Workers' Compensation Board – Alberta

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# C533
# PT FIRST REPORT

## WORKER DETAILS

| | | | |
|---|---|---|---|
| Legal Gender ☐ Male ☐ Female | | | WCB Claim Number |
| Surname | First Name and Initial | | 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) |
| Describe how and when the injury/condition occurred. | | | Date of Exam (yyyy/mm/dd) |

**Examination**
Diagnosis:

| | | |
|---|---|---|
| Diagnostic Code 1: | Diagnostic Code 2: | Diagnostic Code 3: |
| Part of body: | Side of body: | Nature of injury: |

Are you aware of any prior conditions in the same anatomical area? ☐ Yes ☐ No — If yes, describe

Symptoms:

Objective Findings:

Affected Movements Patterns

| Type | ROM Left (degrees) | ROM Right (degrees) | Strength |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| | | |
|---|---|---|
| Pain Scale: | Type of Pain: | Dominant Hand: ☐ Left ☐ Right |

Neurological exam normal? ☐ Yes ☐ No — If no, describe

Gait Normal? ☐ Yes ☐ No — If yes, describe

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| Surname | First Name | WCB Claim Number: |
|---|---|---|
| | | |

Any other findings
(Including functional status)?

Treatment Plan

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:

Surgery? ☐ Yes ☐ No  If yes, actual, or estimated date of surgery *(yyyy/mm/dd)*

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? ☐ Ÿ^• ☐ No  If yes, describe:

Treatment at your clinic complete? ☐ Yes ☐ No  If yes, discharge recommendations:

If no, what is the estimated discharge date from your clinic? *(yyyy/mm/dd)*

Has the patient missed work beyond the date of accident? ☐ Yes ☐ No  Has the patient returned to work? ☐ Yes ☐ No  If yes, date returned *(yyyy/mm/dd)*

If returned to work, what is the patient's current work status? ☐ Full duties and hours ☐ Modified Hours ☐ Modified duties

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:

| Activity | | | |
|---|---|---|---|
| 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

☐ Long Term Temporary restrictions (>12 weeks) ☐ Permanent restrictions anticipated ☐ Unknown

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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)* |

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