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Nurse Practitioner Report

This form is to be completed by the primary care provider, whenever possible.

If applicable, please select the Lock button before submitting the form.
Please note: once the Lock button has been selected, the form will no longer be editable.

CLAIM INFORMATION		
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF NP REPORT (dd/mmm/yyyy)

PATIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER

ARE YOU THE PATIENT'S REGULAR PRACTITIONER?

☐ Yes ☐ No

SUBJECTIVE

KEY SUBJECTIVE FINDINGS:

RELEVANT PRE-ACCIDENT HISTORY

HAS YOUR PATIENT EVER HAD SYMPTOMS AND/OR RECEIVED TREATMENT/MEDICATIONS FOR THE AREA(S) INJURED IN THIS ACCIDENT?

☐ Yes ☐ No

IF YES, DESCRIBE CONDITIONS/TREATMENT AND POSSIBLE IMPACT, IF ANY, ON RECOVERY:

OBJECTIVE

KEY OBJECTIVE FINDINGS:

Diagnosis

PRIMARY DIAGNOSIS — IDENTIFY THE MOST SERIOUS OR SIGNIFICANT INJURY			
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None
OTHER DIAGNOSIS — IDENTIFY ANY ADDITIONAL INJURIES THE PATIENT HAS SUSTAINED			
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None
DIAGNOSIS	ICD 9 CODE	DEGREE/GRADE (WAD, SPRAIN, STRAIN)	ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None

WORK STATUS

IS THE PATIENT EMPLOYED OR ENGAGED IN TRAINING ACTIVITIES? PLEASE INDICATE WHICH ONE(S)

☐ Full time ☐ Part time ☐ Self-employed ☐ Seasonal ☐ Training/Apprenticeship ☐ Student ☐ Retired ☐ Not employed

HAS THE PATIENT BEEN ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?

Work: ☐ Yes ☐ No Training: ☐ Yes ☐ No School/Studies: ☐ Yes ☐ No

If the patient is continuing to work, study or train, indicate their status, as applicable

STATUS OF DUTIES

Work: ☐ Full ☐ Modified Training: ☐ Full ☐ Modified Study: ☐ Full ☐ Modified

STATUS OF HOURS

Work: ☐ Full ☐ Modified Training: ☐ Full ☐ Modified Study: ☐ Full ☐ Modified

PROVIDE REASONS WHY THE PATIENT IS NOT WORKING, TRAINING OR STUDYING IF APPLICABLE

Recommended Care Plan Treatment

RECOMMENDED TREATMENT(S) – INDICATE WHICH TREATMENT(S) ARE APPROPRIATE TO ADDRESS THE PATIENT'S INJURY/INJURIES

TREATMENT TYPE

TREATMENT TYPE

TREATMENT TYPE

TREATMENT NOTES

DO YOU EXPECT THE PATIENT TO RETURN TO NORMAL FUNCTION WITH THE ABOVE RECOMMENDED TREATMENT PLAN?

☐ Yes ☐ No ☐ Unable to determine

IF "NO" OR "UNABLE TO DETERMINE", PROVIDE COMMENTS:

7. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES?

☐ Yes ☐ No

IF YES, INDICATE:

ANTICIPATED DATE OF FULL RECOVERY (dd/mmm/yyyy)

Patient Education – check any/all that have been communicated to the patient

In accordance with evidence informed best practice, and as applicable to the injuries sustained by the patient, the patient has received education with respect to:

- ☐ the desirability of an early return, without limitation, to being able to perform the activities the patient could perform before the injury and if applicable, to the patient's employment, training or study
- ☐ an estimate of the probable length of time that symptoms will last
- ☐ the usual course of recovery
- ☐ the probable factors that are responsible for the symptoms the patient may be experiencing
- ☐ appropriate self-management and pain management strategies

☐ By checking this box, I certify that the information provided is true and correct to the best of my knowledge.

Select one of the following:

- ☐ I have obtained consent from the patient to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.
- ☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

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.

Return To ICBC
PO BOX 2121, STN TERMINAL
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