

## Family Physician (FP) Extended Medical 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.

Complete this form if the patient is **NOT ABLE** to complete work, training or studying activities.

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INVOICE INFORMATION	oice once received by ICBC. There is r	no nood to submit a sonarato invoico				
			VENDODAHUMBED			
CLAIM NUMBER	DATE OF CRASH (dd/mmm/yyyy)	DATE OF FP REPORT (dd/mmm/yyyy)	VENDOR NUMBER			
INVOICE/REFERENCE NUMBER	PAYEE NAME	PAYEE NAME				
PAYEE ADDRESS						
PAYEE ADDRESS						
PATIENT INFORMATION						
FIRST NAME		LAST NAME				
DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)	INTERPRETER REQUIRED?				
		103 1140				
PHYSICIAN INFORMATION						
FIRST NAME		LAST NAME				
MSP/PRACTITIONER NUMBER		ARE YOU THE PATIENT'S REGULAR PHYSIC	CIAN?			
SUBJECTIVE (OPTIONAL)						
RELEVANT PRE-CRASH HISTORY						
	S AND/OR RECEIVED TREATMENT/MEDICATION	NS FOR THE AREA(S) INJURED IN THIS CRASH?				
☐ Yes ☐ No	O AND/OTTIEGEIVED THEATMENT/MEDICATION	NOTOTI THE AHEA(O) INVOITED IN THIS SHASH!				
IF YES, DESCRIBE CONDITIONS/TREATMENT	「AND POSSIBLE IMPACT, IF ANY, ON RECOVEF	łY:				
2. ARE THERE OTHER MEDICAL CONDITIONS  Yes No	S (non-crash related) THAT ARE CONTRIBUTING	TO THE CURRENT DIAGNOSIS OR SYMPTOMS?				
IF YES, PROVIDE COMMENTS:						

3. HAS THE PATIENT HAD ANY MEDICAL INVESTIGATIONS AND/OR REFERRALS TO PHYSICIANS PROVIDING SPECIALIZED SERVICES FOR INJURIES SUSTAINED AS A RESULT OF THE CRASH?  Yes \( \Bigcap \text{No} \)					
IF YES, PROVIDE DETAILS:					
VOCATIONAL STATUS  4. 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 ☐ Homemaker/caregiver ☐ Not employed					
PATIENT'S JOB POSITION, AS APPLICABLE					
5. IS THE PATIENT ABSENT FROM THE FOLLOWING AS A RESULT OF THE CRASH?  Work:  Yes  No Training:  Yes  No School/Studies:  Yes  No	Homemaking/caregiving: ☐ Yes ☐ No				
If the patient is continuing to work, study, train, or provide homemaking/care	giving, indicate their status, as applicable				
6. STATUS OF DUTIES  Work: ☐ Full ☐ Modified Train: ☐ Full ☐ Modified Study: ☐ Full ☐ Mod	dified Homemaking/caregiving: ☐ Full ☐ Modified				
7. STATUS OF HOURS  Work:  Full Modified Train:  Full Modified Study:  Full Modified Homemaking/caregiving:  Full Modified					
If the patient is currently off work or working modified hours/duties, complete	e the following section				
8. CAN THE PATIENT PERFORM ALL REGULAR DUTIES AND REGULAR HOURS?  Yes No					
If patient cannot perform all regular duties at regular hours					
9. WHAT ARE THE PATIENT'S SPECIFIC DUTIES OR PHYSICAL DEMANDS THAT CANNOT BE PERF	ORMED? PLEASE SPECIFY THE DEGREE OF IMPACT				
_					
TO DICADILIDY CTADT DATE (All const.)	ANTIQUATED DIGABILITY FND DATE (44/				
10. DISABILITY START DATE (dd/mmm/yyyy)	11. ANTICIPATED DISABILITY END DATE (dd/mmm/yyyy)				
12. DO YOU SUPPORT A GRADUATED RETURN TO WORK PROGRAM?  ☐ Yes ☐ No					
IF YES, WHEN IS THE EARLIEST ANTICIPATED START DATE? (dd/mmm/yyyy)	DURATION (indicate the number of weeks)  Weeks				
13. DOES THE PATIENT REQUIRE ANY SPECIALIZED SERVICES OR ADAPTIVE EQUIPMENT TO FAC					
Yes No					
IF YES, WHAT TYPE OF SPECIALIZED SERVICE(S) OR ADAPTIVE EQUIPMENT IS REQUIRED?					
AVOCATIONAL STATUS					
14. AVOCATIONAL STATUS (e.g. activities of daily living)					
15. IS THE PATIENT CURRENTLY UNABLE TO ENGAGE IN THEIR PRE-CRASH AVOCATIONAL ACTIVITIES?					
☐ Yes ☐ No  IF YES, WHAT IS THE EARLIEST DATE THE PATIENT COULD RETURN TO THEIR AVOCATIONAL ACTIVITIES?					
16. IF THE PATIENT IS CONTINUING TO ENGAGE IN THEIR AVOCATIONAL ACTIVIITES, INDICATE THEIR STATUS, AS APPLICABLE					
Duties: ☐ Regular ☐ Modified Hours: ☐ Regular ☐ Modified  If modified, provide additional details explaining reasoning and recommendations					

Assessment (See drop down option for list of most commonly used codes)

PRIMARY DIAGNOSIS — IDENTIFY THE MOST SERIOUS OR SIGNIFICANT INJURY						
NATURE OF INJURY	BODY PART	ORIENTATION	ICD 9 CODE	ADDITIONAL COMMENTS		
OTHER DIAGNOSIS -	IDENTIFY ALL OTHER RE	LEVANT DIAGNOSES CAUSED	BY OR RELATED TO THE C	RASH		
NATURE OF INJURY	BODY PART	ORIENTATION	ICD 9 CODE	ADDITIONAL COMMENTS		
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INATORE OF INJURY	BODITANI	Officialion	IOD 3 OODE	ADDITIONAL CONNICTION		
NATURE OF INJURY	BODY PART	ORIENTATION	ICD 9 CODE	ADDITIONAL COMMENTS		
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Key Objective Fi	ndings (Optional)					
PHYSICAL EXAM						
KEY OBJECTIVE COMPLAII	NTS					
MEDICAL RESTRICTIONS AND/OR LIMITATIONS						
17. DESCRIBE ANY MEDICAL RESTRICTIONS OR LIMITATIONS						
	IS/LIMITATIONS	ary Permanent				
Provide details						
BARRIERS TO RECOVERY (including Functional, Physical, Psychosocial, Employer, Medical or Compliance)						

## **Recommended Care Management Plan**

19. PROVIDE MANAGEMENT RECOMMENDATIONS INCLUDING WHICH TREATMENT(S), MEDICAL	NVESTIGATION(S), OR REFERRAL(S) ARE APPROPRIATE TO ADDRESS THE PATIENT'S INJURY/
INJURIES, AS APPLICABLE	
20. DO YOU EXPECT THE PATIENT TO RETURN TO PRE-CRASH FUNCTION WITH THE ABOVE REC	OMMENDED CARE MANAGEMENT PLAN?
☐ Yes ☐ No ☐ Unable to determine	
If "No" or "Unable to determine", provide comments:	
21. WILL THE PATIENT LIKELY REQUIRE ADDITIONAL THERAPY BEYOND THE ABOVE RECOMMEN	DED CARE MANAGEMENT PLAN?
☐ Yes ☐ No If "Yes", indicate:	
iii les , ilidicate.	
PROGNOSIS AND RECOVERY TIMELINES	
22. PROVIDE DETAILS ON PROGNOSIS:	
23. PROVIDE DETAILS ON ANTICIPATED RECOVERY TIMELINES:	
TREATMENT NOTES	
24. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES?	
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24. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES?  Yes No	26. ANTICIPATED TREATMENT REASSESSMENT DATE (dd/mmm/yyyy)
24. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES?  ☐ Yes ☐ No  If Yes, indicate:	26. ANTICIPATED TREATMENT REASSESSMENT DATE (dd/mmm/yyyy)
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24. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES?  Yes No If Yes, indicate:  25. ANTICIPATED DATE OF FULL RECOVERY (dd/mmm/yyyy)	26. ANTICIPATED TREATMENT REASSESSMENT DATE (dd/mmm/yyyy)
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24. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES?  ☐ Yes ☐ No  If Yes, indicate:  25. ANTICIPATED DATE OF FULL RECOVERY (dd/mmm/yyyy)  ADDITIONAL COMMENTS  ☐ By checking this box, I certify that the information provided is true Select one of the following:  ☐ I have obtained consent from the patient to share all information rethe injury related to the motor vehicle accident with ICBC.	and correct to the best of my knowledge.  elated to the history, examination, assessment and management of
24. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES?  ☐ Yes ☐ No  If Yes, indicate:  25. ANTICIPATED DATE OF FULL RECOVERY (dd/mmm/yyyy)  ADDITIONAL COMMENTS  ☐ By checking this box, I certify that the information provided is true Select one of the following:  ☐ I have obtained consent from the patient to share all information rethe injury related to the motor vehicle accident with ICBC.  ☐ This report is being provided pursuant to a request by ICBC under	and correct to the best of my knowledge.  elated to the history, examination, assessment and management of Section 28 or Section 28.1 of the Insurance (Vehicle) Act.
24. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES?  ☐ Yes ☐ No  If Yes, indicate:  25. ANTICIPATED DATE OF FULL RECOVERY (dd/mmm/yyyy)  ADDITIONAL COMMENTS  ☐ By checking this box, I certify that the information provided is true Select one of the following:  ☐ I have obtained consent from the patient to share all information rethe injury related to the motor vehicle accident with ICBC.	and correct to the best of my knowledge.  Plated to the history, examination, assessment and management of a Section 28 or Section 28.1 of the Insurance (Vehicle) Act.  Information and Protection of Privacy Act (BC) and section 28 or 28.1 of the Insurance claim. Questions about the collection of this information may be directed to the claim.

Return To ICBC

PO BOX 2121, STN TERMINAL VANCOUVER BC V6B 0L6

Fax 1-877-686-4222

## Appendix - Common ICD 9 Codes

INJURY TYPE	ICD 9 CODE(S)		
Mental disorders	300 Neurotic disorders		
	309 Adjustment reaction		
Symptoms, Signs, And III-Defined Conditions	781 symptoms involving nervous and musculoskeletal systems		
Fractures	800 Fracture of vault of skull		
	801 Fracture of base of skull		
	802 Fracture of face bones		
	803 Other and unqualified skull fractures		
	804 Multiple fractures involving skull or face with other bones		
	805 Fracture of vertebral column without mention of spinal cord injury		
	806 Fracture of vertebral column with spinal cord injury		
	807 Fracture of rib(s) sternum larynx and trachea		
	808 Fracture of pelvis		
	809 III-defined fractures of bones of trunk		
	810 Fracture of clavicle		
	811 Fracture of scapula		
	812 Fracture of humerus		
	813 Fracture of radius and ulna		
	814 Fracture of carpal bone(s)		
	815 Fracture of metacarpal bone(s)		
	816 Fracture of one or more phalanges of hand		
	817 multiple fractures of hand bones		
	818 ill-defined fractures of upper limb		
	819 multiple fractures involving both upper limbs, and upper limb with rib(s) and sternum		
	820 fracture of neck of femur		
	821 fracture of other and unspecified parts of femur		
	822 fracture of patella		
	823 fracture of tibia and fibula		
	824 fracture of ankle     825 fracture of ane average together and restate real horses.		
	825 fracture of one or more tarsal and metatarsal bones     926 fracture of one or more phalangue of fact.		
	826 fracture of one or more phalanges of foot     827 other multiple and ill defined fractures of lower limb		
	827 other, multiple and ill-defined fractures of lower limb     828 multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s)		
	828 multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum		
Sprain/strains	840 Sprains and strains of shoulder and upper arm		
	841 Sprains and strains of elbow and forearm		
	842 Sprains and strains of wrist and hand		
	843 Sprains and strains of hip and thigh		
	844 Sprains and strains of knee and leg		
	845 Sprains and strains of ankle and foot		
	846 Sprains and strains of sacroiliac region		
	847 Sprains and strains of other and unspecified parts of back		
	848 Other and ill-defined sprains and strains		
Concussion	850 Concussion		
Contusion	920 Contusion of face, scalp, and neck except eye(s)		
	921 Contusion of eye and adnexa		
	922 Contusion of trunk		
	923 Contusion of upper limb		
	924 Contusion of lower limb and of other and unspecified sites		