WCB Workers Compensation Board of Manitoba

Please FAX this form IMMEDIATELY
Winnipeg: 954-4999
Toll free: 1-877-872-3804
333 Broadway • Winnipeg R3C 4W3
Telephone 954-4922 • Toll free 1-800-362-3340

Physiotherapy Progress/ Discharge Assessment

☐ **Progress Report** ☐ **Discharge Form**

Claim No.

Worker Information

Last Name	First Name			
Address	City	Province	Postal Code	Date of Incident DD / MM / YYYY
Date of Birth DD / MM / YYYY	Job Title			Date of Examination/Treatment DD / MM / YYYY

Injury Details

Area of Injury	Request for examination with WCB Physiotherapy Consultants? ☐ Yes ☐ No
Any changes in diagnosis? ☐ Yes ☐ No If yes, state new diagnosis	

Examination Findings & Diagnosis

Current Subjective Complaints

Self Assessment Tool (check tools used - minimum of 2)	Score:		Score:
☐ Numeric Pain Rating Scale (NPRS)	_____	☐ Lower Extremity Activity Profile (LEFS)	_____
☐ Roland Morris Back Pain Questionnaire (back)	_____	☐ Disabilities of the Arm, Shoulder and Hand (DASH)	_____
☐ Neck Disability Index (neck)	_____	☐ Health Status Disability	_____

Current Objective Findings - Impairments

Extension Request

- Anticipated Treatment: _____ / week X _____ weeks
- Rationale for further treatment :

Discharge

- Status at discharge:
- Reason for discharge:

Is recovery satisfactory? ☐ Yes ☐ No If no, what are the complications/other factors impeding progress?

Were findings/recommendations discussed with worker? ☐ Yes ☐ No

Was home program provided? ☐ Yes ☐ No If yes, specify:

Work Capabilities

Will Worker be disabled from work beyond the date of incident as a result of the injury? ☐ Yes ☐ No	When can worker return to regular duties? Date DD / MM / YYYY ☐ Unknown at time of examination
Is Worker capable of alternate or modified work? ☐ Yes ☐ No If yes, outline restrictions:	
Duration of restrictions: _____ weeks	

Therapist Information

Therapist Name			Telephone No. ( )	Fax No. ( )
Facility Name			Email	Date DD / MM / YYYY
City	Province	Postal Code	Therapist Signature	

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