Physical Treatment Plan

Return To ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6

Fax 1-877-686-4222

CLIENT INFORMATION

CLAIM NUMBER	FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)

PRACTITIONER INFORMATION

CLINIC NAME		VENDOR NUMBER
PRACTITIONER FIRST NAME	**PRACTITIONER LAST NAME**	**PRACTITIONER NUMBER**

TREATMENT PLAN INFORMATION

DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF TREATMENT PLAN (dd/mmm/yyyy)

PRACTITIONER/THERAPIST TYPE (select one from list)

PATIENT PERSPECTIVE/RATINGS

1. How well does the patient feel they are recovering from their injuries since this accident?

☐ completely better ☐ much improved ☐ slightly improved ☐ no change ☐ slightly worse ☐ much worse ☐ worse than ever

2. Key subjective findings – (Optional)

3. Is the patient currently missing? (check all that apply)

SELECT IF THE PATIENT IS ABSENT FROM EITHER WORK OR SCHOOL THAT THEY WERE PARTICIPATING IN PRIOR TO THE INJURY:

☐ Work ☐ School

OBJECTIVE FINDINGS

4. How is the patient functionally progressing with treatment?
Please select at least one functional goal for the patient's return to work, return to activities of daily living, or return to school.

RETURN TO WORK:

First Functional Goal:

Second Functional Goal:

Third Functional Goal:

Initial/previous findings:

Current findings:

Overall Progress Towards Goal:

☐ Resolved ☐ Improved Significantly ☐ Improved Moderately ☐ Improved Minimally ☐ Unchanged ☐ Regressed

RETURN TO ACTIVITIES OF DAILY LIVING:

First Functional Goal:

Second Functional Goal:

Third Functional Goal:

Initial/previous findings:

Current findings:

Overall Progress Towards Goal:

☐ Resolved ☐ Improved Significantly ☐ Improved Moderately ☐ Improved Minimally ☐ Unchanged ☐ Regressed

RETURN TO SCHOOL:
First Functional Goal:

Second Functional Goal:

Third Functional Goal:

Initial/previous findings:

Current findings:

Overall Progress Towards Goal:

☐ Resolved ☐ Improved Significantly ☐ Improved Moderately ☐ Improved Minimally ☐ Unchanged ☐ Regressed

5. What treatment modalities will be used to achieve these goals? (check all that apply)

SPECIALITY (only applicable to relevant providers):

☐ Vestibular ☐ Concussion ☐ Spinal Cord ☐ Neurological ☐ Hand Therapy ☐ Complex MSK ☐ Mobile/Community

PASSIVE MODALITIES:

☐ Massage ☐ Manipulation ☐ Manual therapy ☐ Active release ☐ Acupuncture ☐ IMS/dry needling ☐ Ultrasound
☐ Electro-modalities ☐ Shockwave ☐ Laser ☐ Mechanical traction

ACTIVE MODALITIES:

☐ Stretching ☐ Range of motion ☐ Hydrotherapy ☐ Cardiorespiratory ☐ Strengthening ☐ Work simulation

SELF-MANAGEMENT:

☐ Home exercises:
☐ Community/on-field training:
☐ Self-management techniques/equipment:
☐ Bracing:
☐ Education:
☐ Other:

6. Any barriers delaying the patient's treatment progress? Additional Comments

7. Recommended Treatment

NUMBER OF TREATMENT SESSIONS (Completed to Date)	NUMBER OF APPROVED SESSIONS REMAINING	CURRENT TREATMENT FREQUENCY
NUMBER OF ADDITIONAL TREATMENT SESSIONS (Requested)	ANTICIPATED END DATE OF RECOMMENDED TREATMENT	RECOMMENDED TREATMENT FREQUENCY

8. Do you expect the patient to return to a pre-accident level of function at the end of this recommended treatment?

Comments:

Your contact preference? ☐ Email ☐ Phone

Provide an email address or phone number in case we need to contact you

EMAIL	PHONE

This form must be completed in full. Incomplete Treatment Plans may result in delays and impact treatment funding approval.

☐ I certify that the information provided is true and correct to the best of my knowledge and that this Treatment Plan has been completed by a treating therapist.

Providing false or misleading information may result in the cancellation of your vendor number, and ICBC may seek financial restitution and/or take legal action.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.