

HOSPITAL PHYSICAL THERAPY C824 Status Report

C825 Discharge Report

Box 2415, Edmonton
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Triage: 1 2 3 4 5

WCB Claim Number _____
Personal Health Number _____

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? Yes No

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: Yes No
Does the worker have a job to return to? Yes 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 WAC
- Other

Further therapy? Yes No Number of weeks _____ Surgery? Yes No Date _____ (Year / Month / Day)

Any complicating factors / Barriers to return to work affecting recovery? Yes No Describe: _____

Is injury preventing worker from performing date of accident work? Yes No Estimated date of return to pre-accident work _____ (Year / Month / Day)

Can "modified or alternate" work be performed? Yes No Describe work capability: (see over for definitions)
 Sedentary Light Medium Heavy Very Heavy

Any work restrictions? Yes No Describe: _____
 Permanent Temporary Describe: _____

Name and Address to whom fee is payable: (please print) _____
Provider's Signature: _____
Physical Therapist Name: (Please print) _____
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.