

Physiotherapy/ Occupational Therapy Progress Report – Form B

WSCC Claim Number

Worker Information

Last Name			First Name			Middle Initial	Date of Birth YYYY	MM	DD
Date of Injury YYYY	MM	DD	Is the worker working? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe: Modified duties <input type="checkbox"/> Pre-injury work <input type="checkbox"/>						
Case Conference scheduled? Yes <input type="checkbox"/>	Date YYYY	MM	DD	No <input type="checkbox"/> Reason:					

Summary

Current/Reassessment Date YYYY	MM	DD	Number of Treatments	Overall Functional Progress Improving <input type="checkbox"/> No change <input type="checkbox"/> Declining <input type="checkbox"/>
Comments				

Health Care Provider Information

Provider Name		Practitioner ID Number
Practitioner Name	Phone	Fax

Injury Assessment Information

Medical Disability Advisor (MDA) Diagnosis (specify body part)							
Diagnosis Change Yes <input type="checkbox"/> No <input type="checkbox"/>		Sprain/Strain Yes <input type="checkbox"/> No <input type="checkbox"/>		Disability Duration Guidelines YYYY	MM	DD	
Form C – Functional Abilities Report attached? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, why?							
Are there flags/indicators that influence duration? Yes <input type="checkbox"/> No <input type="checkbox"/>							
Expected Return to Work YYYY		MM	DD	Pre-injury Duties Start Date YYYY		MM	DD
<input type="checkbox"/> Modified Duties Start Date							

Job Match Summary

Pre-injury Job Requirements Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy <input type="checkbox"/>					
Present Work Capability Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy <input type="checkbox"/> N/A <input type="checkbox"/>					
Modified Duties Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy <input type="checkbox"/>					

Collaborative Treatment Plan

Goals/Methodology	Progress Related to Goals	Recommended Time Frame			
		From	YYYY	MM	DD
		To	YYYY	MM	DD
		From	YYYY	MM	DD
		To	YYYY	MM	DD
		From	YYYY	MM	DD
		To	YYYY	MM	DD
Additional Requests/Recommendations					

The WSCC may use this information for the administration of legislation under our authority, including the *Workers' Compensation Acts*, the *Safety Acts*, and/or the *Mine Health and Safety Acts*, and their associated *Regulations*, and to contact you in relation to the requirements under the relevant legislation. It is your responsibility when providing an email address to ensure reasonable safeguards are in place to protect the confidentiality and security of your personal information within your email account.

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or

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