



Please FAX this form IMMEDIATELY

Winnipeg: 954-4999

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333 Broadway • Winnipeg R3C 4W3  
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Physiotherapy Progress/  
Discharge Assessment

Progress Report  Discharge Form

Claim No.

Worker Information

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

Injury Details

Area of Injury	Request for examination with WCB Physiotherapy Consultants? <input type="checkbox"/> Yes <input type="checkbox"/> No
Any changes in diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state new diagnosis	

Examination Findings & Diagnosis

Current Subjective Complaints	
Self Assessment Tool (check tools used - minimum of 2)	Score: _____
<input type="checkbox"/> Numeric Pain Rating Scale (NPRS)	<input type="checkbox"/> Lower Extremity Activity Profile (LEFS)
<input type="checkbox"/> Roland Morris Back Pain Questionnaire (back)	<input type="checkbox"/> Disabilities of the Arm, Shoulder and Hand (DASH)
<input type="checkbox"/> Neck Disability Index (neck)	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what are the complications/other factors impeding progress?	
Were findings/recommendations discussed with worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was home program provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:	

Work Capabilities

Will Worker be disabled from work beyond the date of incident as a result of the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	When can worker return to regular duties? Date DD / MM / YYYY <input type="checkbox"/> Unknown at time of examination
Is Worker capable of alternate or modified work? <input type="checkbox"/> Yes <input type="checkbox"/> 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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