wcb Workers' Compensation Board – Alberta

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C534
PT Abbreviated Progress/Discharge Report

WORKER DETAILS

Surname	First Name and Initial	Legal Gender ☐ Male ☐ Female	WCB Claim Number
			Date of Birth *(yyyy/mm/dd)*
Address Street	City/town	Province Postal Code	Telephone Number

Worker's Job Title/Occupation:	Progressive injury? ☐ Yes ☐ No	Date of Injury *(yyyy/mm/dd)*

Is the patient anticipated to have a successful return to work outcome within the authorized physiotherapy episode? ☐ Yes ☐ No

Recovery or return to work barriers? ☐ Yes ☐ No

- ☐ Hesitancy to return to work
- ☐ Not Job attached or lack of appropriate modified work
- ☐ Reported employee/employer issues
- ☐ Pain/impairment barriers beyond expectation for injury
- ☐ High perceived disability
- ☐ Fear of movement of activity
- ☐ Patient appears anxious or depressed
- ☐ Severe injuries with likely long term or permanent work restrictions
- ☐ Other (i.e non-compensable conditions) Explain:

Recommendations

- ☐ Case conference with WCB claim owner or WCB PT Consultant *(Specify)* _____
- ☐ Request additional documents _____
- ☐ Additional services in conjunction with community physiotherapy? _____
- ☐ Further medical investigations _____
- ☐ Return to work services _____
- ☐ Other, describe:

Has the patient received a home exercise program: ☐ Yes ☐ No

Describe:

Next report due: *(yyyy/mm/dd)*

Job Requirements?

If the patient is currently not working, can the patient return to work? ☐ Yes ☐ No

Complete the following. Please make a selection below as they relate to the injury:

Sitting	☐ Able	☐ Unable	☐ Limited to____Hours
Standing	☐ Able	☐ Unable	☐ Limited to____Hours
Walking	☐ Able	☐ Unable	☐ Limited to____Hours
Bending	☐ Able	☐ Unable	☐ Limited
Twisting	☐ Able	☐ Unable	☐ Limited
Kneeling/squatting	☐ Able	☐ Unable	☐ Limited
Climbing	☐ Able	☐ Unable	☐ Limited
Lifting	☐ Able	☐ Unable	☐ Limited, Max of____ (lbs/kg)
Pushing/pulling	☐ Able	☐ Unable	☐ Limited
Overhead reaching	☐ Able	☐ Unable	☐ Limited
Driving	☐ Able	☐ Unable	☐ Limited to____Hours

Other restrictions or additional comments/special considerations:

If not currently able to work, estimated return to modified work *(yyyy/mm/dd)*

Estimated return pre-accident work *(yyyy/mm/dd)*

Or ☐ Long-term temporary restrictions (>12 weeks) ☐ Permanent restrictions anticipated ☐ Unknown

What accommodations/modifications would support sustainable return to work?

☐ Workstation analysis ☐ Modified hours ☐ Modified duties ☐ Gradual return to work ☐ Other, describe:

Recommendations for a gradual return to work plan:

Patient is in agreement with return-to-work details? ☐ Yes ☐ No If no, explain:

Name and address to whom fee is payable: (Please print)	Signature	Physiotherapist Printed Name
	Telephone Number	Fax number
WCB Billing Number: _____	Clinic Email Address	Report Date *(yyyy/mm/dd)*

If you are a physiotherapy provider in Alberta and do not have a contract with WCB Alberta, please contact WCB Healthcare Strategy at hcs.physiotherapy@wcb.ab.ca to discuss provision of services.