MANITOBA PUBLIC INSURANCE

INITIAL THERAPY REPORT

☐ CAT 3/Complex

Claim#

Surname of Patient: | Given Name: | Current Age: | Case Manager:

Date of Examination: YYYY MM DD | Date of Collision: YYYY MM DD

Symptoms: List all symptoms that developed as a result of the collision:

Physical Signs:

Neurologic Examination: ☐ Normal. If abnormal, please list deficits below:

☐ Cognitive Deficit — Describe

☐ Sensory Deficit — Cutaneous Territory

☐ Motor Deficit — Muscles Affected

☐ Reflex Changes — Levels Affected

Y	N	**In the 5 years prior to the collision, did the patient:**	Detail positive responses on questions (1-5)
☐	☐	1. Take time off work > 4 weeks because of a previous injury or health problem?	
☐	☐	2. Use prescription or OTC medications on a regular basis?	
☐	☐	3. Experience any significant health problems requiring ongoing care?	
☐	☐	4. Receive any Chiropractic or Physiotherapy treatment? If yes, list date of last treatment.	
☐	☐	5. Experience any problems with anxiety, depression or substance abuse?	

Self-Assessment Tool: (Check and score all that apply/min of 2)

☐ 1. Numeric Pain Rating Scale (NPRS)	_____	☐ 5. Lower Extremity Activity Profile (LEFS)	_____
☐ 2. Roland Morris Back Pain Questionnaire	_____	☐ 6. Disabilities of the Arm, Shoulder and Hand (DASH)	_____
☐ 3. Neck Disability Index	_____	☐ 7. Health Status Disability (SF-12)	_____
☐ 4. Yellow Flags Questionnaire	_____		

Clinical Diagnoses:

Injury Category: _____

List dx to justify Category 3:

Does this condition post a safety risk to operating a motor vehicle? ☐ Yes ☐ No

Work Status: Is patient currently at work? ☐ Yes ☐ No Occupation:

If no, indicate targeted return date to regular duties YYYY MM DD

When can patient begin modified duties? YYYY MM DD

Will a return to the workplace adversely affect the natural history of the clinical condition? ☐ Yes ☐ No

Yes	No	**Does the patient's clinical condition:**	Explain any "yes" answers:
☐	☐	a) Preclude travel to and from the workplace?	
☐	☐	b) Result in an inability to perform required tasks?	
☐	☐	c) Pose a safety/health risk to the patient or their co-workers?	

Management Plan:

1. State the treatment plan and goals:

2. Indicate which of the above therapies require in-clinic supervision:

3. Anticipated frequency (in next 6 wk.) of in-clinic care:

4. Total forecasted duration of in-clinic care:

5. List any prescribed medication and their dosage:

6. List any prescribed splints or other assistive devices:

7. Has a referral been made to another healthcare practitioner? If yes, where:

Identity of Practitioner:

Surname: | Given Name: | Practice PT ☐ AT ☐ | Manitoba Public Insurance Registered Acct #

Address (Number, Street, Apt. No.)

City | Prov. | Postal Code | Tel. No. (Area Code) | Fax #

Though this report is essential, the patient must file a claim with the Manitoba Public Insurance Corporation before a compensation file can be opened.

Signature of Practitioner — Date: YYYY MM DD

Authorization of Patient or Guardian

I hereby authorize the release of this report to MPI in support of my claim.

Signature - Patient or Guardian — Date: YYYY MM DD

If you wish to discuss this patient with a member of Health Care Services, please phone 204-985-8770 ext 7395