

1 Date of request for report

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Worker's file No.

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Identification of the worker			
Surname (as shown on birth certificate)	First name	Date of original event	
Profession or trade practised at the time of event	Postal code	Date of recurrence, relapse or aggravation	
2 Diagnosis	Left-handed <input type="checkbox"/>	Sex	Health insurance No.
	Right-handed <input type="checkbox"/>	F <input type="checkbox"/> M <input type="checkbox"/>	
Physician			
Physician in charge of the worker		Permit No.	Date of the prescription
Name of the clinic (or health institution)			Telephone
Information on the supplier			
Name of the clinic (or health institution)			Supplier No.
Date of initial evaluation	Number of treatments provided to this day:	Telephone	Fax
Name of the member of the Ordre professionnel de la physiothérapie du Québec who completed the report			Member No.
3 Subjective data (worker's perceptions)			
Intensity of the pain felt: at rest ____/10 in movement ____/10 by palpation ____/10			
Positions or movements affected:			
According to the worker, are daily activities impeded by the employment injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, describe.			
According to the worker, are work activities impeded by the employment injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, describe.			
Worker's perception of his or her return to work as before the injury:			
Worker's perception of his or her evolution: Improvement ____% Stable <input type="checkbox"/> Deterioration ____%			
Other data			

4 Objective clinical data (examination). Fill out both sections: **Initial condition** and **Current condition**.

Initial condition (or at the time of last report sent to the CNESST)	Current condition
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Objective clinical data (neurologic, signs, joint mobility, muscular force, muscular endurance, œdema, atrophy, etc.)	Objective clinical data (neurologic, signs, joint mobility, muscular force, muscular endurance, œdema, atrophy, etc.)

5 Functional data and Ordre professionnel de la physiothérapie du Québec member's opinion. Fill out both sections: **Initial condition** and **Current condition**.

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Observations (presence of mixed signals, sensitivity, balance, etc.)																																																																																																																																													
Have you discussed return to work arrangements with the worker? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify. If not, why?																																																																																																																																													

Functional data and Ordre professionnel de la physiothérapie du Québec member's opinion (cont'd)

Describe the evolution of the **obstacles** to the return to work, if applicable (physical condition or personal and environmental factors or others).

Describe the evolution of the **levers** for the return to work, if applicable (physical condition or personal and environmental factors or others).

7 Treatment plan

Active conditions:

Passive conditions:

8 Worker's condition

Improvement _____% Stable Deterioration _____%

Do you recommend the end of treatment? Yes No

If **yes**, what is the real or planned date of the end of treatment?

Y	Y	Y	Y	M	M	D	D
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What are the residual difficulties? N/A

If **no**, how many additional treatments are you planning?

Planned frequency of treatments: _____ / week Other:

What are the functional objectives pursued by the additional treatments?

Comments / Recommendations

Signature of the member of the Ordre professionnel de la physiothérapie du Québec who completed the report Date

Y	Y	Y	Y	M	M	D	D
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1 Date of request for report

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Objective clinical data (neurologic, signs, joint mobility, muscular force, muscular endurance, oedema, atrophy, etc.)	Objective clinical data (neurologic, signs, joint mobility, muscular force, muscular endurance, oedema, atrophy, etc.)

5 Functional data and occupational therapist's opinion. Fill out both sections: **Initial condition** and **Current condition**.

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Participation of worker during evaluation (cooperation, interest, effort, regularity). Specify:																																																																																																																																					
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Functional data and occupational therapist's opinion. (cont'd)

Analysis of interactions between personal, environmental and work factors that constitute **levers** for the return to work, if applicable.

Opinion of occupational therapist on the return to work and on the performance of daily activities. Specify:

Have you discussed return to work arrangements with the worker? Yes No
If yes, specify. If not, why?

7 Treatment plan

Active conditions:

Passive conditions:

8 Worker's condition

Improvement _____% Stable Deterioration _____%

Do you recommend the end of treatment? Yes No

If **yes**, what is the real or planned date of the end of treatment?

What are the residual difficulties? N/A

If **no**, how many additional treatments are you planning?
Planned frequency of treatments: _____ / week Other:
What are the functional objectives pursued by the additional treatments?

Comments / Recommendations

Signature of the member of the OEQ who completed the report

Date