due to environment, specify No No Limitations due to environment, specify No No Limitations due to environment, specify No Limitations due to environment, specify No Limitations Limitations due to envir		☐ Standing restrictions, spe	ecify					☐ Clir	nbing	(stairs	s / ladde	rs) rest	rictions,	specify					
Restrictions due to medications, specify		☐ Kneeling / crouching res	trictions, s	pecify				☐ Sitt	ing res	strictio	ns, spe	cify							
Other limitations, specify		□ Walking restrictions, spe	cify				I	☐ Up _l	per ex	tremity	y restrict	tions, s	pecify						
What are the recommended work hours? Pre-injury / incident Other: Should the hours be graduated? Yes No 15 Estimate duration of current functional abilities: 1 to 2 days 3 to 7 days 8 to 14 days 15+ days SECTION E - TREATMENT SUMMARY 16 Number of Number of Treatment Estimated treatments frequency treatment to date: appointments: requested: per week: weeks: SECTION F - FOLLOW-UP 17 Have you reviewed the details Yes Have you provided a copy Yes Have you provided a copy of this report with the worker? No to the worker to give to the employer? No 18 Will you be reassessing the worker's Yes If yes, 1 to 7 days 15 to 21 days Do you want WorkplaceNL Yes return-to-work capability? No No 19 Legrify this is a complete and accurate report and L have received no prior payment from WorkplaceNL for this visit Date		Restrictions due to medi	cations, sp	ecify				☐ Lim	nitation	s due	to envir	ronmen	t, specify	/					
SECTION E - TREATMENT SUMMARY		Other limitations, specify																	
SECTION E - TREATMENT SUMMARY 16	14	What are the recommended w	ork hours?	Pr	e-injury /	incident	Ot	ther:		5	Should t	he hou	rs be gra	duated	?	Yes	N	10	
Number of treatments missed treatments frequency treatment to date:	15	Estimate duration of current fu	nctional al	oilities:] 1 to 2 d	days] 3 to 7	days	<u> </u>	to 14	days [15+	days						
treatments missed treatments frequency treatment per week:	SEC	TION E - TREATMENT SUN	IMARY																
SECTION F - FOLLOW-UP 17	16																		
Have you reviewed the details Yes of this report with the worker? No of this report to the worker? No to the worker to give to the employer? No 18 Will you be reassessing the worker's Yes of this report to the worker's Yes of this report to the worker's Yes of this report to the worker to give to the employer? No 18 Will you be reassessing the worker's Yes of this report to the worker's Yes of this report to the worker to give to the employer? No 19 Legrify this is a complete and accurate report and L have received no prior payment from WorkplaceNI for this visit. Date	SEC.		opointmen	ts:		rec	quested:	:							we	eks:_			
18 Will you be reassessing the worker's Yes If yes, 1 to 7 days 15 to 21 days Do you want WorkplaceNL Yes return-to-work capability? No when: 8 to 14 days 22+ days to call you? No 19 Legrify this is a complete and accurate report and L have received no prior payment from WorkplaceNL for this visit.		Have you reviewed the details						_	5										
19 Legrify this is a complete and accurate report and I have received no prior payment from WorkplaceNI for this visit Date	18	Will you be reassessing the wo		Yes	If yes	s,	1 to 7 d	ays		5 to 2	1 days	Do yo	ou want \				Yes		
100000000000000000000000000000000000000	19		accurate r								-					 Da	ate		

Signature_



SEND BY FAX ONLY f 709.738.1479 f 1.866.553.5119 CONTACT US AT: 709.778.1000 t 1.800.563.9000 VISIT US AT: workplacenl.ca

Supporting Information

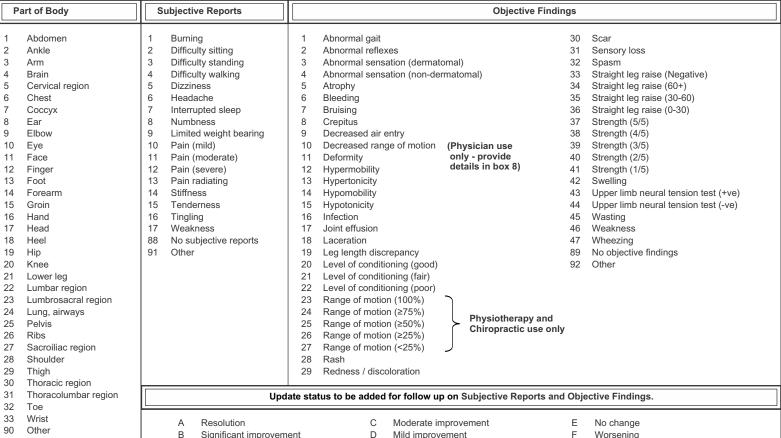
Employers and workers are obligated under the Workplace Health, Safety and Compensation Act, 2022 to co-operate in the worker's early and safe return to suitable and available employment with the injury employer. This may involve modified work, ease back to regular work, transfer to an alternate job, or trial work to assess the worker's capability.

The worker is responsible for providing the employer's copy of the physiotherapist's report, to the employer by the next working day following the physiotherapist's visit. If a worker cannot provide the form in person he/she must contact the employer and provide the information by telephone,

- Worker co-operation:
 (i) contact the injury employer as soon as possible after the injury occurs and maintain effective communication throughout the period of (i) recovery or impairment:
- assist the employer, as may be required or requested, to identify suitable and available employment;
- accept suitable employment when identified; and (iii)
- give WorkplaceNL any information requested concerning the return-to-work plan, including information about any disputes or (iv) disagreements which arise during the early and safe return-to-work process.

Employer co-operation:

- contact the worker as soon as possible after the injury occurs and maintain effective communication throughout the period of the worker's recovery or impairment;
- provide suitable and available employment. The employer is responsible to pay the worker's salary earned during the early and safe (ii) return-to-work plan. WorkplaceNL will pay the differential, if any, between the salary earned during the early and safe return-to-work plan and 85% of the worker's net pre-injury earnings subject to the maximum compensable ceiling; and
- (iii) give WorkplaceNL any information requested concerning the worker's return to work, including information about any disputes or disagreements which arise during the early and safe return-to-work process.



32	Toe			<u> </u>				<u> </u>		
	Wrist				_					
	Other	A	Resolution		С	Moderate improvemen	nt	E No change		
50	0.1101	В	Significant imp	provement	D	Mild improvement		F Worsening		
Dia	gnosis	In	vestigations							
1 2 3 4 5	Abrasion Allergic reaction Amputation Asthma Burn		36 37 38 39 40	Spinal stenosis Spondylolisthesis Tendonitis Tenosynovitis Traumatic spondylolis	thesis /	lysis	1 2 3 4 5	Acupuncture Casting Chiropractic Cold Conditioning exercises	1 2 3 4 5	Blood tests / U/A Bone scan CT scan EMS / NCS Ultrasound
6 7 8 9	Bursitis Carpal tunnel syndrome Chronic obstructive pulmo Contusion Crush	nary disease	93	Other	1103137	,,,,,,	6 7 8 9	Core stability exercises Education Heat Home exercises	6 95	X-ray Other
11	Dermatitis						11	Laser	As	sistive Devices
12	Disc injury						12	Manipulations		
13	Dislocation						13	Massage	1	Ankle brace
14 15	Epicondylitis Fracture						14 15	Mobilizations Motion control	2	Arch supports
16	Frozen shoulder						16	Muscle stimulation	3 4	Back brace Back support
17	Hernia						17	Myofascial release	5	Bandage
18	Herniated disc						18	Occupational rehabilitation	6	Cane
19	Infection						19	Oxygen	7	Cast
20	Inflammation						20	Physiotherapy	8	Cervical collar
21	Laceration						21	Proprioception exercises	9	Cervical pillow
22	Ligament sprain (1st)						22	Range of motion exercises	10	Cold pack
23	Ligament sprain (2nd)						23	Rest	11	Corset
24	Ligament tear (3rd degree	sprain)					24	SMT / adjustment	12	Crutches
25	Mechanical back pain						25	Soft tissue techniques	13	Dressing
26	Meniscal tear						26	Steroid injections	14	Heating pad
27	Muscle strain						27	Strengthening exercises	15	Orthotics
28	Plantar fasciitis						28	Stretching exercises	16	Prosthesis
29	Puncture						29	Suturing	17	Sling
30	Radiculopathy						30	TENS	18	Splint
31	Repetitive strain						31	Traction (manual)	19	Strap, band
32	Rotator cuff impingement						32	Traction (mechanical)	20	Walker
33	Rotator cuff injury						33	Ultrasound	21	Walking boot
34	Rotator cuff tear						94	Other	22	Wheelchair
35	Spinal cord injury								96	Other