

Note: This is a multipurpose form which is used for Initial, Progress, Extension 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.
4. 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, extension, 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.

Section B Example

SECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED

7 Mechanism of injury / incident: <i>Same as previously reported on the initial report.</i>																									
8 Use codes from code sheet <i>use more than one code where necessary</i>																									
Part of Body		Examination						Treatment plan																	
Code	Part of Body	Subjective Reports				Objective Findings						Diagnoses						Treatments						Assist. Devices	
i.	20 <input type="checkbox"/> Left <input checked="" type="checkbox"/> Right <input type="checkbox"/> Centre	10	14	9	4	1	24	39	42	45	26	4	22	27	10	96									
Other: Update Status		C	D	A	C	C	D	D	B																
ii.	28 <input type="checkbox"/> Left <input checked="" type="checkbox"/> Right <input type="checkbox"/> Centre	14	11	91	25	39	33	14	22	23															
Other: Update Status		D	D	D	D	C																			
iii.	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Centre																								
Other: Update Status																									
9 Pain NPRS over the last 24 hours <u>7</u> 0 no pain to 10 the worst pain imaginable																									
10 Did this injury aggravate a prior health issue? <input type="checkbox"/> Yes <i>If yes, please specify in Box 11.</i> <input checked="" type="checkbox"/> No <input type="checkbox"/> Don't know							Are there other issues affecting the worker's injury, recovery and / or disability? <input type="checkbox"/> Yes <i>If yes, please specify in Box 11.</i> <input checked="" type="checkbox"/> No <input type="checkbox"/> Don't know																		
11 Additional Comments - or - If you use any of the "other" codes above (except Part of Body), indicate the code # and provide details. <i>POB i) 96 - Neoprene knee brace POB ii) 91 - Worker complaining of restricted shoulder movement</i>																									

Points to note:

- 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.

Part of Body	Subjective Reports	Objective Findings	Diagnosis	Treatments	Investigations
1 Abdomen 2 Ankle 3 Arm 4 Brain 5 Cervical region 6 Chest 7 Coccyx 8 Ear 9 Elbow 10 Eye 11 Face 12 Finger 13 Foot 14 Forearm 15 Groin 16 Hand 17 Head 18 Heel 19 Hip 20 Knee 21 Lower leg 22 Lumbar region 23 Lumbrosacral region 24 Lung, airways 25 Pelvis 26 Ribs 27 Sacroiliac region 28 Shoulder 29 Thigh 30 Thoracic region 31 Thoracolumbar region 32 Toe 33 Wrist 90 Other* * Provide details in the Other box located under Part of Body	1 Burning 2 Difficulty sitting 3 Difficulty standing 4 Difficulty walking 5 Dizziness 6 Headache 7 Interrupted sleep 8 Numbness 9 Limited weight bearing 10 Pain (mild) 11 Pain (moderate) 12 Pain (severe) 13 Pain radiating 14 Stiffness 15 Tenderness 16 Tingling 17 Weakness 88 No subjective reports 91 Other* * Provide details in the Additional Comments box	44 Upper limb neural tension test (-ve) 45 Wasting 46 Weakness 47 Wheezing 89 No objective findings 92 Other* * Provide details in the Additional Comments box (Physician use only) (Provide details in box 8) } Physiotherapy and Chiropractic use only	1 Abrasion 2 Allergic reaction 3 Amputation 4 Asthma 5 Burn 6 Bursitis 7 Carpal tunnel syndrome 8 Chronic obstructive pulmonary disease 9 Contusion 10 Crush 11 Dermatitis 12 Disc injury 13 Dislocation 14 Epicondylitis 15 Fracture 16 Frozen shoulder 17 Hernia 18 Herniated disc 19 Infection 20 Inflammation 21 Laceration 22 Ligament sprain (1st) 23 Ligament sprain (2nd) 24 Ligament tear (3rd degree sprain) 25 Mechanical back pain 26 Meniscal tear 27 Muscle strain 28 Plantar fasciitis 29 Puncture 30 Radiculopathy 31 Repetitive strain 32 Rotator cuff impingement 33 Rotator cuff injury 34 Rotator cuff tear 35 Spinal cord injury 36 Spinal stenosis 37 Spondylolisthesis 38 Tendonitis 39 Tenosynovitis 40 Traumatic spondylolisthesis / lysis 93 Other* * Provide details in the Additional Comments box	1 Acupuncture 2 Casting 3 Chiropractic 4 Cold 5 Conditioning exercises 6 Core stability exercises 7 Education 8 Heat 9 Home exercises 10 IFC 11 Laser 12 Manipulations 13 Massage 14 Mobilizations 15 Motion control 16 Muscle stimulation 17 Myofascial release 18 Occupational rehabilitation 19 Oxygen 20 Physiotherapy 21 Proprioception exercises 22 Range of motion exercises 23 Rest 24 SMT / adjustment 25 Soft tissue techniques 26 Steroid injections 27 Strengthening exercises 28 Stretching exercises 29 Suturing 30 TENS 31 Traction (manual) 32 Traction (mechanical) 33 Ultrasound 94 Other* * Provide details in the Additional Comments box	1 Blood tests / U/A 2 Bone scan 3 CT scan 4 EMS / NCS 5 Ultrasound 6 X-ray 95 Other* Assistive Devices 1 Ankle brace 2 Arch supports 3 Back brace 4 Back support 5 Bandage 6 Cane 7 Cast 8 Cervical collar 9 Cervical pillow 10 Cold pack 11 Corset 12 Crutches 13 Dressing 14 Heating pad 15 Orthotics 16 Prosthesis 17 Sling 18 Splint 19 Strap, band 20 Walker 21 Walking boot 22 Wheelchair 96 Other* * Provide details in the Additional Comments box
Update status to be added for follow up on Subjective Reports and Objective Findings.					
	A Resolution B Significant improvement C Moderate improvement	D Mild improvement E No change F Worsening			



SECTION A - GENERAL INFORMATION (please print clearly)

Claim #

PO #

1 Worker's last name, First name, Initial, Clinic name, Therapist's last name, First name
2 Mailing address, Contact telephone, Mailing address, WorkplaceNL billing #, Reporting fee requested?
3 MCP, Gender, Telephone, Fax, Report type: Initial, Progress, Discharge
4 Occupation, Employer, Date / time of visit, AM, PM
5 Date of injury / incident, Did this injury develop over time without a specific injury / incident?, Are you the primary health care provider?, Did another health care provider assess this worker before you?, Discharge date
6 Date of referral, Date referral received, Referral source: Worker, Physician, Other, Date of initial assessment

SECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED

7 Mechanism of injury / incident:
8 Use codes from code sheet use more than one code where necessary
Examination: Part of Body, Subjective Reports, Objective Findings, Diagnoses
Treatment plan: Treatments, Assist. Devices
9 Pain NPRS over the last 24 hours
10 Did this injury aggravate a prior health issue?, Are there other issues affecting the worker's injury, recovery and / or disability?
11 Additional Comments

SECTION C - SPECIFIC INFORMATION FOR ALL DIAGNOSES (PERTAINING TO SECTION B)

12 Do you suggest WorkplaceNL arrange any specialty appointments? Yes/No, Interdisciplinary program, Neurosurgeon, Orthopaedic surgeon, EMG/NCS

SECTION D - RETURN-TO-WORK STATUS

13 Explanation of current functional abilities check all that apply and specify details in the space provided
14 What are the recommended work hours? Pre-injury / incident, Other, Should the hours be graduated?
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 treatments to date, Number of missed appointments, Number of treatments requested, Treatment frequency per week, Estimated treatment weeks

SECTION F - FOLLOW-UP

17 Have you reviewed the details of this report with the worker? Yes/No, Have you provided a copy of this report to the worker? Yes/No, Have you provided a copy of this report to the worker to give to the employer? Yes/No
18 Will you be reassessing the worker's return-to-work capability? Yes/No, If yes, when: 1 to 7 days, 8 to 14 days, 15 to 21 days, 22+ days, Do you want WorkplaceNL to call you? Yes/No
19 I certify this is a complete and accurate report and I have received no prior payment from WorkplaceNL for this visit. Signature, Date



SECTION A - GENERAL INFORMATION (please print clearly)

Claim # _____

1	Worker's last name	First name	Initial	Clinic name	Therapist's last name	First name
2	Mailing address Province _____ Postal code _____	Contact telephone	Date of birth yyyy/mm/dd _____	Mailing address Province _____ Postal code _____		
3	Gender <input type="checkbox"/> M <input type="checkbox"/> F			Telephone	Fax	
4	Occupation	Employer	Date / time of visit yyyy/mm/dd _____	hh:mm _____	<input type="checkbox"/> AM <input type="checkbox"/> PM	
5	Date of injury / incident yyyy/mm/dd _____	Did this injury develop over time without a specific injury / incident? <input type="checkbox"/> Yes <input type="checkbox"/> No				

SECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED

8 Use codes from code sheet
use more than one code where necessary

Part of Body	
Code	
i. <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Centre	
Other: _____	Update Status
ii. <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Centre	
Other: _____	Update Status
iii. <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Centre	
Other: _____	Update Status

Code details provided on reverse.

**This is a revised physiotherapist reporting form (Sept. 2008).
If you have any questions regarding this form, please call
your case manager or 1.800.563.9000.**

SECTION D - RETURN-TO-WORK STATUS

13 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 < 10 lbs < 20 lbs < 50 lbs Avoid repetitive lifting No lifting

Bending / twisting restrictions, specify No bending / twisting Avoid repetitive bending / twisting

Standing restrictions, specify _____ Climbing (stairs / ladders) restrictions, specify _____

Kneeling / crouching restrictions, specify _____ Sitting restrictions, specify _____

Walking restrictions, specify _____ Upper extremity restrictions, specify _____

Restrictions due to medications, specify _____ Limitations due to environment, specify _____

Other limitations, specify _____

14 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 F - FOLLOW-UP

17	Have you reviewed the details of this report with the worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you provided a copy of this report to the worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you provided a copy of this report to the worker to give to the employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
18	Will you be reassessing the worker's return-to-work capability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when: <input type="checkbox"/> 1 to 7 days <input type="checkbox"/> 8 to 14 days <input type="checkbox"/> 15 to 21 days <input type="checkbox"/> 22+ days	
19	I certify this is a complete and accurate report and I have received no prior payment from WorkplaceNL for this visit.		
Signature _____			Date yyyy/mm/dd _____

Employers and workers are obligated under the *Workplace Health, Safety and Compensation Act* 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:

- (i) 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:

- (i) 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	11 Face	21 Lower leg	31 Thoracolumbar region
2 Ankle	12 Finger	22 Lumbar region	32 Toe
3 Arm	13 Foot	23 Lumbrosacral region	33 Wrist
4 Brain	14 Forearm	24 Lung, airways	90 Other
5 Cervical region	15 Groin	25 Pelvis	
6 Chest	16 Hand	26 Ribs	
7 Coccyx	17 Head	27 Sacroiliac region	
8 Ear	18 Heel	28 Shoulder	
9 Elbow	19 Hip	29 Thigh	
10 Eye	20 Knee	30 Thoracic region	



SECTION A - GENERAL INFORMATION (please print clearly)

Claim # _____

1	Worker's last name	First name	Initial	Clinic name	Therapist's last name	First name
2	Mailing address Province _____ Postal code _____	Contact telephone	Date of birth yyyy/mm/dd _____	Mailing address Province _____ Postal code _____	CODES FOR SECTION B ON REVERSE	
3	MCP _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Telephone _____	Fax _____		
4	Occupation _____	Employer _____	Date / time of visit yyyy/mm/dd _____ hh:mm _____ <input type="checkbox"/> AM <input type="checkbox"/> PM			
5	Date of injury / incident yyyy/mm/dd _____	Did this injury develop over time without a specific injury / incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you the primary health care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did another health care provider assess this worker before you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6	Date of referral yyyy/mm/dd _____	Date referral received yyyy/mm/dd _____	Referral source: <input type="checkbox"/> Worker <input type="checkbox"/> Physician, specify _____ <input type="checkbox"/> Other, specify _____	Date of initial assessment yyyy/mm/dd _____		

SECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED

7 Mechanism of injury / incident: _____

8 Use codes from code sheet *use more than one code where necessary*

Code	Part of Body	Examination						Treatment plan									
		Subjective Reports				Objective Findings		Diagnoses		Treatments				Assist. Devices			
		1	2	3	4	1	2	1	2	1	2	3	4	5	6	1	2
i.	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Centre																
	Other: _____	Update Status															
ii.	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Centre																
	Other: _____	Update Status															
iii.	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Centre																
	Other: _____	Update Status															

9 Pain NPRS over the last 24 hours _____ 0 no pain to 10 the worst pain imaginable

10 Did this injury aggravate a prior health issue? Yes *If yes, please specify in Box 11.* No Don't know
Are there other issues affecting the worker's injury, recovery and / or disability? Yes *If yes, please specify in Box 11.* No Don't know

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 WHSCC arrange any specialty appointments? Yes *If yes, please indicate:* Interdisciplinary program Neurosurgeon Orthopaedic surgeon
 No EMG/NCS Orthopaedic surgeon *Please provide rationale in Box 11.*

SECTION D - RETURN-TO-WORK STATUS

13 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 < 10 lbs < 20 lbs < 50 lbs Avoid repetitive lifting No lifting

Bending / twisting restrictions, specify No bending / twisting Avoid repetitive bending / twisting

Standing restrictions, specify _____ Climbing (stairs / ladders) restrictions, specify _____

Kneeling / crouching restrictions, specify _____ Sitting restrictions, specify _____

Walking restrictions, specify _____ Upper extremity restrictions, specify _____

Restrictions due to medications, specify _____ Limitations due to environment, specify _____

Other limitations, specify _____

14 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 treatments to date: _____ Number of missed appointments: _____ Number of treatments requested: _____ Treatment frequency per week: _____ Estimated treatment weeks: _____

SECTION F - FOLLOW-UP

17 Have you reviewed the details of this report with the worker? Yes No
Have you provided a copy of this report to the worker? Yes No
Have you provided a copy of this report to the worker to give to the employer? Yes No

18 Will you be reassessing the worker's return-to-work capability? Yes No
If yes, when: 1 to 7 days 8 to 14 days 15 to 21 days 22+ days
Do you want WorkplaceNL to call you? Yes No

19 I certify this is a complete and accurate report and I have received no prior payment from WorkplaceNL for this visit.
Signature _____ Date yyyy/mm/dd _____

Employers and workers are obligated under the *Workplace Health, Safety and Compensation Act* 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, e-mail or fax.

Worker co-operation:

- (i) 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:

- (i) 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	Subjective Reports	Objective Findings	
1 Abdomen	1 Burning	1 Abnormal gait	30 Scar
2 Ankle	2 Difficulty sitting	2 Abnormal reflexes	31 Sensory loss
3 Arm	3 Difficulty standing	3 Abnormal sensation (dermatomal)	32 Spasm
4 Brain	4 Difficulty walking	4 Abnormal sensation (non-dermatomal)	33 Straight leg raise (Negative)
5 Cervical region	5 Dizziness	5 Atrophy	34 Straight leg raise (60+)
6 Chest	6 Headache	6 Bleeding	35 Straight leg raise (30-60)
7 Coccyx	7 Interrupted sleep	7 Bruising	36 Straight leg raise (0-30)
8 Ear	8 Numbness	8 Crepitus	37 Strength (5/5)
9 Elbow	9 Limited weight bearing	9 Decreased air entry	38 Strength (4/5)
10 Eye	10 Pain (mild)	10 Decreased range of motion	39 Strength (3/5)
11 Face	11 Pain (moderate)	11 Deformity	40 Strength (2/5)
12 Finger	12 Pain (severe)	12 Hypermobility	41 Strength (1/5)
13 Foot	13 Pain radiating	13 Hypertonicity	42 Swelling
14 Forearm	14 Stiffness	14 Hypomobility	43 Upper limb neural tension test (+ve)
15 Groin	15 Tenderness	15 Hypotonicity	44 Upper limb neural tension test (-ve)
16 Hand	16 Tingling	16 Infection	45 Wasting
17 Head	17 Weakness	17 Joint effusion	46 Weakness
18 Heel	88 No subjective reports	18 Laceration	47 Wheezing
19 Hip	91 Other	19 Leg length discrepancy	89 No objective findings
20 Knee		20 Level of conditioning (good)	92 Other
21 Lower leg		21 Level of conditioning (fair)	
22 Lumbar region		22 Level of conditioning (poor)	
23 Lumbrosacral region		23 Range of motion (100%)	} Physiotherapy and Chiropractic use only
24 Lung, airways		24 Range of motion (≥75%)	
25 Pelvis		25 Range of motion (≥50%)	
26 Ribs		26 Range of motion (≥25%)	
27 Sacroiliac region		27 Range of motion (<25%)	
28 Shoulder		28 Rash	
29 Thigh		29 Redness / discoloration	
31 Thoracic region	Update status to be added for follow up on Subjective Reports and Objective Findings.		
32 Thoracolumbar region			
33 Toe	A Resolution	C Moderate improvement	E No change
90 Other	B Significant improvement	D Mild improvement	F Worsening

Diagnosis	Treatments	Investigations
1 Abrasion	1 Acupuncture	1 Blood tests / U/A
2 Allergic reaction	2 Casting	2 Bone scan
3 Amputation	3 Chiropractic	3 CT scan
4 Asthma	4 Cold	4 EMS / NCS
5 Burn	5 Conditioning exercises	5 Ultrasound
6 Bursitis	6 Core stability exercises	6 X-ray
7 Carpal tunnel syndrome	7 Education	95 Other
8 Chronic obstructive pulmonary disease	8 Heat	
9 Contusion	9 Home exercises	
10 Crush	10 IFC	
11 Dermatitis	11 Laser	
12 Disc injury	12 Manipulations	
13 Dislocation	13 Massage	
14 Epicondylitis	14 Mobilizations	
15 Fracture	15 Motion control	
16 Frozen shoulder	16 Muscle stimulation	
17 Hernia	17 Myofascial release	
18 Herniated disc	18 Occupational rehabilitation	
19 Infection	19 Oxygen	
20 Inflammation	20 Physiotherapy	
21 Laceration	21 Proprioception exercises	
22 Ligament sprain (1st)	22 Range of motion exercises	
23 Ligament sprain (2nd)	23 Rest	
24 Ligament tear (3rd degree sprain)	24 SMT / adjustment	
25 Mechanical back pain	25 Soft tissue techniques	
26 Meniscal tear	26 Steroid injections	
27 Muscle strain	27 Strengthening exercises	
28 Plantar fasciitis	28 Stretching exercises	
29 Puncture	29 Suturing	
30 Radiculopathy	30 TENS	
31 Repetitive strain	31 Traction (manual)	
32 Rotator cuff impingement	32 Traction (mechanical)	
33 Rotator cuff injury	33 Ultrasound	
34 Rotator cuff tear	94 Other	
35 Spinal cord injury		

Assistive Devices

- 1 Ankle brace
- 2 Arch supports
- 3 Back brace
- 4 Back support
- 5 Bandage
- 6 Cane
- 7 Cast
- 8 Cervical collar
- 9 Cervical pillow
- 10 Cold pack
- 11 Corset
- 12 Crutches
- 13 Dressing
- 14 Heating pad
- 15 Orthotics
- 16 Prosthesis
- 17 Sling
- 18 Splint
- 19 Strap, band
- 20 Walker
- 21 Walking boot
- 22 Wheelchair
- 96 Other