

MAIL FORM TO: P.O. Box 9000 St. John's, NL A1A 3B8 t 1.800.563.9000 FAX FORM TO:

CALL US AT: t 709.778.1000 workplacenl.ca

DROP OFF IN PERSON: 146-148 Forest Road, P.O. Box 9000 St. John's, NL A1A 3B8

Instructions for Completing Physiotherapy Report PR

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.
- Recurrences The injury may be a recurrence of a previous work-related injury. 2.
- Progress reporting When there is a significant change in the worker's: (1) condition; (2) treatment; or (3) return-to-work status. 3.
- 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.

The Assistive Devices category is only intended for devices which are being recommended at this time. Recommendations for *Note: 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.

								Se	ctior	ı B E	Exan	nple											
SEC	CTION	B - SPECI	FIC INFORMATION	ON FO	OR PA	RTS	OF B	ODY I	NJUR	ED													
7	Mec	hanism of ir	njury / incident:																				
	Sá	me as pre	eviously reporte	d on	the ir	nitial	repo	rt.															
8			code sheet ode where necessary						Е	xamiı	nation							Tre	atmei	nt pla	n		
	Code	Part of E	Body	Su	bjective	e Repo	rts	1	Ob	jective	Findin	gs 5	6	Diagn	oses	1	2	Treat	ments	5	6	Assist. D	evices
i.	20	Left 🗹	Right Centre	10	14	9	4	1	24	39	42	45		26	-	4	22	27	10			96	
Oth	er:		Update Status	С	D	A	C	C	D	D	В							•					
ii.	28	Left 📝	Right Centre	14	11	91		25	39					33		14	22	23					
Oth	er:		Update Status	D	D	D		D	C														
iii.		Left	Right Centre																				
Oth	er:		Update Status															•					
9	Pain	NPRS over	the last 24 hours	7	-	0 no p	ain to	10 the \	vorst pa	ain ima	ginable)											
10		this injury a		s If ye	s, pleas	se spec	cify in E	Box 11.				issues				ker's		Yes If			-	n Box 11	۲.
	a pri	or health iss	sue?		Don't	know			Inju	ігу, ге	covery	and /	or alsa	ability !			√	No [Don	't kno	W		
11	Addi	tional Comm	nents - or - If you	use an	y of the	e "othe	r" code	es abov	ve (exc	ept Pa	rt of B	ody), in	dicate	the co	de#a	and pro	vide d	etails.					
	PO	08 i) 96 -	Neoprene knee	brace	e Po	08 ii)	91 -	Work	er co	mpla	ining	of res	trict	ed sh	ould	er ma	ovem	ent					
_	201040	to noto:																					

- 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.

сомтаст из ат: workplaceni.ca 8/10, 8/10c and PR Code Sheet t 709.778.1000 workplaceni.ca t 1.800.563.9000

WorkplaceNL f 709.738.1479 f 1.866.553.5119

Effective Date: April 2017

Part of Body	Subjective Reports	igo	Objective Findings	Diagnosis	Treatments	Investigations
		111111111111111111111111111111111111111			\tag{2}	4)
Abdomen 2 Apdo	2 Difficulty eithing	Abnormal galt	44 Opper IImb neural tension test (-ve)	Abrasion Angeraion A Norwice recognition	Acupuncture	Blood tests / U/A
		-		-	2 Casulig	
		A Abnormal constitut (non dormatemat)				
	4 Dillically Walking	•	'nα			
6 Chest		. –				
				7 Carnal tunnel syndrome		LC
	_		* Provide details in the Additional		8 Heat	
			Comments box			
0	0	0	Decreased range of motion (Physician use only) (Provide details in box 8)	0	0	Assistive Devices
	_	11 Deformity		11 Dermatitis	_	
12 Finger	_	12 Hypermobility		12 Disc injury	12 Manipulations	
		13 Hypertonicity				
14 Forearm	0,			14 Epicondylitis	14 Mobilizations	
15 Groin	15 Tenderness	15 Hypotonicity		15 Fracture	15 Motion control	4 Back support
16 Hand	16 Tingling	16 Infection		16 Frozen shoulder	16 Muscle stimulation	
		17 Joint effusion				o Cane
18 Heel		_		18 Herniated disc		
19 Hip	91 Other*	19 Leg length discrepancy		19 Infection	19 Oxygen	
20 Knee	odt ai oliotob obisona *	20 Level of conditioning (good)		20 Inflammation		
21 Lower leg		21 Level of conditioning (fair)		21 Laceration	21 Proprioception exercises	
	box	_		_	22 Range of motion exercises	
23 Lumbrosacral region		23 Range of motion (100%)				
24 Lung, airways		Range of motion (≥75%)				
25 Pelvis		25 Range of motion (≥50%)	Physiotherapy and Chiromactic use only	25 Mechanical back pain	25 Soft tissue techniques	
26 Ribs			onit optactic use only		26 Steroid injections	
27 Sacroiliac region		27 Range of motion (<25%)			27 Strengthening exercises	
28 Shoulder		28 Rash		28 Plantar fasciitis	28 Stretching exercises	
29 Thigh		29 Redness / discoloration		29 Puncture	29 Suturing	
30 Thoracic region		30 Scar		30 Radiculopathy	30 TENS	
31 Thoracolumbar region		31 Sensory loss			31 Traction (manual)	
32 Toe					32 Traction (mechanical)	
33 Wrist		33 Straight leg raise (Negative)			33 Ultrasound	
90 Other*		34 Straight leg raise (60+)		34 Rotator cuff tear	94 Other*	96 Other*
* 0		35 Straight leg raise (30-60)		35 Spinal cord injury	* Drovido dotaile is the	* Provide defails in
Other hox located					Additional Comments box	the Additional
under Part of Body				37 Spondylolisthesis		Comments box
`				38 Tendonitis		
				•		
				93 Other*		
		-		* Provide details in the		
		43 Upper limb neural tension test (+ve)		Additional Comments box		
	Update st	Update status to be added for follow up on Subjective Reports and Objective Findings	tive Reports and Objective Findings.			
		O COL	Mild improvement			
	(0	Significant improvement	E No change			
	_	Moderate improvement				
		-				

W	VorkplaceNL 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 VISIT US AT: workplacenl.ca Instructions for Completing Physiotherapy Report PR Apr. 2017													
							_							PK
5E	CTION A - GENERAL INFO Worker's last name		st name	cieariy)	Initial	Clain Clinic	n #			1	PO Therapis	t's last nar	ne First	name
E.			T											NII 1 202 //
2	Mailing address		Contact tel	ephone		Maili Provin	ng addı ce ı	ress						NL billing #
			Date of birt	:h yyyy/mm	/dd								Reporting Ye	fee requested?
	Postal code					Postal	code						Applica	ble reporting as per MOA.
3	MCP		Gender	M	F	Telep	hone			Fax			Report type	
4	Occupation	Emplo	yer			Date	/ time o	of visit	yyyy/mm/	/dd h	nh:mm	AM	Initial	
_	Date of injury / incident								1	Did anoth	er health	PM	Progres	
5	yyyy/mm/dd	Did this injur over time wit	hout a	Yes		prima	ou the ry health provider	' =	Yes c	are prov		Yes	yyy	narge date y/mm/dd
6	Date of referral	specific injur Date referral	,		erral sou		Wor		10 b	pefore yo	u?		te of initial a	essesment
	yyyy/mm/dd	yyyy/m			Physicia	ın, <i>spe</i>	cify	Ker				Da	yyyy/mr	
050	FIGN B. SPECIFIC INFORM	ATION FOR R	A DTC OF DO		Other, s	specify						<u> </u>		
7	Machaniam of injury / incident		ARTS OF BO	ODY INJU	URED									
	Mechanism of injury / incident	•												
8	Use codes from code sheet use more than one code where necessa	n/			Fvam:	nation						Treatm	ent plan	
	Part of Body		ve Reports		Objective				iagnose	s		Treatments		Assist. Devices
i.	Code Left Right Centr	re 1 2	3 4	1 2	3	4	5	6	1 2	1	2	3 4	5 6	1 2
Othe	": Update State	ıs								\top				
ii.	Left Right Centr	те												
Other	Update State	ıs												
iii.	Left Right Centr	re												
Othe	Update State	ıs												
Pain NPRS over the last 24 hours 0 no pain 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.														
10	Did this injury aggravate a prior health issue?	Yes If yes, plea	ase specify in B		Are ther injury, re					orker's			please specify on't know	/ in Box 11.
11	Additional Comments - or - If y			s above (e	except P	art of B	ody), ind	dicate th	e code i	# and pr			on t know	
	·	•			·									
SEC	TION C - SPECIFIC INFORI	MATION FOR	ALL DIAGI	NOSES	(PFRT/	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	3 TO 5	SECTIO	ON B)					
FT	Do you suggest WorkplaceNL	Yes	If yes, pleas		<u> </u>		nary pro			eurosurg	eon		Please pro	vide
	arrange any specialty appointm	ents? No	indicate:		EMG	/NCS			Or	thopaed	lic surge	eon	rationale in	Box 11.
SEC	TION D - RETURN-TO-WO													
13	Explanation of current function Worker has full functional													
	☐ Lifting restrictions, speci		٠.	•		,		e liftina	○ No	liftina				
	☐ Bending / twisting restric		_		_			_	_					
	☐ Standing restrictions, spe	ecify			[☐ Clin	nbing (s	stairs / la	adders)	restrict	ions, sp	ecify		
	☐ Kneeling / crouching res						-							
	☐ Walking restrictions, spe													
	Restrictions due to medi				[Lim	itations	due to	environ	ıment, s	pecify _			
14	Other limitations, specify		☐ Pro injury /	incident		hor:		Sho	uld the	hours h	o gradu	uatod2 [7 Vaa	l No
15	What are the recommended w	_										iaiou!	Yes	ן ויוט
	Estimate duration of current fu		J. □ 1 10 2 0	uays _] 3 (0 /	uays		o 14 ua	yo	ıo+ ua	yo			
	TION E - TREATMENT SUN Number of N	umber of		Nu	ımber of	:			Treatm	ent			Stimated	
16	treatments m	nissed ppointments:		tre	atments quested:	i			frequer per wee	псу		tr	reatment reeks:	
SFC	TION F - FOLLOW-UP				,JJ				P 21 W					
17	Have you reviewed the details	Yes	Have you pro	vided a c	ору [Yes						this repor	t Yes	
	of this report with the worker?	□ No	of this report	to the wo	rker? [No		to the	worker	to give	to the er	mployer?	□ No	
18	Will you be reassessing the woreturn-to-work capability?	orker's Ye	1 .	- =	1 to 7 da 8 to 14			to 21 d + days		Do you v Vorkpla		call you?	☐ Yes ☐ No	
19	I certify this is a complete and	accurate repor	and I have re	eceived n	o prior p	aymen	t from \	Vorkpla	ceNL fo	or this vi	sit.		Date yyyy/mm/dd	
	Signature												1 1	

										Apr. 2017
W	orkplace NL	SEND BY FAX ONLY	CONTACT US AT:		IT US AT: orkplacenl.ca	Physiothera	pist's			PR
4.4	OINPIGCEIVE	f 709.738.1479 f 1.866.553.5119	t 709.778.1000 t 1.800.563.9000	wc	лкриоспі.0а	Report	ļ			1-1/
SEC.	TION A - GENERAL INFORMA	TION (please pr	int clearly)		Claim #	1 1 1 1				
1	Worker's last name	First name	Ir	nitial	Clinic name		Therapist's las	t name	First name)
2	Mailing address	Cont	act telephone		Mailing addres	SS				
	Province				Province					
	Postal code	Date	of birth yyyy/mm/dd		Postal code					
3					Telephone	Fax				
		Gend	er M F				h.h			
4	Occupation	Employer			Date / time of	visit yyyy/mm/dd	1=	AM PM		
5	Date of injury / incident	l Did this injury devel	op 🗆 Vaa							
	7777	over time without a specific injury / incid	ent? No							
		, , , ,								
SEC	TION B - SPECIFIC INFORMATI	ON FOR PARTS (OF BODY INJUR	FD						
SEC.	HON B - OF ECH TO INTORMATE	ONTORTARIO	or bobt insor							
8	Use codes from code sheet									
	Part of Body	-								
	Code	-								
i. Other	Left Right Centre Update Status		Code deta	ils p	orovided or	n reverse.				
ii.	Left Right Centre									
Other										
iii.	Left Right Centre	-								
Other										
			This is a r	evis	ed nhysiat	herapist repo	ortina form	(Sent 2	2008)	
						s regarding				
			your case	ma	nager or 1.	800.563.9000).			
SEC.	TION D - RETURN-TO-WORK	STATUS								
13	Explanation of current functional a									
	☐ Worker has full functional at☐ Lifting restrictions, specify		•		,	fting \(\sum \) No lifting	,			
	☐ Bending / twisting restriction			_						
	☐ Standing restrictions, specif			_						
	☐ Kneeling / crouching restrict									
	☐ Walking restrictions, specify									
	☐ Restrictions due to medicati									
	Other limitations, specify									
14	What are the recommended work	hours? Pre-i	njury / incident	Oth	ner:	Should the hour	s be graduated	? Yes	☐ No	
15	Estimate duration of current function	ional abilities:	I to 2 days 3	to 7 d	days	14 days	days			_
SEC	TION F - FOLLOW-UP									
17	Have you reviewed the details		ou provided a copy			lave you provided			Yes	
18	of this report with the worker? Will you be reassessing the worker		report to the worke	r? <u> </u> o 7 da		o the worker to giv	ve to the employ	/er?	No	
10	return-to-work capability?	□ No	· · · =	o 14 c						
19	I certify this is a complete and acc	curate report and I h	ave received no p	rior pa	ayment from Wo	orkplaceNL for this	s visit.	D; yyyy/	ate mm/dd	
	Signature									



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 VISIT US AT: workplacenl.ca

Supporting Information

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:

- 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.

art	t of Body						
1	Abdomen	11	Face	21	Lower leg	31	Thoracolumbar region
2	Ankle	12	Finger	22	Lumbar region	32	Toe
3	Arm	1	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		

WorkplaceNL SEND BY FAX ONLY 1709, 738, 1479 1,1806, 553, 5119 1,1800, 563, 9000 1,1800, 5000 1,18																		A	or. 2017
Worker's last name	W	orkpla	ceNL	f 709.73	38.147	9 t	709.7	78.1000	W					erapist'	S				
Worker's last name	SEC1	ION A - GENE	RAL INFORM	ATION	(plea	se print	t clea	arlv)		Claim	#								
Date of latin yyphemids		1			-			y ,	Initial	Clinic	name			Ther	apist's las	st name	First n	ame	
Cocupation Comparison Com	2		s			Contact	t telep	hone	1		_								
Cocupation Employer		Postal code				Date of	birth	yyyy/mm	ı/dd	Postal	code	7							
4 Occupation Employer Date / time of visit /yyy/minds	3	MCP	1	1		Gender		L L	F F	Teleph	none		F	ax					
Date of Injury / Incident Dit of this injury develop Specific injury / Incident? No See provider? No See provider No See provide	4	Occupation	1 1 1 1	<u> </u>	mploy					Date	/ time of vis	sit уууу	/mm/dd	hh:mr	n				
B Date of referral sysphirmoids Date of referral source: Worker Physician, specify Date of initial assessment Physician Ph	5							=		primar	y health	=	car	e provider		Yes			
Physicians, apacity	_				, ,		it?					No			DIKEI _				
Section B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED	6		II.						Physicia	an, <i>spe</i>	cify					Date			nent
Weeknarism of Injury / incident: Subjective France Subjective Reports Objective Findings Disproses Treatment plan Objective Findings Disproses Treatment plan Objective Findings Disproses Treatment plan Objective Findings Disproses Treatments Assist. Dev. Objective Findings Disproses Treatments Assist. Dev. Objective Findings Disproses Treatments Objective Findings Disproses Treatments Objective Findings Objective Findings Disproses Treatments Objective Findings Obje				1 1			I		-	specify .						Ц,	\vdash		
B Use codes from code sheet use motivations or code sheet use motivations, specify	SECT	TION B - SPECI	FIC INFORMAT	TION FO	OR PA	RTS OF	BOD	DY INJ	URED										
Part of Body	7	Mechanism of ir	njury / incident:																
Section C - SPECIFIC Information For ALL DIAGNOSES (PERTAINING TO SECTION B) Section D - RETURN-TO-WORK STATUS Separation of current functional abilities to return to work (please go to Section E) Worker has full functional abilities to return to work (please go to Section E) Wilsing restrictions, specify Walking restrictions due to environment, specify																			
Left Right Centre Commerce Update Status Update St	8								Exami	ination					Tro	eatmen	t plan		
Lest Right Centre Update Status Upda		Part of E	Body	Su	bjectiv	e Reports			Objectiv	e Finding	js	Diagr	oses				•	Assist	Devices
Description			Right Centre	1	2	3 4	4	1 2	3	4	5 6	1	2	1 2	3	4	5 6	1	2
Cother:							+												
Update Status Update Statu	ii	Left	<u></u>				+					+						1	
Pain NPRS over the last 24 hours							+											+	
Pain NPRS over the last 24 hours																			
10 Did this injury aggravate		<u> </u>	Update Status				\top					1							
a prior health issue? No Don't know injury, recovery and / or disability? 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. 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	9	Pain NPRS over	the last 24 hours			0 no pain	to 10	the wors	st pain im	aginable									
SECTION C - SPECIFIC INFORMATION FOR ALL DIAGNOSES (PERTAINING TO SECTION B) 12 Do you suggest WHSCC arrange	10					, ,	in Box							ker's			, ,	in Box	11.
Do you suggest WHSCC arrange	11	Additional Comm	nents - or - If you	use any	y of the	e "other" c	odes	above (except P	art of Bo	ody), indicat	e the co	de # a	and provid	e details.	<u> </u>			
Do you suggest WHSCC arrange																			
Do you suggest WHSCC arrange	SEC	TION C - SPEC	IFIC INFORM	ATION	FOR	ALL DIA	AGNO	OSES	(PERT	AINING	TO SEC	TION	B)						
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		Do you suggest	WHSCC arrang	e 🔲 `	Yes	If yes, p	lease		Inter	disciplin			Neur	-					
Worker has full functional abilities to return to work (please go to Section E) Lifting restrictions, specify	SEC	ΓΙΟΝ D - RETU	JRN-TO-WORK	STAT	US														
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 What are the recommended work hours? Pre-injury / incident Other: Should the hours be graduated? Yes No 14 What are the recommended work hours? In to 2 days In to 2 days In the frequency Standard Interatment Standard Interatment Interated Interatment Interatment Interatment Interatment Interatment	13	Explanation of c	current functional	abilities	check	all that appl	ly and s	specify det	tails in the	space pro	vided								
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 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							٠.	•		,									
Standing restrictions, specify Climbing (stairs / ladders) restrictions, specify Sitting restrictions, specify Sitting restrictions, specify Upper extremity restrictions, specify Limitations due to environment, specify Other limitations, specify Upper extremity restrictions, specify Should the hours be graduated? Yes No 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 Number of Number of Treatment Estimated treatments frequency treatment		Lifting res	trictions, specify	○ < ·	10 lbs	<u> </u>	lbs () < 50 I	bs O	Avoid re	petitive lifti	ng 🔾	No lif	ting					
Kneeling / crouching restrictions, specify Sitting restrictions, specify Upper extremity restrictions, specify Upper extremity restrictions, specify Upper extremity restrictions, specify Limitations due to environment, specify Other limitations, specify Upper extremity restrictions, specify Upper extremity specify Upper extremity restrictions, specify Upper extremity specify Upper extremity specify Upper extremity sp		_	_			_	_					_		_					
Walking restrictions, specify									_										
Restrictions due to medications, specify Limitations due to environment, specify Other limitations, specify 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																			
Other limitations, specify																			
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					pecify_				I	Limi	tations due	to env	ironm	ent, spec	ify				
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SECTION E - TREATMENT SUMMARY 16 Number of Number of Treatment Estimated treatments frequency treatment	_														auuale0	· <u> </u>	res	INO	
Number of Number of Number of Treatment Estimated treatments missed treatments frequency treatment					omues	1 10	J∠ U∂	4y3 _	J 5 10 /	uays	0 10 14	uays	:	o uays					
treatments missed treatments frequency treatment								ķi.	ımbor of	:		Tro	atmon	ıt.		Enti	mated		
	16	treatments	mis	sed	ts:			tre	atments	3		frec	uency	/		trea	tment		

SECT	TION F - FOLLOW-UP				
	to date:	appointments:	requested:	per week:	weeks:
10	treatments	missed	treatments	frequency	treatment
16	Number of	Number of	Numper of	Treatment	Estimated

17	Have you reviewed the details Yes of this report with the worker?	Have you provided a copy Yes of this report to the worker? No	Have you provided a copy of this report to the worker to give to the employer?	Yes No
18				Yes No
19	I certify this is a complete and accurate rep	ort and I have received no prior payment from	n WorkplaceNL for this visit.	Date yyyy/mm/dd

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 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,

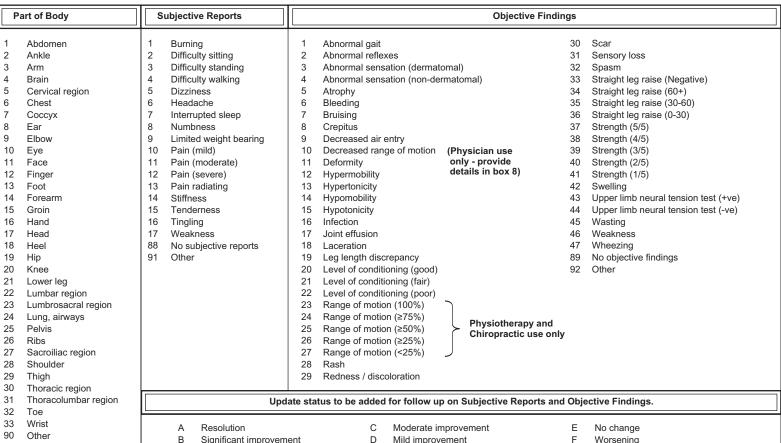
- Worker co-operation:
 (i) contact the injury employer as soon as possible after the injury occurs and maintain effective communication throughout the period of (i) recovery or impairment:
- assist the employer, as may be required or requested, to identify suitable and available employment; (ii)
- accept 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:

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Spinal cord injury

- 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.



31 32	Thoracolumbar region Toe			Update status to b	oe added	for follow up on Subj	ective	Reports and Objective Findings.		
33	Wrist									
90	Other	Α	Resolution		С	Moderate improvement	nt	E No change		
30	Outer	В	Significant im	provement	D	Mild improvement		F Worsening		
D:							 -	, ,	I	timations
Dia	agnosis						<u> </u>	reatments	∟ In	vestigations
1	Abrasion		36	Spinal stenosis			1	Acupuncture	1	Blood tests / U/A
2	Allergic reaction		37	Spondylolisthesis			2	Casting	2	Bone scan
3	Amputation		38	Tendonitis			3	Chiropractic	3	CT scan
4	Asthma		39	Tenosynovitis			4	Cold	4	EMS / NCS
5	Burn		40	Traumatic spondylol	isthesis /	lysis	5	Conditioning exercises	5	Ultrasound
6	Bursitis		93	Other		•	6	Core stability exercises	6	X-ray
7	Carpal tunnel syndrome						7	Education	95	Other
8	Chronic obstructive pulmo	nary disease					8	Heat		
9	Contusion	•					9	Home exercises		
10	Crush						10	IFC		
11	Dermatitis						11	Laser	As	sistive Devices
12	Disc injury						12	Manipulations	-	
13	Dislocation						13	Massage	1	Ankle brace
14	Epicondylitis						14	Mobilizations	2	Arch supports
15	Fracture						15	Motion control	3	Back brace
16	Frozen shoulder						16	Muscle stimulation	4	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
25	Cainal aard injury						1			