



Workers' Compensation Board

Alberta

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Triage: 4 5

PHYSICAL THERAPY

(C-534) Status Report

(C-535) Discharge Report

Worker's Surname			First Name			Initial			Date of Birth (Year / Month / Day)		
Address Street						City/Town			Province		
Postal Code			Telephone Number			Date of Accident (Year / Month / Day)			Is the worker working? <input type="checkbox"/> Yes <input type="checkbox"/> No		

WCB Claim Number
Personal Health Number

TREATMENTS (List Modalities, education, exercises, and home program)

TREATMENT DATES (MONTH/DAY)							
wk	sun	mon	tues	wed	thur	fri	sat
1							
2							
3							
4							

Describe changes in diagnoses and or status:	Diag Code	Diag Code	Diag Code

Treatment completed:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the worker have a job to return to?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FUNCTIONAL STATUS/OBJECTIVE MEASURES

(e.g. neurological / dural findings, ROM, strength, pain rating scale, weight bearing status)

Critical job demands met? Yes No Explain: _____

Current Status (check one only)

- Employment / Pre-Accident Level
- Employment / Modified Level
- Not Employed / Capable of Pre-Accident Level
- Not Employed / Capable of Modified Level
- Further Medical Investigation
- Further Treatment
- Discharged due to Non-Compliance/Non-Attendance
- Recommend RTW Assessment
- Other

Further therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of weeks	Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date (Year / Month / Day)
Any complicating factors / Barriers to return to work affecting recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:		
Is injury preventing worker from performing date of accident work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated date of return to pre-accident work (Year / Month / Day)		
Can "modified or alternate" work be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe work capability: (see over for definitions) <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy		
Any work restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:		
<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	Describe:		

Name and Address to whom fee is payable: (please print)	Provider's Signature:	
	Physical Therapist Name: (Please print)	
WCB Billing Number.	Date (Year / Month / Day)	Telephone Number

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

WORK DEFINITIONS

Modified	Alternate
<ul style="list-style-type: none">- a change in or adaptation of the date-of-accident work, based on the worker's capabilities.- may be temporary or permanent.	<ul style="list-style-type: none">- a different job with duties within the worker's capabilities..

WORK CAPABILITIES Definitions

Sedentary <ul style="list-style-type: none">- Lifting 10 lbs maximum- Occasional lifting and/or carrying	Medium <ul style="list-style-type: none">- Lifting 50 lbs. maximum- Frequent lifting and/or carrying up to 20 lbs.- May involve sitting with pushing and pulling or arm and/or leg controls
Light <ul style="list-style-type: none">- Lifting 20 lbs. maximum- Frequent lifting and/or carrying up to 10 lbs.- May require walking/standing to a significant degree- May involve sitting with pushing and pulling of arm and/or leg controls	Heavy <ul style="list-style-type: none">- Lifting 100 lbs. maximum- Frequent lifting and/or carrying up to 50 lbs. Very Heavy <ul style="list-style-type: none">- Occasional lifting in excess of 100 lbs.- Frequent lifting and/or carrying excess of 50 lbs.