PHYSIOTHERAPY REPORT
Occupational health and safety

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

Worker's file No.

Identification of the worker

Surname (as shown on birth certificate)	First name	Date of original event Y Y Y Y M M D D
Profession or trade practised at the time of event	Postal code	Date of recurrence, relapse or aggravation Y Y Y Y M M D D
2 Diagnosis	Left-handed ☐ Right-handed ☐ Sex F ☐ M ☐	Health insurance No.

Health professional

Health professional in charge of the worker	Permit No.	Date of the prescription Y Y Y Y M M D D
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 Y Y Y Y M M D D	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? ☐ Yes ☐ No ☐ N/A

If yes, describe.

According to the worker, are work activities impeded by the employment injury? ☐ Yes ☐ No ☐ 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 ☐ 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**
Date of examination Y Y Y Y M M D D	Date of examination Y Y Y Y M M D D
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**.

6 Initial condition (or at the time of last report sent to the CNESST)

Date of examination Y Y Y Y M M D D

	Minutes	Hours	
Standing:	______	______	☐ N/A
Sitting:	______	______	☐ N/A
Crouching:	______	______	☐ N/A
Kneeling:	______	______	☐ N/A
Walking:	______	______	☐ N/A

Stairs: ☐ 5 à 10 steps ☐ +10 steps ☐ N/A

Pushing: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Pulling: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Grip strength: ______ kg N/A ☐

Handling: ________________________ ☐ N/A

Lifting loads: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Moving loads: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Other functional data:

Current condition

Date of examination Y Y Y Y M M D D

	Minutes	Hours	
Standing:	______	______	☐ N/A
Sitting:	______	______	☐ N/A
Crouching:	______	______	☐ N/A
Kneeling:	______	______	☐ N/A
Walking:	______	______	☐ N/A

Stairs: ☐ 5 à 10 steps ☐ +10 steps ☐ N/A

Pushing: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Pulling: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Grip strength: ______ kg N/A ☐

Handling: ________________________ ☐ N/A

Lifting loads: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Moving loads: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Other functional data:

Observations (presence of mixed signals, sensitivity, balance, etc.)

Have you discussed return to work arrangements with the worker? ☐ Yes ☐ 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

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

CNESST

OCCUPATIONAL THERAPY REPORT

Occupational health and safety

1 Date of request for report | Worker's file No.

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 / Right-handed / Sex F M	Health insurance No.

Health professional

Health professional 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 des ergothérapeutes 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? Yes No N/A

If yes, describe.

According to the worker, are work activities impeded by the employment injury? Yes No 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 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**
Date of examination Y Y Y Y M M D D	Date of examination Y Y Y Y M M D D
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 occupational therapist's opinion. Fill out both sections: **Initial condition** and **Current condition**.

6 **Initial condition** (or at the time of last report sent to the CNESST)

Date of examination Y Y Y Y M M D D

	Minutes	Hours	
Standing:	______	______	☐ N/A
Sitting:	______	______	☐ N/A
Crouching:	______	______	☐ N/A
Kneeling:	______	______	☐ N/A
Walking:	______	______	☐ N/A

Stairs: ☐ 5 à 10 steps ☐ +10 steps ☐ N/A

Pushing: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Pulling: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Grip strength: ______ kg N/A ☐

Handling: ______________________ ☐ N/A

Lifting loads:
☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Moving loads:
☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Other functional data:

Current condition

Date of examination Y Y Y Y M M D D

	Minutes	Hours	
Standing:	______	______	☐ N/A
Sitting:	______	______	☐ N/A
Crouching:	______	______	☐ N/A
Kneeling:	______	______	☐ N/A
Walking:	______	______	☐ N/A

Stairs: ☐ 5 à 10 steps ☐ +10 steps ☐ N/A

Pushing: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Pulling: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Grip strength: ______ kg N/A ☐

Handling: ______________________ ☐ N/A

Lifting loads:
☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Moving loads:
☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A

Other functional data:

Observations (presence of mixed signals, sensitivity, balance, etc.)

Participation of worker during evaluation (cooperation, interest, effort, regularity). Specify:

Analysis of interactions between personal, environmental and work factors that pose **obstacles** to the return to work, if applicable.

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? Y Y Y Y M M D D

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 Y Y Y Y M M D D