Workers Compensation Board of PEI
Promoting Safe Workplaces…Protecting Employers and Workers

PHYSIOTHERAPIST REPORT

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☐ Initial Assessment ☐ Progress Report ☐ Discharge Report ☐ Amended Billing

Claim #	Clinic Name
Name	Address
Injury Date	Phone

Fee Code		Report Only ☐	

Treatment Dates

Total # of Treatments		# Missed Appointments		Reason:

Initial Diagnosis:	Present Diagnosis:

Describe Injury History *(Initial Assessment Only)* /Current Subjective Status:

Initial Objective Findings:	Current Objective Findings:

Goals	Treatment Plan	Time Frames

☐ Education/Home Program Provided ☐ Request for WORK CONDITIONING / WORK HARDENING

Recommended Work Status:	☐ Full Duties ☐ Not Able ☐ Ease back ☐ Modified Duties
Conflicting Circumstances:	☐ None ☐ Compliance ☐ Other Explain:

Physiotherapist's Signature: ______________________

Date: ______________________

EXPECTED RETURN TO WORK DATE: