# PTI USER MANUAL

**Physiotherapist's Initial Report** **WCB Claim No.:** _____

**Clinic No.:** _____ **PT No.:** _____ **Personal Health No.:** _____

**Phone No.:** _____ **Fax No.:** _____ **Date of Birth:** _____ **Phone #** _____

**Employer Name:** _____

Physiotherapist's Name, Address, Postal Code

Print/stamp/sticker

Worker Name, Address, Postal Code

Print/stamp/sticker

**Clinic Name:** _____

*(The physical therapist will not have an individual number. Leave this blank. The clinic billing number should be filled in. The employer to be included in above should be the pre-injury employer. It is understood that there may be some instances where the current employer is different from the pre-injury employer. It is requested that this section only include the pre-injury employer)*

**1. Injury Date:** _____dd/mm/yyyy_____ **2. Date of initial exam** _____dd/mm/yyyy_____

**3. Part of body injured** _____ **4. Diagnosis** _____

**5. Mechanism of injury** *(Where possible please be as specific as possible)*

**6. Subjective complaints** *(Include quantifiable measures where possible i.e. Numeric pain scale rating)*

**7. Objective findings** *(Include quantifiable measures where possible i.e. Range of motion, straight leg raise testing, manual muscle testing, deep tendon reflex testing.)*

**8. Treatment goals** *(Please use goals that are functional including return to work)*

**9. Assessment of recovery status (0-10)**____(0= no recovery, 10=recovered to preinjury)

*(The assessment of recovery is a measure that asks the provider to summarize available information to provide an estimate of the expectation of recovery within typical primary timelines. The clinician is asked to incorporate clinical findings, self-report measure change, objective functional change where testing is appropriate as well as possible psychosocial issues. A score between 0 and 10 representing no recovery and 10 representing recovery to pre-injury status is established. This score will represent the practitioners' assessment of the complexity of this primary worker's presentation and potential for recovery.)*

**10. Intensity Score:** *(0= An injured worker who displays medical and psychological factors that will allow successful outcome with average treatment resources. 1= An injured worker who requires a high level of complex treatment programming to achieve a successful outcome with average treatment resources.)*

**11. Treatment Plan** ☐**Chiropractic** ☐**Massage** ☐**Biomechanical** ☐**Electrophysical**

☐**Regional conditioning, Supervised**____**Home** ____ ☐**Supervised global conditioning** ☐**Transitional RTW**

☐**Other** *(This section is meant to communicate services that you understand to be part of the current treatment plan. Also, please identify if you are aware of other caregivers who are involved in the care of the worker even if you didn't refer to these practitioners.)*

**12. Frequency of treatment:**_____**per week 13. Expected number of treatments to discharge** *(This should represent the total expected number of treatments to discharge)*

**14. Have you advised the patient to be off work due to the injury** ☐**Yes** ☐**No**

**If NO, is the patient to be working with restrictions** ☐**Yes** ☐**No**

**15. Are you aware of previous injury/treatment for this area** ☐**No** ☐**Yes Time Frame(s):** *(This is dependent on the worker's recall of previous injuries. Therefore, the year of injury is satisfactory.)*

**16. Self-Report (score) Roland Morris_____Quick Dash_____QD Work module_____NDI_____LEFS _____**

*(The self-report measures have been developed based on instruments that were reviewed at the Outcome Measures Workshop in May 2006. The instruments chosen are based on body parts involved i.e. Roland Morris for thoracic and lumbar spine, Quick Dash for upper quadrant, and NDI for cervical spine and LEFS for lower quadrant injuries. It is mandatory to use the instruments described above. Please include the raw score for the initial measure when providing the information about the self-report measure)*

**17. Restrictions ☐Subjective ☐Measured**

**☐lifting (# of lbs.) ____ ☐pushing/pulling (# of lbs) ____ ☐reaching**

**☐overhead reaching ☐turning ☐walking_____ ☐stairs ☐ladders ☐standing (# of hrs) _____**

**☐sitting (# of hrs) ____ ☐environment_____☐ other_____**

**Client and practitioner agreed ☐Yes ☐No** *(Explain in comments)*

*(Use the boxes above to indicate if the restrictions that are provided are based on functional testing (where appropriate) or by client perception of function in combination with clinical judgment. If you have already advised that the worker is not suitable for work of any kind at this time (question 14), then the restriction sections should be left blank. Your rationale for indicating the worker's inappropriateness for return to work of any kind should be included in the comments section.)*

**18. Effects of the injury may affect work activity for: # of days ☐<8 ☐8-14☐15-21** ☐>21 **RTW Date _____**

**19. Has a RTW been discussed with the worker? ☐Yes ☐No the employer? ☐Yes ☐No**

**20. Has a transitional RTW been arranged? ☐Yes, TRTW start date _____ ☐No** *(Explain barriers in the comments section)*

**21. Are there any specific safety concerns in a TRTW ☐No ☐Yes** *(If Yes, explain in the comments section. If there are concerns expressed by the physical therapist regarding medication, a discussion between the physical therapist and physician regarding return to work issues should be initiated and should be commented on in the comments section below)*

**22. Comments _____**

_____

_____

**Signature_____Date:_____Copy to _____**