CNESST

PHYSIOTHERAPY AND OCCUPATIONAL THERAPY CARE OR TREATMENT ACCOUNT

Occupational health and safety

☐ Physiotherapy ☐ Occupational therapy Worker's file No.

Identification of the worker

Surname (as shown on birth certificate)	First name	Health insurance No.
Postal code	Date of original event Y Y Y Y M M D D	Date of recurrence, relapse or aggravation Y Y Y Y M M D D

Physician

Physician in charge of the worker	Permit No.
Name of the clinic (or health institution)	Date of the prescription Y Y Y Y M M D D

1. Diagnosis

2. Diagnosis requiring consultation in occupational therapy before the 6th week from the date of the event?
☐ Yes ☐ No

3. Consultation in occupational therapy before the 6th week from the date of the event indicated by the physician in charge?
☐ Yes ☐ No

4. More than 3 treatments per week indicated by the physician in charge?
☐ Yes ☐ No

Information on the supplier

Name of the clinic (or health institution)		Supplier No.
5 Transfer from clinic (or health institution) ☐ Yes ☐ No	Telephone	Fax

6 Indicate the care and treatment or services rendered by using the appropriate codes available on the Website of the CNESST.

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Specify the date of the last treatment or last absence if it is the cause of the end of the treatment — Date of the end of treatment Y Y Y Y M M D D

Health worker

Name of the member of the professional order who made the initial evaluation	Member No.
Signature	Date Y Y Y Y M M D D
Name of the member of the professional order who provided treatment	Member No.
Signature	Date Y Y Y Y M M D D
Name of the member of the professional order who provided treatment	Member No.
Signature	Date Y Y Y Y M M D D