

PHYSIOTHERAPY AND OCCUPATIONAL THERAPY CARE OR TREATMENT ACCOUNT

Occupational health and safety

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Identification	of the worker																																
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Section (1) Mail continuity														Ιï	Toda			CAT TO															
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Postal code								Date of original event Date											of recurrence, relapse or aggravation														
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Health profess	sional sional in charge o	f the	w	orke	r															P	em	nit No.											
Name of the cli	nic (or health institu	tion)																		D	ate reso	e of the scription											
1 Diagnosis																																	
2 Diagnosis r	equiring consultatio	n in c	occ	upati	onal	the	rapy	bef	ore	the (6th v	weel	k fro	m th	ie (date o	of the	e ev	ent′)							_						
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3 Consultation in occupational therapy before the 6th week from the date of the event indicated by the health professional in charge? Yes No																																	
More than 3	3 treatments per we	ek in	dic	ated	by th	ne h	ealt	h pr	ofe	ssic	onal	in (chai	rge	?												_						
Yes	No																																
Information or	the supplier																																
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Transfer fro	m clinic (or health i	nstitu	rtio	n)	Y	es	П	No					T	elep	ho	ne						Fax											
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Specify the date	e of the last treatme	nt or	las	st abs	senc	e							-														Ť	7					
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Health worker																																	
	alth worker me of the member of the professional order who made the initial evaluation															Member No.																	
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Signature																						Date Y Y Y M M D D											
Name of the me	ember of the profes	siona	al o	rder	who	prov	rideo	d tre	atm	ent												Member No.											
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Signature																						Date VYYY MM DDD											